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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, June 5, 2017, at 9:30 a.m.

Yvette Arnold,
Court Reporter

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1 A P P E A R A N C E S :

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DR. PAMELA MURPHY,
Committee Chair

3

4 DR. MARK PAPISH,
Medical Director

5

DR. BERKOWITZ,
Helicopter Subcommittee

6

7 WILLIAM HUGHES, EMT
HVREMSCO Executive Director

8

JEFFREY CRUTCHER,
QI Coordinator

9

10

11

GOOD SAMARITAN HOSPITAL

12

DR. DENNIS MAO,
Director

13

14

HEALTH ALLIANCE OF THE HUDSON VALLEY

15

DR. GUTMAN,
Director

16

17

NYACK HOSPITAL

18

DR. RABRICH,
Director

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ORANGE REGIONAL MEDICAL CENTER

21

DR. McGINLEY,
Physician Representative

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1 PUTNAM HOSPITAL CENTER
2 DR. BUTTERFASS,
Director
3
4 MID HUDSON REGIONAL HOSPITAL OF WMC
5 DR. PAPISH,
Director
6
DR. BERKOWITZ,
7 Physician Representative
8
ST. LUKE'S CORNWALL HOSPITAL
9
DR. SCOTT HILL,
10 Director
11
SHARON HOSPITAL
12
DR. SANTOS,
13 Director
14
15 WESTCHESTER REMAC LIAISON
16 DR. ERIK LARSEN,
Physician Representative
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20
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1 A P P E A R A N C E S :

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3 DAVID VIOLANTE
MIKE BENENATI
4 RICHARD PARRISH
ISRAEL KNOBLOCH
5 MATT NOLAN
TIM MURPHY
6 JOE SOLDA
GUY CARPICO
7 KEVIN GAGE
DAVID GRASS
8 KATHRYN MININI
B.J. LEIDNER
9 MATTHEW BRENNAN
MICHAEL MURPHY
10 CHRISTOPHER PRICE
ANU GOPALAN
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1 Proceedings
2 DR. MURPHY: All right, if everybody is
3 ready we will get started. We can start and
4 we'll get everything going.
5 The attendance sheet is coming around if
6 everyone could sign in.
7 Thank you for coming this morning. The
8 minutes went out attached to your agenda for
9 this morning. Hopefully, people read them.
10 And if I have any motions for corrections,
11 additions, deletions, please make them now.
12 Otherwise we'll approve them --
13 MS. DELAUNAY: I checked everyone off.
14 DR. MURPHY: Okay. Any problems with
15 the minutes?
16 DR. MAO: Motion to approve.
17 MR. PARRISH: Should you do the roll
18 call first?
19 DR. MURPHY: We don't -- well, we can if
20 you want --
21 (Discussion held off the record.)
22 So Dennis is the first motion. A
23 second?
24 DR. McGINLEY: Second.
25 DR. MURPHY: Thank you. So I might be

1 Proceedings
2 amiss, however, I'm Pam Murphy. I don't know
3 you, Jeffrey, you are new from Nyack?
4 DR. RABRICH: I am.
5 DR. MURPHY: Okay, introduce yourself a
6 little bit.
7 DR. RABRICH: I'm Dr. Jeffrey Rabrich.
8 I took over at Nyack ER a month ago. I have
9 a long history of EMS in the region. I
10 started with Ramapo Volunteer Ambulance Corp
11 in Rockland County and worked many years with
12 Rockland Paramedics Services --
13 DR. MURPHY: You had to worked with
14 Murphy?
15 DR. RABRICH: Yes, I had to work --
16 DR. MURPHY: I'm sorry.
17 DR. RABRICH: Currently medical director
18 for Tactical Medical Support Unit, Rockland
19 Paramedics subspecialty board in EMS and also
20 the vice-chair of New York City REMAC.
21 DR. MURPHY: Perfect. Thank you for
22 coming.
23 Okay, so this morning we have some old
24 business to go over and then we have some
25 upgrades and we will make our way through.

1 Proceedings
2 It's a pretty hefty agenda, but you know me,
3 I can fly.
4 So under old business, the 2017
5 collaborative protocols rollout update.
6 Mikey?
7 MR. BENENATI: So we are still working
8 on the policy procedures manual, that's all
9 of the pieces that came out of the
10 collaborative from its last addition. We are
11 breaking them and putting it into individual
12 policies. There will be one on medication
13 and medical control, transfer of care,
14 aeromedical utilization, emergency incident
15 rehab, specialty care transport, medication
16 facilitated intubation, which is now again
17 called RFI and clinician on scene.
18 One of the things that we did want to
19 bring before the body today was use of OG
20 tubes. It's in the collaborative protocols
21 and we'd like the region to adopt that.
22 DR. MURPHY: So what the point there
23 is -- and they have been using it in other
24 regions -- is to place the OG tube just to
25 decompress the tummy and help facility proper

1 Proceedings
2 oxygenation and good CPR and compressions and
3 take some of the resistance away. So they
4 have been using it in other regions, we just
5 never had and so it's a new addition of -- to
6 our protocol. So we wanted to bring it forth
7 to you guys this morning and open it for
8 discussion and then vote.
9 Any discussions about OG tubes? Don't
10 everybody talk at once.
11 So a motion on the floor? You want to
12 make -- I'll make a motion on the floor.
13 Motion on the floor to accept the
14 protocol to include administration and
15 application of OG tubes for patients that
16 require it during the resuscitative phase.
17 All those in favor?
18 So we have -- unanimous.
19 Thank you everybody.
20 Go ahead, Mike.
21 MR. BENENATI: There was discussion with
22 regards to BLS protocols and agencies and
23 providers following the collaboratives. At
24 the last SEMAC SEMSCO meeting it was
25 announced that protocols are both driven by

1 Proceedings
2 the State as well as a regions. Therefore,
3 the regions are allowed to have BLS providers
4 follow the collaborative protocols. We
5 discussed this at the last protocol meeting
6 and the State is actively working on the
7 development of New York State BLS protocols.
8 They look very similar to that of the
9 collaboratives and Dr. Dailey is spearheading
10 that group.
11 And so it's the recommendation of the
12 protocol committee to not rollout any
13 education from the region at this point for
14 BLS providers and wait and see what the state
15 does. They are hoping to bring the first
16 copy for approval at the September meeting.
17 So rather than try to roll this out over the
18 next couple months and confuse providers with
19 a new one potentially coming out by the end
20 of the year we just decided that we'd bring
21 to you to just hold off on any BLS education.
22 DR. MURPHY: Yeah. And what it will be
23 is much more smoother rollout and we will all
24 do it at the same time and all be on the same
25 page of using the same resources again, just

1 Proceedings
2 like ALS so it only makes sense for us to
3 wait on that and roll it forward when it's
4 ready.
5 MR. HUGHES: One question on that. The
6 BLS protocols, the original collaborative BLS
7 protocols were rolled out and some of the
8 agencies are using them. So will they be
9 allowed to use them as well as the New York
10 State?
11 MR. BENENATI: Yeah. Lee made it very
12 clear that providers could follow either the
13 collaboratives or the New York State and be
14 within their scope of practice. It's just
15 that educational component bill that we don't
16 want to confuse everybody about, but a
17 provider could use either protocol and be
18 within their scope.
19 There are also several things that are
20 in the new collaboratives that the region
21 needs to discuss with regards to reporting
22 and it's the recommendation of the protocol
23 committee to just do this. So that there
24 would be a monthly report that would be
25 provided by the agencies that would report

such things -- and, Jeff, let me know if I miss any -- needle decompression, chemical restraint and excited delirium, a requirement that medical control be contacted for adult and pediatric hypoglycemic patients wishing to refuse transport, OG use, pediatric allergic reaction, contact medical control for an RMA, and also approve the use of nasal tracheal intubation.

So those are pieces that are all regional options in the collaboratives that we want to move forward with all of those.

DR. MURPHY: Okay. Now, it's really more so part of the educational process and people get to see all those things so it's really more a notification because it was all in there. It does change what some people do, we have one agency that has applied for and has received, I believe, their ketamine?

MR. HUGHES: Um, um.

DR. MURPHY: And that's just the one. So I think that otherwise we can just move forward because we don't have to act on that, that's more just a passing along the

1 Proceedings
2 information --
3 MR. BENENATI: That's all I have.
4 DR. MURPHY: Okay. Great.
5 Narcan update, Bill?
6 MR. HUGHES: Jeff, do you have it?
7 DR. MURPHY: Jeffrey -- I'll pass that
8 baton all the way around.
9 MR. CRUTCHER: We finally did get
10 another shipment of Narcan about a month ago.
11 By the day after we had about half of it
12 left. We have gone through -- we have
13 distributed approximately 900 doses so far
14 this year, which has already exceeded what we
15 did last year total. We still have some
16 agencies that have yet to apply. We are also
17 waiting on some agencies to submit the
18 training plans.
19 The last set of paperwork that we
20 received was from Kiryas Joel last week,
21 their paperwork is complete, the training
22 plan is complete. We should probably bring
23 that up for approval this morning and we can
24 give them their Narcan before they leave
25 today.

1 Proceedings
2 DR. MURPHY: Okay. I'm sorry, somebody
3 just sent me a text -- who was it for, Kiryas
4 Joel?
5 MR. CRUTCHER: Kiryas Joel.
6 DR. MURPHY: Okay. You want to do it
7 now? We will do it now so you have completed
8 application, everything is there?
9 MR. CRUTCHER: Everyone is there.
10 DR. MURPHY: So basically with these
11 processes it's really us just saying we want
12 to facilitate people getting Narcan and put
13 it out there.
14 The process is the agency puts together
15 the application, gets all their ducks in a
16 row, gets their educational process, makes
17 sure all their people are on board, sends all
18 the information to the office, we sign off on
19 it, make sure it's all there, and that the
20 feedback will be there, we get the cases, we
21 get the data back and then we're really just
22 giving it a blessing.
23 So this morning why don't we -- we will
24 make a motion for approval of K.J. to
25 participate in the Narcan program with a

1 Proceedings
2 completed application and completed processes
3 that are all substantiated.
4 And I put a motion out there to approve
5 them for Narcan.
6 All those in favor?
7 Great. Again, we are unanimous.
8 And I can announce this one too at the
9 same time. We have two agencies that are
10 service upgrades, you will see them on the
11 agenda.
12 Cragsmoor Fire Department has BLS first
13 responder program and Putnam Lake Fire
14 Department has a BLS responder program. And
15 they too put through all the paperwork, was
16 all approved. And, actually, we have the
17 letter back from the Department of Health
18 that they even have their agency code numbers
19 already.
20 So both Cragsmoor and Putnam lake are
21 approved. They are registered into the
22 agency code and CME process. And really,
23 again, a notification for the region, but
24 something that -- this is great, everybody
25 moving forward doing upgrades. It's all good

1 Proceedings
2 stuff.
3 MR. HUGHES: We need a vote on that
4 also.
5 DR. MURPHY: Okay, guys, I have to vote
6 again. To vote on Cragsmoor Fire Department
7 for their BLS first responder upgrade, all
8 those in favor?
9 Anybody know where Cragsmoor is? It's
10 like the most beautiful place. Actually,
11 it's Sullivan County really, right --
12 MR. BENENATI: No, Ulster --
13 DR. MURPHY: It's still Orange --
14 DR. LARSEN: It almost got wiped out by
15 the large fire.
16 DR. MURPHY: It's Ulster?
17 MR. BENENATI: Yes.
18 DR. MURPHY: I guess you crossover --
19 DR. LARSEN: You go up 52, your general
20 approach is 52, towards Ellenville.
21 DR. MURPHY: It's beautiful. You can
22 hike up there and like they say Cragsmoor,
23 crags are the elevated mountains in Scotland
24 is where they came from. And it's filled
25 with Scottish people, I know so many Scottish

1 Proceedings
2 people that live up there. It's a beautiful
3 area. Okay, I digress.
4 Next one is Putnam Lake Fire Department
5 BLS first responder. And they also were
6 approved.
7 Again, asking the committee here, all
8 those in favor?
9 Unanimous again. Thank you, guys.
10 So on the agenda I skipped over it, but
11 we will jump back -- hospital diversion. I
12 don't have anything more on this. Yeah, I
13 think it's -- anybody has anything more to
14 add? We were watching it and making sure
15 that diversion didn't become an issue. You
16 know, we utilized the resources of
17 Westchester where you can go onto the site
18 and look at every single time someone asks
19 for diversion and goes on diversion and all
20 the tally --
21 DR. PAPISH: I think there was some plan
22 to send a letter out to all the CEOs and all
23 the players involved --
24 DR. MURPHY: We did that.
25 DR. PAPISH: We did that?

1 Proceedings
2 DR. MURPHY: Didn't we do that, Karen?
3 We did that -- that this committee favors no
4 diversion, right?
5 MS. DELAUNAY: I don't know.
6 MR. BENENATI: I don't believe that
7 went --
8 DR. MURPHY: It didn't --
9 (Everyone is speaking at once.)
10 MR. BENENATI: There was discussion, we
11 were going to write a policy to was there
12 not -- there was a policy that was going to
13 be written, the manual from Westchester would
14 be distributed and the distribution was going
15 to occur and that has not --
16 DR. PAPISH: It was stuck on the letter.
17 MR. PARRISH: Wasn't it supposed to be
18 the OEM dispatch centers advised to follow
19 it --
20 DR. MURPHY: Yep, but I thought you
21 didn't want the letter to go out so that's
22 why we stopped it, I think. Because you said
23 you wanted something else done before the
24 letter went out. You wanted to make sure --
25 do you remember? You wanted to make sure --

1 Proceedings
2 DR. PAPISH: I wanted to vote to get rid
3 of it of and then Arshad said, wait, we have
4 to bring everyone involved --
5 DR. MURPHY: Maybe it was Arshad that --
6 somebody stopped it that day. Remember we
7 had to table it? Maybe it was Arshad --
8 DR. PAPISH: I think we said we were
9 going to send a collaborative letter saying
10 this is what we feel is best for the region
11 and this is what we are doing. And once that
12 circulated I thought we were going to revisit
13 the issue to sort of vote to potentially get
14 rid of diversion except for specialty --
15 DR. MURPHY: Yes, the emergency kind of
16 processes, like you guys at Westchester.
17 DR. BERKOWITZ: We don't have general
18 diversion anymore except disaster --
19 DR. MURPHY: -- disaster or emergency
20 inside the facility. Since he is not here,
21 let's have a vote. Because I'm pretty
22 sure -- I wasn't sure how it stopped, but you
23 are right we had to put it on hold because he
24 wanted to make sure --
25 DR. PAPISH: Frankly, we sort of stopped

1 Proceedings
2 it because as I recall we were talking about
3 it for about 45 minutes.
4 But the -- I don't know -- I mean it's
5 nice that we send a collaborative letter to
6 the CEOs, but I think they are aware of
7 whether they're holding patient in the --
8 DR. LARSEN: They aren't. You know, I
9 mean, look, this is still a chronic problem
10 for emergency medicine, that they are not
11 moving patients up fast enough from the
12 thing. So I think we should definitely send
13 it out --
14 DR. MURPHY: Yeah, I think it gives our
15 --
16 DR. LARSEN: -- and we probably have to
17 repeat it every year, you know, because until
18 these folks finally get it --
19 DR. PAPISH: They are complicit in it
20 because --
21 DR. LARSEN: I think we need to push
22 it --
23 DR. RABRICH: Yeah. And I would
24 reference the letter sent by the
25 commissioner regarding ED overcrowding --

1 Proceedings
2 (The speaker cannot be understood.)
3 DR. RABRICH: -- where they specifically
4 talk about diversion and you need to activate
5 your disaster plan in regard to diversion
6 so --
7 DR. MURPHY: You weren't here Jeffrey,
8 but what we were discussing is, we as a body,
9 could say, we don't believe in diversion.
10 You can do it on an emergency basis, you
11 know, a disaster, lab --
12 DR. RABRICH: Facility issue --
13 DR. MURPHY: Facility issue, something
14 that is out of your control. Hurricane comes
15 and takes you out, that's what we are looking
16 at. Westchester had, you know, a pretty
17 straightforward -- you read us part of the
18 letter too.
19 DR. BERKOWITZ: Yeah. And that was a
20 couple years ago and it's helped a lot.
21 DR. MURPHY: Yeah. So we as a body
22 wanted to do it, but we did have one
23 dissension that was, let's wait -- so let's
24 vote again.
25 So all those in favor, I would like to

1 Proceedings
2 draft a letter to go to all the CEOs of
3 hospitals and as Rich aptly pointed out, we
4 want it to go to each one of the 9-1-1
5 dispatch centers. And what we would say is,
6 our policy, our stance is that we just don't
7 believe that diversion is good for our
8 community, for our patients --
9 DR. RABRICH: It's bad public policy.
10 DR. MURPHY: -- bad public policy, I'll
11 quote you.
12 And that we send this out, you know,
13 with all of us on it. You know, we can list
14 all of our names on there and as a body, as a
15 group, as a medical advisory committee to the
16 area, this is our stance.
17 All those in favor? Great.
18 Unanimous again.
19 DR. HILL: Can we talk about enforcement
20 now?
21 DR. MURPHY: Yes, absolutely --
22 DR. PAPISH: If you have somebody that
23 is chronically -- you know, we say it's a
24 problem, but we haven't really had to address
25 it. When we looked at the listing for last

1 Proceedings
2 year there was one hospital that was
3 problematic and they fixed themselves, pretty
4 much.
5 DR. MURPHY: Yeah. It was -- it
6 became -- the administration that they didn't
7 really realize how many times it was
8 happening. And what was happening was,
9 people at the mid management level were
10 calling for it and the real administrative
11 people on-call -- one person who was there
12 like your on-call person in the middle of the
13 night who had no clinical stuff was being
14 called and it was going on. So once that
15 quantity was brought to them and showed and
16 the processes -- so, yeah, I'll take
17 responsibility for that one, but it's really
18 since January 15th there's been none.
19 DR. PAPISH: And take credit for it too.
20 DR. MURPHY: No. No. It's everybody's
21 work. It's everybody's work. But it's a
22 thing where it really was a thing, he didn't
23 realize the amount.
24 DR. LARSEN: Well, I mean, after we
25 implemented it in Westchester, you know,

1 Proceedings
2 basically if someone starts asking for
3 diversion, John and I will get called by
4 Michael Volpe from EMS and Westchester County
5 and he will let us know. And so then we did
6 a little investigation and, you know, so it
7 was that kind of same thing. There was just
8 like, okay, no one really knows what the rule
9 is and then some administrator says, you
10 know, hey, you know what? We are getting
11 overflow, let's go on diversion and they
12 started kicking it over there. So anyway
13 that came to an end, so it the same thing.
14 Sometimes it is -- it's new folks coming in,
15 it's -- you know, administrators unfamiliar.
16 So it's helpful if the policy is in
17 place and then, you know, there is a feedback
18 mechanism so that if it starts -- the
19 violations start happening you can get on top
20 of before it goes anywhere.
21 DR. BERKOWITZ: Yeah. And I think the
22 website is useful in requiring any kind of
23 diversion to be through the website because
24 you can track it at the onset. And I think
25 that's something regardless of we can make a

1 Proceedings
2 very hard policy on that. It's hard to say
3 there have been cases in Westchester where
4 someone went on diversion and people are like
5 oh, you know, it wasn't -- it wasn't the end
6 of the world, you know. The goal isn't to,
7 you know, make everyone's life harder, but it
8 reduced it dramatically. But the thing that
9 is helpful is to have the tracking ability
10 and you can make a policy that says if you
11 want to go on diversion you have to go to the
12 website and say that.
13 DR. LARSEN: I think that should be
14 added into that because that tracking, you
15 know, thing is good. And it's also good for
16 sort of disaster and MCI response because it
17 puts all the hospitals in at least one place
18 where people know to go and see what their
19 status is and availability and their
20 capabilities, it has that too. So that's the
21 kind of stuff we need to centrally track --
22 DR. MURPHY: Okay, Karen, ready? We are
23 doing this after the meeting.
24 MS. DELAUNAY: What?
25 DR. MURPHY: The letter, okay?

1 Proceedings
2 MS. DELAUNAY: Okay, you and Jeff can
3 work on that.
4 MR. BENENATI: It's important also that
5 the 9-1-1 centers be educated with regard to
6 this system because certainly the ones in the
7 upper portion don't use that today. So as
8 that gets built into the letter the 9-1-1
9 centers need to know how to use it that and
10 need the access to it.
11 DR. MURPHY: We can add it onto the
12 bottom of the letter and just explain it is a
13 centralized tracking system --
14 DR. LARSEN: Yeah, it's run out of 60
15 Control.
16 DR. PAPISH: And everybody already has
17 an account, if they don't know the password
18 they can send it out.
19 MR. BENENATI: And the manual can go out
20 with the letter right, Bill? You have a
21 manual so that should go out with the letter
22 so they have a new copy.
23 DR. BERKOWITZ: The manual is a little
24 bit annoying so I wrote a one page document
25 on it to put with all the other one page

1 Proceedings
2 documents in the ER on the Board.
3 (Everyone is speaking at once.)
4 (Discussion held off the record.)
5 DR. MURPHY: You want to just send it to
6 the office because I think it's better to
7 send a one pager than the whole manual --
8 DR. BERKOWITZ: Well, I can give you
9 both because there is some functionality in
10 the manual that I couldn't put in the one
11 pager. But for general how to use it and
12 that kind of stuff, it's enough, you don't
13 need 15 20 pages.
14 DR. PAPISH: You almost can do it if you
15 have the log in and never learned.
16 DR. BERKOWITZ: Well, we say that. And
17 then someone calls us at 3:00 in the morning
18 saying I don't understand.
19 DR. MURPHY: All right, great. Thanks,
20 guys.
21 We are down to evaluation subcommittee
22 report.
23 I don't think we had anything, right?
24 Dr. Arshad is not here, but I don't think we
25 had any issues.

1 Proceedings
2 MR. HUGHES: No.
3 DR. PAPISH: No badness.
4 DR. MURPHY: No badness.
5 Dr. Berkowitz, helicopter committee
6 report?
7 DR. BERKOWITZ: Nothing really new on
8 the helicopter front. Unless anyone had
9 issues of recent there is no report.
10 DR. MURPHY: This is going quite fast.
11 RTAC?
12 DR. BERKOWITZ: I'll speak to that.
13 So a couple things, their PI project for
14 RTAC, the last one they did is regarding
15 transfer times and the focus now is regarding
16 oxygen. Both on, I think, the two main
17 groups of patients they are looking at are
18 interfacility transfers with TBI and, you
19 know, significant TBI, but not intubated. So
20 that's one we are looking at. And the other
21 one is scene calls where they have
22 significant trauma.
23 And they are still working on the
24 parameters. They did share some data
25 regarding patients that arrived that are on

1 Proceedings
2 oxygen and clearly pretty significant
3 patients who were hypotensive and in shock,
4 who might not be hypoxic, but certainly would
5 have warranted to have oxygen on.
6 And I think that we should be
7 encouraging that. And I spoke to them about
8 the methodology because I wanted to make sure
9 they weren't missing patients who maybe had
10 the oxygen pulled coming from the ambulance
11 into the hospital. And they said they are
12 reading the PCRs and a lot of times someone
13 was asking the crew when they arrived if the
14 patient had oxygen en route.
15 So I think it was a pretty reasonable
16 assessment they put together and I think
17 that, you know, generally they are going to
18 go forward with it.
19 So just putting it out there, that they
20 be looking at that as a QI project. Because,
21 you know, this is so EMS heavy, the RTAC
22 project. I'm going to, you know, I'm talking
23 to them to get really anyone in the EMS
24 community, specially the county coordinators
25 and those folks, invited to all the RTAC

1 Proceedings
2 meetings so they could participate so it's a
3 bigger table. So you should expect to see
4 more people on that.
5 DR. MURPHY: Yeah, you just can't vote,
6 anybody can go --
7 DR. LARSEN: Just a little bit more on
8 this, so the study came out -- this is out of
9 the Epic trial, I guess, wasn't it?
10 DR. BERKOWITZ: Epic one in Arizona --
11 DR. LARSEN: Yeah, the one in Arizona
12 where they are really trying to look at the
13 whole oxygenation thing from the data that
14 they are reporting is that someone who has a
15 significant head trauma one episode of below
16 90 percent oxygenation has something like six
17 times worse outcome in terms of their coming
18 out of traumatic brain injury. So pretty
19 important thing. So the guidelines -- I'll
20 just read these, the prehospital
21 identification of moderate to severe TBI. I
22 think it's the first category, any injured
23 patient with a loss of consciousness
24 especially those with GCS less than 15, or
25 confusion, or multisystem trauma requiring

1 Proceedings
2 intubation -- yeah, no kidding -- and post
3 traumatic seizures, whether they are
4 continuing or not. So the last two, pretty
5 obvious. We are going to probably be tubing
6 them or certainly giving them full oxygen.
7 But it's that any injured patient, see, what
8 they were starting to see was folks that were
9 coming in, vital signs are stable, you know
10 maybe -- whatever, they have a broken arm,
11 something, some other trauma stuff going on,
12 but then they find out that actually this
13 person got knocked out. Okay? And probably
14 has at least some type of concussion or
15 something and so far the data shows oxygen
16 helps in that kind of situation and so those
17 people should be oxygenated. And those are
18 the people I think that were sort of slipping
19 through the cracks. So that's one of the
20 things that they are really --
21 DR. RABRICH: What study is this?
22 DR. LARSEN: This was -- I think it's
23 called the Epic study. And they came out
24 with the Epic TBI, traumatic brain injury,
25 algorithm for adults. So I think they are

1 Proceedings
2 really doing a pretty hard study on this in
3 Arizona somewhere.
4 DR. RABRICH: I don't think we honestly
5 know the answer, if someone is saturating and
6 they are concussed I don't think it is --
7 DR. LARSEN: Yeah, okay, but at least
8 this is --
9 DR. RABRICH: -- before we reverse
10 course and start confusing our providers I
11 think we should be clear on the data.
12 DR. BERKOWITZ: I think the groups the
13 study is looking at are the more severe. I
14 don't think they are actually looking at
15 patient with GCS of 15 and LSC, and I don't
16 think that -- that was in the data that the
17 trauma presented, that wasn't the group they
18 presented. They were presenting people who
19 were coming in hypotensive, severely injured,
20 maybe with or without head injury, regardless
21 of that they should have a breather on them,
22 as well as transfers with -- where the
23 patient was GCS and transferred for head
24 injury and they were also without oxygen. I
25 think that, you know, in general that the

1 Proceedings
2 minor head injury group, which I think we all
3 agree, GCS 15 with LSC, would fall into --
4 the data is not on that, I think that's not
5 part of the focus. And I will, for the sake
6 of interests and -- I'll make sure I get
7 their criteria that they have because I think
8 it's different from what they are doing in
9 Phoenix. There definitely is a group of
10 patients when he put the data up, everyone is
11 like, wow, I can't believe that, you know, we
12 didn't --
13 DR. PAPISH: I think, you know, what you
14 just said, we know it's harmful if the sats
15 are low, but we haven't proven anything.
16 When they are above 93 or 94 is it really
17 beneficial, right?
18 DR. BERKOWITZ: Yeah, there -- if there
19 is nothing benefiting they have to have an
20 injury where they have potential of
21 decompensation that they are preventing
22 hypoxia.
23 DR. RABRICH: Right. You are trying to
24 prevent the desaturation that may or may not
25 occur --

1 Proceedings
2 DR. BERKOWITZ: Exactly. You know, in
3 the world of trauma outcomes are so good and
4 mortality is so low in the trauma center that
5 it's hard to get -- you are really looking at
6 preventing things because it's not the era --
7 DR. RABRICH: That becomes somewhat
8 theoretical because you are trying to --
9 DR. BERKOWITZ: Correct --
10 DR. PAPISH: We don't know.
11 DR. BERKOWITZ: But we do know that --
12 the hypoxia especially with hypotension
13 really worsens the outcome, we do know that.
14 So we know that a certain percentage of
15 patients do deteriorate en route and we are
16 trying to figure out --
17 DR. RABRICH: -- out to identify those.
18 DR. LARSEN: The other addition in the
19 study is certainly in the matter of
20 ventilation, they also talk and caution very
21 heavily against hyperventilation, so that's
22 the other end --
23 (Everyone is speaking at once.)
24 DR. LARSEN: So that's the other sort of
25 corollary to that is -- so, yeah. I don't

1 Proceedings
2 think it's -- but just something to be wary
3 about. And so that's one of -- certainly one
4 of the focuses of what they are looking at.
5 DR. BERKOWITZ: The other thing is after
6 the RTAC they had a training on Stop the
7 Bleed, which is ACS, essentially kind of a
8 first aid type of program for -- you know,
9 for civilians and a bunch of us got trained
10 as instructors. And I'm going to see -- they
11 had like a box of gear and stuff after one of
12 the REMACs -- Hudson Valley REMAC. If you
13 folks want I can put together a training
14 session and training instructor session
15 potentially to really widen the scope. So,
16 you know, I'll put that out there and if you
17 want me to set it up, let me know. I'll look
18 at it.
19 DR. PAPISH: Do we get a box?
20 DR. LARSEN: Yeah -- yeah, it is a good
21 thing. And basically you can turn everyone
22 into instructors here pretty quickly, that's
23 the way this course is setup. So I think
24 it's a very important thing to -- it's good
25 for certainly all first responders, but it's

1 Proceedings
2 something that they are pushing out into the
3 public. Just like you have a D box posted in
4 a public spot like an airport, right next to
5 it you'll have a Stop the Bleed box that you
6 are going to rip open and it will set off an
7 alarm and signal appropriate -- but it will
8 have things like, you know, clotting stuff,
9 tourniquets, that kind of stuff in it.
10 DR. BERKOWITZ: We can talk afterwards,
11 but if there is interest we will make it
12 happen.
13 DR. MURPHY: Okay, great. Thank you.
14 MR. BENENATI: When is the next RTAC?
15 DR. BERKOWITZ: It's after --
16 DR. LARSEN: -- has not been set.
17 MR. BENENATI: It's hard to find that
18 information out. I mean, if we want to
19 increase attendance, maybe you can get the
20 stuff and, Bill, you can put it up on the
21 website and push it out. But finding the
22 dates of RTAC is difficult --
23 DR. BERKOWITZ: Yeah, there is -- well,
24 like all trauma centers there is always a
25 change of personnel. I'm trying to get a --

1 Proceedings
2 because we are focused on EMS we need to make
3 it as open a table as we can. I'll make that
4 that everyone is involved.
5 DR. MURPHY: Okay, great. Thanks.
6 Quality improvement report, Jeff?
7 MR. CRUTCHER: EPCRs remains a big
8 topic. We have ESO coming here today after
9 the REMAC meeting about 12:30. Again,
10 tomorrow Mid Hudson Regional from 10:00 to
11 noon. And, again, any agency, agency
12 representatives, anybody interested in how
13 the data moves and where it's going and how
14 to get the data culled back from the
15 hospitals eventually, more than welcome to
16 attend. They will be supplying some food and
17 refreshments.
18 The other portion that we are looking at
19 is, per New York State, the final move to the
20 Nemesis 3 Bridge should be, theoretically, in
21 place the end of this month. Although we
22 have heard this rumor before, we are hoping
23 there is some truth to it this time and Mike
24 Taylor has assured us that they are ready.
25 DR. MURPHY: Okay, thank you.

1 Proceedings
2 Protocol committee? Did you cover
3 everything under collaboratives? Oh, you
4 want to talk about the manual?
5 MR. BENENATI: No, I -- did I -- I got
6 everything covered.
7 DR. MURPHY: Are we going to send that
8 manual out so everyone can look at it and
9 comment?
10 MR. BENENATI: Yeah. We're going to
11 discuss it more on Thursday, the components
12 and then once we do we will push it out in a
13 draft --
14 DR. MURPHY: Okay, so the manual is --
15 we mentioned this the last time -- the manual
16 is all the stuff we removed from the
17 protocols that doesn't have to do with the
18 whole collaborative committee and really is
19 our local stuff. And so that's what Jeff and
20 the protocol committee are organizing in a
21 separate manual. We'll get it out to
22 everybody when it's in a usable format.
23 Thanks.
24 Okay, under new business, there was a
25 memo and some e-mails out and about about the

1 Proceedings
2 EpiPen recall. Just wanted to bring it to
3 everybody's attention to please make sure you
4 look at your equipment. The Milan company
5 has setup a website that you can go on for
6 updates on the recall information and how to
7 replace the product. So just go onto
8 milan.com has EpiPen recall as the site. But
9 we wanted to make sure everybody out there
10 with them checks their equipment.
11 MR. HUGHES: Can I just speak on the --
12 since we are on the topic of epi, the Check
13 and Inject Program has been approved by New
14 York State. The policy is out and the
15 requirements are out under a new policy for
16 this year. So as a region I think we have to
17 decide if we are going to participate in the
18 Check and Inject. I think it's left on a
19 regional level, we had something --
20 MR. VIOLANTE: There is also more
21 information with that from the State. The
22 State actually has changed the scope of
23 practice of EMT to include the ability to
24 draw up and administer using syringe needle
25 and vial epinephrine only in the case of

2 anaphylaxis and severe allergic reaction. So
3 there is a training program dealing with
4 that, it's all set by the State. It's being
5 rolled out as a requirement to new EMT
6 programs and as a component of refresher
7 programs. So that will -- that is a thing
8 now. So you may get EMTs to call in to
9 administer epinephrine and this is all --
10 DR. MURPHY: Check and Inject --
11 MR. VIOLANTE: It's a function of much
12 Check and Inject and gouging by the
13 pharmaceutical company.
14 DR. MURPHY: It was that company. But
15 didn't the State change part of Check and
16 Inject because of the special syringe we
17 used? They changed --
18 MR. PARRISH: Yeah. It used to be that
19 you got the kit with a special syringe that
20 was marked with P for the pediatric dose and
21 A for -- that you would just draw up to. Now
22 they have changed because they can not
23 recommend a specific brand, all right? So
24 now you have to be trained to use a one
25 milligram syringe with a number 23 needle,

1 Proceedings
2 you draw it up. And they did change that it
3 could be given IM in the deltoid, not just in
4 the thigh and there was some discussion about
5 that.
6 The training is mandatory or all CIC,
7 CLIs, you have to go on-line to sign for it.
8 And as Dave mentioned, it's incorporated now
9 in all basic training programs.
10 MR. BENENATI: Just some additional
11 information, if anybody wants to look it up
12 it's 17-06, called syringe epinephrine for
13 basic EMT. As Rich said, one ml syringe 23
14 gauge, one inch safety needle. And, yeah,
15 it's pretty simple. There is no reporting to
16 the region, there is for BLS agencies need to
17 report to the State with their intent and a
18 revised medical director form. But other
19 than that it's not called Check and Inject,
20 it does not require their equipment and
21 agencies can begin roll it out on their own.
22 MR. VIOLANTE: Only for epinephrine --
23 MR. BENENATI: That's correct.
24 DR. MURPHY: Yeah. Yeah. And only in
25 the clinical scenario of anaphylaxis

1 Proceedings
2 supposedly.
3 MR. BENENATI: Correct.
4 MR. PARRISH: But -- that's not in here.
5 But if you got a severe asthmatic you can
6 call in and get medical direction to give the
7 epi, so does that apply, or you still have to
8 have the Epipen for that?
9 MR. BENENATI: I think it's --
10 DR. MURPHY: Well, they're replacing the
11 EpiPens with this apparatus so I would think
12 they would be using that because they gave
13 approval for the EpiPen to treat asthma in
14 certain scenarios. They are going to have to
15 clarify that.
16 MR. HUGHES: Well, once it's in the
17 scope of practice they can use the injectable
18 epi. It will still be in the scope of
19 practice to use it for the asthma.
20 DR. MURPHY: All righty then, so -- and
21 you talked about BLS protocols that is coming
22 down. We will wait for the final product to
23 come down and then we'll discuss it again.
24 I put on the agenda this morning
25 psychiatric patients and dispositions of

1 Proceedings
2 patients, determination where do these
3 patients go?
4 We had a meeting with the Office of
5 Mental Health and a bunch of other players to
6 talk about the problems with psychiatric
7 patients in this region. It's really an
8 issue since we have lost so many beds and
9 it's become kind of catastrophic. Where
10 these patients end up, how these patients end
11 up, and what is the disposition of them?
12 It's even more impressive with the adolescent
13 group because no one has beds for these kids
14 anymore. So when it comes to the pediatric/
15 adolescent group it's really become
16 catamount. We are having some patients stay
17 in hospitals for days awaiting a bed and
18 still not getting a bed.
19 So the Office of Mental Health reached
20 out and said that they have submitted plans
21 for institutions who do not have psychiatric
22 services, that the patients get cleared and
23 evaluated in the emergency department. And
24 what they have said, especially like St.
25 Luke's, is that the mobile mental health unit

2 is supposed to come when they call to
3 evaluate every single patient to decide, do
4 they have a mental health issue that requires
5 inpatient hospitalization for psychiatric
6 disorder?
7 So it's on the forefront because there
8 is so many issues and these patients are just
9 having such a terrible time. So, please,
10 people, realize we still want patients going
11 to the institution that is the closest nearby
12 and that they need to be evaluated and mobile
13 mental health is there -- is supposed to be
14 called to help evaluate the patient from a
15 mental health perspective.
16 And they can be called to a scene. We
17 don't realize that mobile mental health can
18 be called to a home to evaluate a patient
19 and, you know, decide.
20 DR. PAPISH: Is it the mobile -- like
21 Dutchess County mobile crisis who is --
22 DR. MURPHY: It's -- mobile mental
23 health here is Dutchess County mental health
24 crisis, they just name it differently in each
25 county.

1 Proceedings
2 DR. PAPISH: Same organization?
3 DR. MURPHY: Yep. And it's supported by
4 the State. And we realize that a lot of
5 people aren't using it because -- I didn't
6 know actually that they were obligated to go
7 do those evaluations. So that's what has
8 been brought forward by the commissioner.
9 So more to come, they are working on
10 trying to solve some of the issues,
11 especially with adolescents. You know, you
12 have Four Winds, you have Arms Acres, you
13 have a few places and it's just difficult for
14 these patients and parents and families so we
15 are trying to get it solved. More to come.
16 DR. McGINLEY: Can I clarify something?
17 So if mobile mental health is called and they
18 recommend admission to inpatient psychiatric
19 unit and say we are full and they call us and
20 say we are at capacity and can't take them
21 right now. You know, where is our
22 obligation? If we have room in the access
23 center, do we say okay. Or mobile mental
24 health says they need admission, admission
25 tells them you have to look for inpatient bed

1 Proceedings
2 somewhere else on your own? How --
3 DR. MURPHY: What happens is you can --
4 I would do is direct the call to the
5 psychiatrist. Because the psychiatrist is
6 going to know what they have upstairs and
7 know what is in their access center and the
8 people they are dealing with now. So as an
9 ED physician I would ask the psychiatrist,
10 this is what they are calling about and this
11 is what they have. And generally the mental
12 health coordinator, or the ambulatory, the
13 mobile people will contact the psych people
14 directly, they should be. Because then they
15 can discuss it and decide what the patient's
16 needs are and discuss is it something that
17 needs to be inpatient or not?
18 DR. HILL: Can I interject? First of
19 all, mobile mental health never makes the
20 determination whether they need inpatient or
21 not, they make determination whether they
22 need evaluation by psychiatrist.
23 DR. MURPHY: Correct, it's the
24 psychiatrist who makes the inpatient call.
25 DR. HILL: Right. And as far as I know

1 Proceedings
2 they -- the majority of the time I don't
3 think that they actually speak to a
4 psychiatrist in real time unless there is a
5 question, you know.
6 DR. MURPHY: Yeah. You know, it's a
7 thing where it's supposed to be a
8 coordination of effort. I don't think that
9 it always happens. Like I didn't even know
10 they were obligated to do this --
11 DR. HILL: So I guess they are obligated
12 if we call them. But, you know, there is a
13 lot of cases where it's absolutely clear cut,
14 like somebody tried to kill themselves and
15 they are still trying to kill themselves.
16 And they are on one-to-one that -- I don't
17 feel we need to call. Them they are not
18 going to contribute anything and take-up
19 time. But there is, you know, probably 70 or
20 80 percent of the cases like if you had some
21 help in the community and some promises you
22 can get them.
23 DR. PAPISH: That's where they are
24 useful, they are in our ER. They have one
25 person dedicated that sits in the ER because

1 Proceedings
2 we get a large psych volume. They are
3 usually solving --
4 (Everyone is speaking at once.)
5 DR. PAPISH: -- and they are perfectly
6 reasonable. They see the person still trying
7 to kill themselves, they are not going to try
8 and find a game plan for tomorrow.
9 DR. SANTOS: Well, I would just add that
10 we service Connecticut. We have something
11 like a mobile unit. Their response times
12 have been so erratic that we basically
13 switched to just full -- two social workers
14 now almost dedicated entirely to the ER.
15 They are much much more efficient. And they
16 are talking to the psychiatrist and setup all
17 the -- ultimately disposition them because we
18 don't have adolescents, we only do geriatric
19 psych patients.
20 MR. MURPHY: I didn't hear -- the mobile
21 crisis teams being called to do ER
22 evaluation? In Rockland we have the mobile
23 mental health team and their designed to keep
24 the person out of the emergency room.
25 DR. MURPHY: Yeah, they go to the

1 Proceedings

2 scene --

3 MR. MURPHY: -- and if they decide an

4 evaluation is needed, they will remand to the

5 ER and speak to the psych people. Then their

6 design is to deal with stuff either by

7 telephone or when you see outreach designed

8 to keep them from going to the emergency room

9 and referring them to.

10 (Everyone is speaking at once.)

11 MR. MURPHY: -- both hospitals have a

12 psych worker in the ER that deal with the

13 walk-ins and deal with the cases that come

14 in. So I didn't hear of behavior health

15 being called to ERs.

16 DR. MURPHY: This is what the State is

17 saying, is the process they've setup for

18 places that don't have the social worker or

19 any kind of person to help evaluate, or to

20 help assist. It's a Band-Aid that the State

21 devised for when we lost all the psych beds.

22 Because they are finding it's just falling on

23 the ER so to try and help out they made these

24 mobile units in each county supposedly to

25 help evaluate the patients.

1 Proceedings
2 DR. BERKOWITZ: Is there a missed
3 opportunity here of maybe not utilizing the
4 mobile crisis teams to go to the scene? Is
5 that happening? Our -- our -- our EMS is --
6 or police when they are encountering a
7 patient who they think needs psychiatric
8 assessment, but isn't an imminent risk --
9 just so I understand are they allowed to be
10 called?
11 DR. PAPISH: Yeah, they go to --
12 DR. HILL: The problem, like --
13 (Everyone is speaking at once.)
14 DR. BERKOWITZ: I definitely see
15 patients, you know, in the Mid Hudson ER who
16 are brought in not by the parents or anyone
17 else, they are brought in by ambulance or
18 police, who did not have -- were not
19 intoxicated or anything like that, really
20 just need to get plugged into the appropriate
21 -- and what I do is call them and -- what a
22 waste of resources.
23 (Everyone is speaking at once.)
24 DR. HILL: The trouble with mobile
25 mental health is they are resource stressed

2 and so sometimes you call them and they will
3 be like, I can't get anyone there for two
4 hours. And so in those situations
5 prehospital then what is EMS going to do? Do
6 they wait around for two hours or what?
7 DR. MURPHY: Families know -- families
8 know to call and ask for help -- but, again,
9 it's not a perfect system, but it's out
10 there. I wanted to make sure -- I didn't
11 realize that was the resource they have put
12 up as an idea when all these beds were gone.
13 DR. LARSEN: Just a point of
14 clarification, so EMS or first responder,
15 whatever, get involved with the mental health
16 care team, that's an okay for them to leave
17 that patient behind and not transport? Is
18 that clear?
19 DR. HILL: It may or may not be, that's
20 a decision they --
21 DR. LARSEN: That -- that -- that needs
22 to be very clearly pinned down if this is
23 going to work otherwise. It's a total waste
24 if they are going to transport no matter
25 what. Why have the team come to the home --

1 Proceedings
2 DR. MURPHY: Well, it might be a place
3 where EMS has not been called. The mobile
4 mental health just came to the house because
5 they have a relationship and know the
6 patient. A lot of times they know the people
7 in the community, they know who is around and
8 who acts up and what happens is sometimes
9 they can come in and give a little TLC and
10 the situation is cooled down. And they
11 orchestrate, you know, hey, see your guy
12 tomorrow, blah, blah, blah, blah. But they
13 will decide if someone in is immanent danger
14 and they don't feel it's safe for them to
15 stay there then they will call either an EMS
16 agency or if they need police to bring them
17 in because they don't transport. They don't
18 transport, they are, you know, they just --
19 you know, evaluate.
20 DR. PAPISH: I see what you are saying.
21 There are certainly some potential issues
22 that could arise when they are involved and
23 mobile intervenes, diffuses the situation,
24 but then is the patient signing out AMA or
25 RMA?

1 Proceedings
2 DR. MURPHY: The medic would have to
3 decide or first responder what the scene is
4 like and what they feel comfortable with,
5 just like anybody else. And they should
6 transport if they are --
7 DR. LARSEN: Okay, but given the
8 assessment of the mobile crisis team, can
9 they say -- you know, discuss with the mobile
10 crisis team they feel the patient does not
11 need to be transported to the ER? Is that
12 enough for EMS to document and walk away from
13 it safely?
14 DR. MURPHY: I would call medical
15 control --
16 DR. RABRICH: Or a preexisting policy by
17 the agency medical director about what the
18 plan is going to be. I don't need a call
19 every single time, you know, as long as you
20 have a policy around it.
21 DR. MURPHY: Just so that people have
22 resources I want them to be able to, you know
23 --
24 DR. HILL: So just for context, we have
25 been doing this I think almost three years at

2 St. Luke's and above 60 percent of the time
3 we divert them into community stuff so.
4 DR. MURPHY: Okay, thank you, everybody.
5 MR. VIOLANTE: We made just need to make
6 a clear recommendation on this from this
7 group to EMS agencies to be able to follow
8 either a policy by the medical director, call
9 medical control, or have something that they
10 specifically can do to give them clear
11 guidance. Because it may end up being an
12 issue if they have police, EMS and the group
13 on the scene who is doing what. We want for
14 our guys to be clear, especially if there is
15 volunteers that don't come to a lot of
16 these --
17 DR. MURPHY: I think -- I think if they
18 are called to the scene they do the same
19 thing no matter what it is, if it's a heart
20 attack, person can't breathe, whatever, they
21 do the same thing. The mobile mental health
22 should not impair what their general practice
23 is because we don't want to deviate.
24 However, if their medical director has
25 devised a plan for them and signed off on it

1 Proceedings
2 and it's something they approve and have
3 notified and let everybody know, that's a
4 different story. But I think you have to
5 just do it the same way as you approached any
6 kind of patient. And if they have been
7 called there they should transport, you know,
8 the patient if they have been asked for help.
9 If the patient doesn't want to go and they
10 feel comfortable with the person, can RMA,
11 that's fine. If there is a discussion I
12 would call medical control and ask for
13 assistance.
14 MR. VIOLANTE: Yeah -- no, I completely
15 agree. We are just adding another piece into
16 that and they may say --
17 DR. MURPHY: Yeah, I think we need to
18 keep it the same way for everything across
19 the board so there is not the exceptions that
20 everyone needs to learn about. Just the way
21 it is, this is the way you respond to a call
22 no matter what the complaint was.
23 DR. PAPISH: I think if mobile crisis is
24 evaluating a patient, at the very least if
25 they are comfortable saying the patient can

1 Proceedings
2 stay home, then they are saying that the
3 patient has capacity.
4 DR. MURPHY: And the patient --
5 (Everyone is speaking at once.)
6 DR. BERKOWITZ: In which case they will
7 call medical control and get an RMA.
8 DR. MURPHY: Yeah, and they should just
9 have them sign.
10 DR. LARSEN: So then that's the plan?
11 There needs to be a plan.
12 MR. MURPHY: I normally don't disagree
13 with my distinguished colleague, but I think
14 most of the behavioral response teams, mobile
15 mental teams are run on a local basis. I
16 think it should be left to the locality. We
17 have a perfect system in place in Rockland
18 with volunteers and agencies and with the
19 behavioral health social worker who happens
20 to be the clinician of expert on the scene
21 and that's been realized and accepted by
22 everyone there is a plan by medical
23 directors. I would respectfully ask the
24 REMAC just to kind of stay out of it right
25 now and just let the individual teams do what

1 Proceedings
2 they do and not confuse the issue.
3 DR. LARSEN: But just to clarify, so if
4 the medics do get called, so that's okay for
5 them, is that right?
6 MR. MURPHY: Yes. Often times the
7 medics on the scene will call and realize
8 this is not a medical emergency, this is an
9 emotional issue, it's a behavioral issue.
10 This person does not need to the -- go to the
11 emergency room, it's not in their best
12 interests. And they will call the behavioral
13 health response team, who comes and they
14 transfer the care to them because it's a
15 behavioral issue. And they go back in
16 service and the behavioral deal with the
17 person, do what they need, TLC, maybe a half
18 hour of engagement, referral to MHA in
19 Rockland and everybody goes about their
20 business and the patient gets what was
21 required. Obviously, if the medics get there
22 and they are psychotic they are not going to
23 call behavioral health, they're going to
24 transport. That's the way it works and it
25 works well.

1 Proceedings
2 DR. LARSEN: And there hasn't been any
3 -- no one is trying to come back on EMS for
4 this?
5 MR. MURPHY: No. And we are in year
6 three.
7 DR. LARSEN: Okay.
8 MR. VIOLANTE: So that's more of an
9 agency policy so I think that fits in
10 appropriately --
11 DR. BERKOWITZ: You know, what we are
12 talking about is in the absence of that what
13 do you do in that situation? Clearly, you
14 are highly evolved in that regard. We are
15 talking about a situation where someone might
16 not have the policy. I don't think we are
17 trying to change what you do.
18 MR. MURPHY: No, I understand that --
19 DR. RABRICH: I think agencies that work
20 closely with these and have the system setup,
21 that's already worked out through medical
22 director and agency policy. But I think what
23 you are saying is you don't have a working
24 relationship for this, you don't have any
25 clear guidance in certain areas. And there

1 Proceedings

2 might need to be something there, but it
3 wouldn't supersede what is already in place
4 and works in other areas.
5 DR. MURPHY: Correct. All right, great.
6 SEMAC report. So, Mike, I don't know if
7 you want to jump in at any time. I missed it
8 because of family illness. However, the
9 notes pretty much from the committee, a few
10 things went through from different areas,
11 some protocol changes, the SEMAC had sent out
12 an advisory regarding hyperventilation and
13 severely traumatized brain injured patients,
14 and they removed a very very old advisory
15 that was out about hyperventilation that was
16 still out there in the books so they made
17 sure that came down.
18 MR. BENENATI: Just for the record, that
19 was 97-03, which was redacted.
20 DR. MURPHY: Yeah. And there was a
21 presentation by the Coverdell Stroke Hospital
22 data collection program, that's the
23 centralized New York Stroke Program that
24 takes all the QI data from all the
25 institutions. They made a presentation.

1 Proceedings
2 There was a lot of discussion about the
3 statewide BLS protocols and how the training
4 and education committee are going to come up
5 with the protocols on the system for them.
6 I don't know if you want to add
7 anything.
8 MR. BENENATI: The only other thing is
9 that the State also decided that the critical
10 care program would be sunsetted. And there
11 will be no new programs approved after
12 January 1st of '18. And lots of dates were
13 thrown around, but I believe that no
14 recertifications after 10 years from that, so
15 January 1 of 2028, the CC program. All CCs
16 would have to either bridge to a paramedic,
17 which was discussed and they are going to
18 development a program for people to bridge
19 up, or they can go down to AEMT level. But
20 extensive discussions and everybody really
21 was understanding of the need to eliminate
22 the program because there is not a national
23 curriculum. They estimated the cost to keep
24 the program around would be 1.2 million
25 dollars because of the materials that would

1 Proceedings
2 have to be rewritten and for only 1,500
3 providers across the State.
4 DR. MURPHY: Ad so now they are going to
5 disburse that money to all of us?
6 MR. BENENATI: That will be coming in
7 your next check.
8 DR. MURPHY: So yeah, that was a big
9 discussion because there are some areas in
10 New York State that heavily relied on CCs.
11 And so what we did was through the
12 collaborative protocol is say -- and Mike
13 made the pitch of a transition program. A
14 program to just do a certain amount of
15 interaction, education, supervision, make
16 sure they are comfortable with certain
17 procedures and to bridge them to the
18 paramedic level, which only makes sense. And
19 so hopefully this will flow forward.
20 They had a lot of discussion about the
21 stroke protocols and primary stroke centers
22 and comprehensive stroke center so that's
23 pretty much what they -- wanted make sure
24 it's the last known well time on all these
25 interactions. On-line medical control to be

1 Proceedings
2 contacted. And they were -- suggested
3 changing the three and a half hours for
4 transport destination decision to six hours.
5 So -- just so that patients get to the
6 participating stroke centers rather than to
7 outlying institutions.
8 Check and Inject demonstration project
9 was 635 agencies participating, 77 uses were
10 done over the last quarter since our last
11 meeting. And there were no reported
12 problems.
13 And that was about it. The CC thing was
14 the biggest discussion.
15 MR. PARRISH: At training and ed they
16 are no longer issuing instructor
17 notifications. If your instructor card is
18 going to lapse you have to know it. It used
19 to be they would send you a letter a month or
20 two ahead of time. They are not doing that
21 anymore.
22 Instructor exams, the folks that are
23 taking it, the CLI seem to be doing better,
24 about 80 percent passing, CIC about
25 70 percent passing.

1 Proceedings
2 On-site scoring is a big discussion.
3 You can do on-site scoring, but you cannot
4 get a piece of paper saying you are cleared
5 to go to work. They found that there was
6 some issues with course sponsors not sending
7 in all the correct paperwork and they were
8 issuing cards to people that hadn't finished
9 all the course requirements. So now you can
10 take the on-site scoring for your own
11 satisfaction, but you still have to wait for
12 the card to show up before you can go to
13 work.
14 The TAG regional faculty update that
15 they were pushing has died because of lack of
16 funding.
17 The budget constraints, Lee Burns talked
18 about that. They can't fill any of their
19 positions. The budget last year was 6.3 mil,
20 this year 5.7 mil, but given a cap of 4.9 mil
21 to run the office.
22 The new Office of Hospital Emergency
23 Preparedness contract is coming out and there
24 is going to be a regional point of contact.
25 The region or myself is supposed to be

1 Proceedings
2 notified about it. They want EMS involvement
3 in it, but there is no grant money available
4 for EMS involvement in this thing -- like we
5 have talked about before.
6 The next SEMSCO is 26-27 and they are
7 reviewing the statewide mobilization plan.
8 DR. MURPHY: Okay, thanks, Rich.
9 Under announcements, we talked about
10 Cragsmoor and Putnam, the two new programs
11 and voted on it.
12 From the Department of Health there were
13 two citations sent down for the Westfield
14 Fire Department. The Village of Westfield,
15 New York has been suspended for one year and
16 assessed a civil penalty of $5,000.00 for
17 violations of Part 800.
18 And Andrew Lestay (phonetic) of East
19 10th Street, New York, New York, Manhattan,
20 was suspended for one year effective
21 June 9th. And he has a six month actual
22 suspension serving concurrently for a
23 violation of Part 800. He was assessed a
24 $2,000.00 civil penalty. And he is required
25 to report back, they have all these

1 Proceedings
2 stipulations for him.
3 Those are the notifications from the
4 State.
5 Now, open forum. Anything anyone wants
6 to bring up?
7 MR. BENENATI: I have two announcements.
8 The first is that there is going to be an
9 educational opportunity, which is called
10 Navigating the Business of EMS a Strategic
11 Vision, run by the Catskill Hudson Area
12 Health Foundation Center, it's July 14th from
13 8:00 to 4:30 at Marist College.
14 And, Bill, is that up on the website?
15 MR. CRUTCHER: Um, um.
16 MR. BENENATI: So you can get to it on
17 the website. I know there has been fairly
18 wide distribution. It's an all day seminar
19 that maybe a good opportunity for some
20 folks --
21 MR. VIOLANTE: Those are really good
22 seminars AEG does during the last number of
23 years.
24 MR. BENENATI: And the other thing I
25 just saw this morning is, there is a grant

1 Proceedings
2 which is available through the U.S.
3 Department of Agriculture for distance
4 learning and telemedicine. And so I know at
5 the State there was lots of discussion about
6 distance learning for those folks that need
7 to take advanced programs. And some of the
8 rural parts of the State one of the biggest
9 complaints with doing away with the CC
10 program is that they need to drive an hour to
11 get to a class. So if anybody is interested,
12 U.S. Department of Agriculture distance
13 learning in telemedicine grant.
14 That's all I have. Thank you.
15 DR. MURPHY: Anybody else?
16 MR. BRENNAN: Math Brennan. With
17 epinephrine, 1 to 10,000 shortage. Am I
18 correct in remembering that several years ago
19 we were in the same situation and there was
20 guidance provided by the REMAC as to what to
21 do?
22 DR. MURPHY: Yeah. I think we sent out
23 an advisory at that time so --
24 MR. BRENNAN: Any chance we can dust it
25 off and send it again?

1 Proceedings
2 DR. MURPHY: We'll revisit -- that
3 little Karen sitting right next to you, she
4 is a good resource person.
5 MR. BRENNAN: We are at the point as an
6 agency where we do not have 1 to 10,000
7 epinephrine anymore.
8 DR. MURPHY: The other thing that came
9 out of -- you know, one of my throwaway
10 journals electronically is that sodium bicarb
11 is now like becoming extremely short. That
12 there are -- many institutions are canceling
13 elective surgeries that require the use of
14 bicarb in their procedures or whatever they
15 are doing. And they are going to cancel them
16 because the shortage is to that much of a
17 dire straight.
18 DR. PAPISH: We were down to four
19 lorazepam in the hospital last week.
20 DR. GUTMAN: We have eight lorazepam we
21 are out of epi atropine, calcium and sodium
22 bicarb at our hospital --
23 DR. PAPISH: Soon it will be chicken
24 soup.
25 DR. GUTMAN: We do have Haldol, we do.

1 Proceedings
2 That we do have --
3 DR. MURPHY: Dave?
4 MR. GRASS: I have something else.
5 DR. MURPHY: Sorry?
6 MR. GRASS: Can I say something?
7 DR. MURPHY: Yeah.
8 MR. GRASS: Dave Grass, Mobile Life.
9 Just to kind of comment, I heard the protocol
10 committee talk about before adding high risk
11 low use procedures into our protocols. Once
12 we adopted the collaborative agreement and
13 diversified what the protocols are across the
14 State, I would encourage this body to look at
15 each of the high risk low use procedures and
16 either approve and start to evaluate whether
17 they make sense in the Hudson Valley. Just
18 because a region that has five critical cares
19 doing something in the field may not make
20 sense here. And I don't want to just see us
21 get into a situation where just simply
22 because another region in the State is
23 utilizing it, we now put that risk on the
24 agencies and you start looking at does it
25 make sense for them to be doing it. And one

2 can argue back and forth whether the OG
3 insertion post intubation has relevance. I'm
4 sure the argument can be made that
5 occasionally it will, there will be a
6 situation where it's relevant. The question
7 is, if we write it in the protocol and ask
8 the ALS providers to do it, they are going to
9 question is it something that has to be done
10 before it gets there? What if I don't use
11 it? What are the risks of that?
12 So I encourage the REMAC as we look at
13 the high risk low use procedures that have
14 benefit across the State, do they make sense
15 in the Hudson Valley before we start using
16 them.
17 DR. MURPHY: Yeah, definitely I think we
18 keep that in the back of every conversation
19 and point well-taken. Under the protocol,
20 it's used to consider, it's considered. It's
21 not something they have to do, but they can
22 consider it if they feel that, you know, they
23 think it would assist the patient. Are they
24 having trouble bagging? Are they -- you
25 know, certain things happening and is it a

1 Proceedings
2 distance for them to get to where they are
3 going? So it's there as consider.
4 MR. GRASS: And I respectfully agree
5 with that. Unfortunately, some people will
6 interpret it's now in the protocol, does it
7 have to be done? And how are the receiving
8 facilities going to say, why wasn't it done
9 prior to approval? Again, for anybody in the
10 back of that ambulance when all heck is
11 breaking loose, is that a priority of
12 something they should be thinking about and
13 how it will be received?
14 All I'm asking for is consideration as
15 we move forward adopting some of the high
16 risk low use skills.
17 DR. MURPHY: Yeah, that's why it says
18 considered.
19 DR. PAPISH: I don't worry -- I don't
20 think -- I mean, I don't think the majority
21 of receiving facilities would be upset or --
22 about the lack of an OG tube --
23 DR. BERKOWITZ: Unless the OG tube is
24 your EG tube.
25 DR. PAPISH: -- when it's sucking the

1 Proceedings
2 air out.
3 DR. MURPHY: Point well-taken.
4 Any other comments, concerns, or
5 anything in the open forum?
6 All right, I'll ask for a motion for
7 adjournment?
8 You guys want to sit here?
9 DR. BUTTERFASS: (Indicating.)
10 DR. McGINLEY: Second.
11 DR. MURPHY: Thank you everybody for
12 coming. I know your schedules are tough and
13 I appreciate it so much. We all appreciate
14 it.
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6 THE FOREGOING IS CERTIFIED to be a true
7 and correct transcription of the original
8 Stenographic minutes to the best of my ability.
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12 Yvette Arnold
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