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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 3, 2019, at 9:31 a.m.

Yvette Arnold,

Court Reporter

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

DR. PAMELA MURPHY,
Committee Chair

DR. MARK PAPISH,
HVREMSCO Medical Director

DR. ARSHAD,
Evaluation Subcommittee Chair

DR. ERIK LARSEN,
Helicopter Subcommittee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

OFFICE STAFF

JEFFREY CRUTCHER, QI Coordinator
KAREN DELAUNAY, Office Manager

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Physician Representative

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. MADORE,
Director

NYACK HOSPITAL

DR. GREENHUT,
Physician Representative

ORMC

DR. ANUJ VOHRA,
Director

PUTNAM HOSPITAL CENTER

DR. BUTTERFASS,
Director

MID HUDSON REGIONAL HOSPITAL OF WMC

DR. PAPISH,
Director

VASSAR BROTHERS MEDICAL CENTER

DR. ARSHAD,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT:

MICHAEL BENENATI
DAVID GRASS
RICHARD PARRISH
JOHN MAHONEY
FRANK CASSANITE
DENISE MONTANA
JAMES JENSEN
ISRAEL KNOBLOCH
NELSON MACHADO
SHARON FRAZIER

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DR. MURPHY: We will bring the meeting to order. Thank you all and happy June 2nd morning. So what I would like to do is start with -- everyone had the minutes, right?

MR. HUGHES: Yeah.

DR. MURPHY: A review and acceptance of the minutes from the previous meeting, if anyone has any additions, completions, corrections, or insertions please let me know. Otherwise I'll ask for a -- what is the word?

DR. ARSHAD: Motion to approve --

DR. MURPHY: Motion to accept -- sorry -- I'm a little not myself this morning, but thank you everyone.

Can I have a motion to approve the minutes?

DR. ARSHAD: I would like to put forth a motion to approve.

DR. MURPHY: And can I have a second please.

DR. VOHRA: Second.

DR. MURPHY: Thank you. And good morning everybody. What we are going to do

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is start off with some old business this morning.

A lot is going to come up through our protocol process and where we are with the protocols now. I'll turn it over to Michael -- thank God.

MR. BENENATI: So both the BLS and the ALS protocols have been approved by New York State Bureau of EMS and the Department of Health. The implementation for both is August 1st of 2019. The regional office is beginning to work on sending out letters to providers, agencies, EMS coordinators and the delegates to the region in an attempt to begin to push the information down through all of those channels to the providers. Ultimately, every provider in the region, which is about 8,000 need to be aware there are new New York State BLS protocols that they need to become familiar with and get trained on. So we are going to begin to push that information out and we will continue then to push that information out as summer proceeds here. Ultimately, getting that

information down, again, is critical. We feel that we have met some roadblocks at some of those higher level choke points and one of the things the regional office is working on doing is using a new e-mail tool, which will allow providers to subscribe and get this information pushed down from the regional office.

Additionally, the regional office has updated the website and Facebook at this point with links to the protocols so that the providers can get those. I believe Jeff is also working on trying to get a Twitter account setup as well.

Dr. Arshad and Dr. Fullagar developed extensive training programs at the Laerdal Corporation, they have been working on editing those. And we will turn it over to Dr. Arshad to give us an update on where we stand with that. But that is going to be a significant piece of the BLS training component.

Do you have a moment to speak about that now so we know we are at now --

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DR. MURPHY: If you have time.

MR. BENENATI: Ready?

DR. ARSHAD: We collected a great group of providers throughout the region to really highlight some of the protocols and bring to light the primary premise that be the best BLS that you can be.

DR. MURPHY: Oh, my goodness.

DR. ARSHAD: Yes, absolutely. And to be able to stage, prepare and manage complex patients and not always to assume that ALS is on the way, which can definitely be a foible, especially in this region and throughout New York at large.

We have recorded several different scenarios highlighting components from high performance CPR, to tourniquet deployment, to pelvic binder application, to social aspects in regards to, you know, out of hospital care. And we are also working on a series of audio podcasts to supplement really pulling off some national experts on, again, pelvic fractures, tourniquet deployments, starting high quality simulation programs, continuing

medical education and how we can really improve on a day-to-day basis with very few resources or capital expenditures.

We are working now similar to the ALS collaborative protocols video to insert bubbles or captions throughout the simulation videos so we can highlight salient points, reference different medical papers, journal articles and bring home some of those, you know, key takeaways.

One of the challenges, and I'm not sure if -- this was still challenging for me to comprehend -- is the BLS protocol update is for the entire state in comparison to the ALS collaborative protocol update from the past in which regions elected to participate in the collaborative protocols. These new BLS protocols are essentially going to be for every EMT within the State --

DR. MURPHY: And it's the first time in 17 years it's all been changed so the other thing we are going to run up against is people aren't expecting that, number one. And two, they have been like the forgotten

stepchild. No one has every really gotten out there and said this is what we had to do. We did a little bit when we rolled out ALS the last time, however, this is going to be a new augmentation and support system for them.

DR. ARSHAD: So there are some additional hurdles that the State has put forth that we have accepted responsibility to help facilitate in order to make sure that all the check boxes are being marked off and that this is palatable for the BLS providers all across the State.

DR. MURPHY: Yeah. It's going to be daunting to certain areas, let's just put it that way. I got out there the last time to do some of the front end, front line discussions, so a lot of them don't really realize. So it's a thing that we just have to keep communicating and making sure we get information out there. One of the things that may occur is more of the BLS agencies maybe reaching out to have some kind of guidance from us and guidance from local docs in the area and their EDs so we hopefully can

fulfill that gap that's been really quite void in the past.

MR. BENENATI: And the training and ed is going to work on it some as well trying to develop some additional on-line stuff and make sure there is CME credit that is awarded as well.

DR. MURPHY: Yup. And they changed the way you can get CME. They increased the amount of on-line education you can use now, so they allowed and facilitated for easier education for everybody. So the State has opened up the amount of material you can garnish on-line so that also will help.

MR. BENENATI: Yeah. So that stuff will not be approved unfortunately until September --

DR. MURPHY: Yeah, it's still --

(Everyone is speaking at once.)

DR. MURPHY: -- a step we are trying to join the rest of the of world.

MR. BENENATI: And the other thing too we will try to be doing is push out a flier so that people can post. Again, I think one

of the biggest discussions that we had is being able to penetrate down to the provider level. Again, we have about 8,000 EMTs, or EMTs and advanced in the region and every single one of those needs to know there is new protocol out there. So we are going to try and get fliers out there through the EMS coordinators and hospital EDs, every single one of those needs to be aware that there is a new protocol out there and then needs to be become familiar with the content of that.

So that's it on the BLS protocols --

DR. LARSEN: You said there is 8,000 BLS providers in Hudson Valley?

MR. BENENATI: Bill, that's the number, right?

MR. HUGHES: Yeah, BLS and ALS. There is about 800 ALS and about 7,120 that live within the Hudson Valley.

DR. LARSEN: And that doesn't include Westchester?

MR. HUGHES: No. No.

DR. MURPHY: Yeah, you guys --

DR. LARSEN: That's a lot, I didn't

realize that.

Another question along this line, so what is the -- what does it take to be an EMT now? What do you have to do? What is -- how many hours --

MR. BENENATI: Rich, I'm going to defer to you.

MR. PARRISH: One hundred thirty and it can go longer.

DR. MURPHY: Depending how you do it, right? It depends upon your curriculum and how you do it.

MR. PARRISH: One hundred thirty, one hundred fifty hours. And even at that you are not coming out complete. The agencies have to take on the role of how do we apply this to the street type of stuff.

DR. MURPHY: Give them on-line and kind of buddy buddy training and mentorship.

MR. PARRISH: Yup, mentorship is a big problem.

DR. LARSEN: And that's still a national federal oversight course?

MR. PARRISH: Oh, yeah, we adopted --

was it '95 -- they adopted the national curriculum and that is what we follow. New York State used to develop their own instructor guide, now they don't. You follow the national curriculum.

DR. MURPHY: I think it was '95.

MR. PARRISH: Yep.

DR. LARSEN: Okay.

MR. BENENATI: So the interesting piece, and as Dr. Arshad has alluded to, these protocols are completely different. This is a complete rewrite from the beginning of the document to the end and there is a lot of material that needs to be shared with the providers.

DR. MURPHY: But it's all good stuff, it just --

MR. BENENATI: Absolutely --

DR. MURPHY: Sorry, but it's something that should have been done a long time ago so it puts out a tremendous amount of good information, it gives them a lot of resources, there is a lot of great TAGs to information and way to explain things. But

it's really well written and kudos to the collaborative committee to everybody on the protocol committee and Dr. Fullagar and Dr. Arshad. Thank you.

MR. BENENATI: So moving right along to the ALS collaborative, at the same time we are working on a comparison document between the existing collaborative and the new. The changes are certainly not as sweeping and so we are trying to pull together a document that will help the providers just see what that bridge is so we can bridge that gap. And that document is not out yet so that's the BLS and ALS.

DR. MURPHY: Great, thank you.

MR. BENENATI: And that implementation is also August 1st.

DR. MURPHY: So we are going to table regional stroke for now, right?

MR. BENENATI: So there was a discussion and request that the protocol committee look at a stroke policy --

(Dr. Mao entered the meeting.)

MR. BENENATI: -- similar to the one

that REMO had adopted. And after discussing it -- and in theirs they talk about a primary center as well as a comprehensive center since then New York State has come out with a document that talks about stroke designations for primary, phlebectomy and comprehensive. But at a statewide program agency conference call there was lots of concerns that it was not -- that individual regions were going to address it rather than at a state level. And the State says that in the very near future they are going to address this. So while we had developed a draft and it was e-mailed out to you the protocol committee decided it's inappropriate at this point to move it forward until more information is available from the state.

DR. MURPHY: Yeah, we will see what they say. It is going to come under the arm -- they are going to give the designation of whoever makes it in under the wire and then beyond that it will be under whatever agency -- not agency -- but whatever governmental certification development, either you use

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joint commission or you use -- is it DVM --

(Everyone is speaking at once.)

DR. LARSEN: They are four agencies --

DR. MURPHY: Right, so it will fall under that and after that they'll take-over the recertification. So everybody is trying to scramble to get under the wire and get their certification from the state and it will go forward from there. But we will wait for their final policy and how they want to roll it all out and then we will go and we'll adopt it for us.

DR. LARSEN: Just my understanding from that conference call, webinar, you were probably on --

MR. BENENATI: I was not, Bill was on that.

DR. LARSEN: Okay, so was March of 2022, right? That was when all -- it was either '21 or '22 I can't remember --

MR. HUGHES: They were all required.

DR. LARSEN: That you as a hospital were required to undergo one of those three designations.

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MR. HUGHES: Right. But I think they're going to be working on it a lot sooner then that --

DR. LARSEN: Oh, yeah. People are jumping on the band wagon, but it seemed like the deadline for New York State you were just -- you know, the new system was coming into place in March of -- I thought they said three years so I think it was '22.

MR. HUGHES: Okay.

DR. MURPHY: I think that's the drop dead date.

DR. LARSEN: Yeah.

DR. MURPHY: I think 2022 -- March 2022 was the drop --

DR. LARSEN: For the hospitals.

DR. MURPHY: Yeah.

DR. LARSEN: We will probably then start working on some type of destination protocols, you know. But, you know, and they did as you said leave it up to the regions.

DR. MURPHY: Okay, service upgrades there is none.

Evaluation subcommittee report, Dr.

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Arshad?

DR. ARSHAD: No news.

DR. MURPHY: Enforcement notifications, I have one.

This is for José Rivera out of the Bronx. He is -- his certification has been revoked as of April 2nd for violations of Part 800. So it's José Rivera out of the Bronx.

Helicopter committee report, Dr. Larsen?

DR. LARSEN: Nada.

DR. MURPHY: Okay, RTAC, Bill?

DR. LARSEN: There has not been a meeting.

MR. HUGHES: No meeting.

DR. MURPHY: This is going to be a record meeting.

Quality improvement, Mr. Crutcher?

MR. CRUTCHER: Work is still progressing on the upgrade to Nemesis 3.4. We do have a final New York State supplemental dictionary, new Schematron has been posted to the vendors. We found an issue with one of the rules that New York City EMS wanted

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implemented regarding stroke scale. And essentially what it did is our data on our regional bridge we would show a document having 100 percent validation. When we compared that document to when it was posted on the State bridge it had a score of negative 180. We brought that problem to New York State Department of Health folks, they said we are going to have to send this problem to Image Trend. Somewhere in Image Trend's code they either dropped a parenthesis, or bracket, or something, but it was implementing that rule where the rule never should have been implemented. For example, on a call cancelled, it was dropping it by 50 points, but there is no other data that is required for a call cancelled other than call cancelled.

The other thing we have been working on with Image Trend is obtaining a Hospital Hub connection, which would provide us with the ability to post all of the EPCR data onto the patient's record as soon as it's submitted by the provider, which would eliminate the need

of using the old technology of faxing or leaving a copy so it can get lost someplace. But it would be much better for QA QI purposes on both the hospital agency and the region's part. And we are waiting to hear back on what the cost of that is going to be.

And that's about it.

DR. PARRISH: What's a Schematron?

MR. CRUTCHER: Schematron is actually the HTML code that the data gets broken down into. I can show it to you, but --

MR. PARRISH: Sounds like a EKG --

DR. VOHRA: Sounds like an abnormal EKG.

MR. CRUTCHER: Pretty much. And you shock it until you get something you recognize.

MR. JENSEN: Is that data posted as soon as the provider signs their chart and submits it?

MR. CRUTCHER: Yes.

MR. JENSEN: It doesn't have to wait for an upload?

MR. CRUTCHER: Nope.

DR. MADORE: What is the mechanism it

gets that into a chart, it is like an HL 7 feed?

MR. CRUTCHER: That's what the Hospital Hub does, is it translates the code into HL 7 and posts it in the chart.

DR. ARSHAD: Jeff, our understanding was our region didn't qualify for the trial period from Hospital Hub?

MR. CRUTCHER: That is correct.

DR. ARSHAD: So the future steps in integrating to Hospital Hub are?

MR. CRUTCHER: Well, we're going to have to pay for connection and that is based upon call volume throughout the region and we will see what they come back with. And we will do what we can to speak with Image Trend to see if we can get the price down. I've heard very high quotes, very low quotes depending on who you talk to and apparently on what kind of relationship you have with Image Trend. We have a really good one so I'm hoping it's a low price.

MR. PARRISH: Is that hospital cost or region cost?

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MR. CRUTCHER: It would be region cost, but my fervent hope is to break that up among the hospitals.

DR. MADORE: Is it similar to user sending an e-mail, secure e-mail.

MR. CRUTCHER: Well, that ability has been there for the last 10 years, but nobody used it. It's not as simple as that, it doesn't integrate. And with the Hospital Hub the receiving facility would be able to essentially post back results of patient care to that agency, which would allow the provider to take a look and see if they were good, bad, or indifferent on that call. And that would be for a specified time period and then that portal would be shutdown and that patient, which complies with all current HIPAA laws.

MR. JENSEN: Does that provide provider outcome feedback?

MR. CRUTCHER: Yes, it does.

DR. MURPHY: All right, thanks, Jeff.

Protocol committee, anything else to add Michael?

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MR. BENENATI: Yeah. Just a follow-up on the EMS summit that we had in February. We are moving that along to a TAG and Bill is facilitating that and there will also be a steering committee to work with that just to keep all of that initial and good work up on the State EMS and in the region.

And then one new topic that we want to open up for discussion today is regarding termination of resuscitation in the region. There have been some recent cases that were brought to our attention where there was some confusion in terminology and some patients were, quote, unquote, pronounced in the field and it caused a number of concerns with regards to time of death and also crossing county lines with patients.

And so actually I'm going to turn it over to Dr. Papish to take this.

DR. PAPISH: Yeah, it's almost not really a new topic in the sense that when you look at the regulations for New York State anyone can actually pronounce somebody dead, you don't have to be a doctor or paramedic,

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or -- you could be a carpenter. There is no real like inclusion. However, historically EMS has terminated resuscitative efforts when patients are deemed unresusable (sic) and turned the case over to the police, who then called the medical examiner and they get a time of death and the medical examiner takes the case, et cetera. Usually, at least in our region, we haven't been pronouncing people dead, we have been terminating resuscitative efforts. And the responsibility of the person that pronounces the person dead is they have to stay with the body until the medical examiner gets involved and the body is appropriately turned over. And we have steered clear of that as a system because we just cease resuscitative efforts and then sort of the process gets handed over to the police for the most part.

There were a couple of cases where the paramedics pronounced, which isn't illegal. But then there were issues where the body, now the patient was pronounced dead, got transported across county lines and medical

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examiner offices are responsible for investigating wherever the body is when they get involved. And I don't remember the exact details, but the long and short of it is because the paramedics had called the case and the body was then able to be transported to a different county there -- it became very confusing as to which medical examiner office is responsible for overseeing the investigation, et cetera.

And so we wanted to just reiterate to the providers for the most part, why get involved? We can terminate resuscitative efforts and then hand the rest of the process over to the authorities as we have historically been doing as opposed to getting involved in making pronouncements. We can if we wanted to as a region we can put out a document that says, you know, you can pronounce people dead and then you are responsible for the rest of the process. Or we can just do what we've been doing, which seem very easy. So my take on this and everybody we discussed it with because it

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came up as a result of these couple of cases, is that we should issue an advisory saying we don't pronounce people dead prehospital, we terminate efforts and then hand that over to the authority as a matter of policy.

Open for discussion.

DR. MURPHY: It came from the medical examiner of Dutchess County, who received a patient from Orange County. So it kind of, like Dr. Papish said, opened up a can of worms I never knew was in existence. Because I didn't think medics could determine and call it as a time of expiration more so stopping resuscitative efforts and why would you terminate. And that's what our protocols have always mirrored, you know, the head is over there and the body is over there we are going to say we are not going to resuscitate.

So we are going to look at this and develop something and put out an advisory to everybody. But I think why we wanted everybody to discuss it here was just to have your feelings on the pronouncement in the field. And we felt like we should leave it

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the way it is, that it's not a pronouncement. And I think the reason why it became confusing was the police were watching the medic terminate efforts and saying, what is the time of death? What is the time of death? And it's really not the time of death but the medic was trying to say to them this is the time of termination of resuscitation, which is different. So that's where I think the confusion came from.

DR. PAPISH: And I think there are places in the State, like the City, the medics pronounce, they call and put a time and -- but then they are -- they hangout.

DR. MURPHY: But they probably have somebody there pretty quickly too, whereas here I don't know how quickly and --

MR. MAHONEY: Westchester County does it but because that they have a twenty-four hour, seven day a week investigator at the ME's office. If I'm working in Westchester and I cease resuscitation, I call the ME's office, I give them a time, they give me a death certificate number and that's what the

police get and then it's turned over to the police.

DR. MURPHY: Yeah, that's what we do at the hospital you know we tell them the story -- Anuj --

DR. VOHRA: -- who determines the time of death and who does the death certificate?

DR. MURPHY: Yeah, your favorite, electronic death certificates.

DR. GREENHUT: So this is really a clarification on what the physicians are telling EMS when they get that phone call. Because I can imagine if EMS is not feeling confident in having that conversation they may bring more people to the hospital without confirmation over the phone. So it's really the words that we are using, terminate resuscitative efforts at this time.

DR. MURPHY: You can call them in the field. Like you've had a case I'm sure of a hospice patient, we say what is going on, da dada, da dada, we call it there and then the funeral home will come pickup the patient and it's going to go on and PCP will fill out the

death certificate because they are aware of the case, the patient is in hospice, et cetera. So there is going to be case by case, but that's where I would think our medics would not be the ones wanting to be on the front line to hold onto the whole case until everything is said and done.

DR. PAPISH: You brought up another point. One of the caveats of that and a point we are going to put in the advisory is if a patient -- you know, EMS can terminate efforts on the field if it seems like there is no chance of resuscitation, or there is obvious death. However, once they start transporting the patient, this is always -- becomes an issue because they start transporting, if they stop halfway -- if they are in a vehicle and they stop resuscitation and they show up at the hospital there have been several cases I know of, at least three, where the hospital has said, no, no, no, take the body somewhere else, you stopped. You know, and really to remind all the hospitals that once the patient has begun transfer the

obligation is to accept the patient, call it, it's a DOA, it's a very easy visit. But this has happened in couple of different hospitals, it's happened in my hospital. So --

MR. JENSEN: The protocols on that are actually confusing, they say if the patient is coming from a nursing home the patient is to be returned back to the nursing home --

DR. MURPHY: Yeah. It's not written well, I have to agree with you. We have to clarify it a little bit and make it a little more facilitated to follow because I agree with you I think it's written poorly. I brought it to Chris so we'll look at that because I agree, the way the collaborative protocols and termination of efforts talks about a nursing home patient who dies en route is to turnaround and go back. We have to discuss and write it so it's really clear.

MR. JENSEN: I've had a case like that where I show backup at the nursing home and they freak --

DR. MURPHY: And they are like --

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DR. PAPISH: Yeah, here's your body, things didn't workout.

DR. MURPHY: No, it becomes an issue, there is no question. So we have to get that clarified and, you know, make it so --

MR. JENSEN: The other thing is obvious deaths, when you walk in and you are confirming an obvious death where you do a three lead on that patient and the investigators are already there. And the investigators are hounding you for time of death. And basically what I've done is give them the strip. You can reflect back to that time, this is a termination, it's obvious death, there is nothing I can do here.

DR. PAPISH: Yeah, you mean the investigators like the police, not the medical examiner. Because --

DR. MURPHY: Because ME would take the case --

DR. LARSEN: I just think it needs to be really clearly spelled out for the medic because they are going to be there, you know, holding the bag and police officers are going

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to be -- so we have got to educate.

DR. MURPHY: Yeah.

DR. PAPISH: I think right now the system works for 99.997, you know, we have had five cases where things are -- you know, I'm inflating that number -- where things have kind of been problematic. But for the most part the system is as it is and we want to make sure to remind everybody that this is our process just to prevent these issues when they arise.

The only thing I was saying with the hospital perspective we really shouldn't be -- you know, when the ambulance brings in the cardiac arrest it's the easiest case of seeing a patient, pronouncing them, processing and taking care of the body.

DR. MURPHY: Exactly. Any other comments or concerns? Okay.

SEMAC report. Help me. Let's see, so we talked about New York City brought forward all their last changes to their protocols because they are really the only ones now outside of the collaborative, they brought

forward changes to bring their protocols through.

We approved the BLS protocols as Mr. Benenati talked about.

We talked about some of the educational things and CME changes that are coming forward.

DR. PAPISH: Did the blood people come back?

DR. MURPHY: No. I think they are afraid to come back.

MR. PARRISH: The way they got attacked.

DR. MURPHY: I think they are afraid to come back.

DR. PAPISH: The reason I ask is our transfusion team in our hospital came and said there are some changes coming down the pipeline regarding blood and when they described it -- I don't remember all the details -- it sounds like they made it more laborious as opposed to facilitating the process.

DR. MURPHY: They did not come to the meeting.

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Anything else anybody can think of? I'm sorry, I'm like a lunch bag today.

Okay, open forum.

Rich Parrish, you are up.

MR. PARRISH: A couple things -- we will get this one done first.

Been asked to present the MACE team. RTAC made a request for it and whenever we get the schedule for the next meeting we will be presenting to that.

The MACE team is the hospital Mutual Aid Coordinating Entity. It started back in '06, there was a big regional exercise and when we started dealing with the State we couldn't get bed information. So we started looking at putting this team together and six of us worked on developing this and it's been in effect since '06.

The region talked about what is the size of it, you know, 2.2 million people, it entails seven counties, we brought Westchester into it, and the square miles, the police, all that. You know, these are the different organizations that we

potentially can deal with, the hospital beds 7,000 of them, nursing homes, this is becoming a big issue, joint commission -- not joint commission -- CMS has now mandated that they follow the same EM standards as hospitals do. So we will look -- they are looking to us for some involvement and we are working with them. And all the different agencies that we potentially can deal with. Again, this is the region, the lower Hudson Valley.

And this, like I said, back in '06 we are 34 hospitals all the like -- original six and then we got all the other emergency managers involved in it and came up with the operations guide and sent it out and surprisingly all the hospitals signed off on it. What it is is they do make a commitment to supply personnel, pharmaceuticals, anything as available, not that you will supply this, but as available. And as you'll see, we have used it. We have shared beds, White Plains was hurting at one point for beds, put out the request for it. Another

hospital was doing construction and they had a wing with available beds, yeah, come pick them up, that type of thing. So that's how it was working and it continues to work.

Like I said, it first started with this exercise, Catskill Regional, Vassar and St. Anthony's, White Plains were evacuating and when we went into the HERD system to look for bed availability it just wasn't there. So we wound up putting this program together and there is always two of us on-duty. And it's every month two of us are on-duty and you get the call, there is a common number, I'll share that with you. And one person will go to that hospital and sit on their command and the other one will go to -- either they could come here and make the phone calls or to their own office, start calling all the other EMs and saying such and such hospital, or White Plains has this issue, what can we do to help them? And we start putting things in place and we had it done within like a half hour. We could tell, hey, this hospital has got this, this hospital can take this many

patients, what have you.

So this is out of the hot wash that came out of it, how do would go about it? So we came up with the signal coordinating entity. So we came up with the goals and everything to go with it, we recruited members from the hospitals and surprisingly all the hospitals signed onto it.

State emergency management offices, county EOCs may not be available. And that's what we found especially at the State level to get them involved it has to go through the county and get the county involved that type of stuff. County Health Departments, we are finding that they don't have a real good grasp on emergency management, with the latest measles we helped them. Rockland County didn't have enough IG so they put out a request through the Rockland County Health Department that does sit on the MACE team requesting it, within 15 minutes Phelps said, hey, we can help you, and got it to them. And then more recent ones, Orange County has been looking for IG and we were able to help

them.

So we come up with this standard operating guide and it's -- anybody is welcome to it. It's got the introduction, the membership, how do you activate communications. We come up with a job action sheet. If you are familiar with the hospital command system it's got job action sheets. We developed one along those lines for the MACE team representative, what he is supposed to do. All right, different forms, resource management. How do we integrate with other facilities? And we do training and exercises for our own people dealing with public relations. We leave that up to whoever the incident commander is, they should have their PIO, we will work with them. And how do we transfer operations and the reports that we generate.

It's all volunteer. In my case, you know, I'm the cochair of it, volunteer, my boss has to sign off that I -- he agrees to do that. And every other member of the team does have that. You have to have 100, 200,

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700 and 800 to be part of the team and be employed by a facility that does sign off on it. We would like you to have 300 and 400 also. So this is the form that the boss would signed off on that you can join the team and you are actively participating in it.

As I mentioned, the job action sheet we developed so you follow that. We recommend that the hospitals put it into their emergency management plan so when they get to that point where they need them they know who to call, how to go about it. And there is your cheat sheet, it has the standard number. Now at midnight on the first of the month the number rolls over to whoever is on-duty and they get the phone call.

All right, so only a signatory of the agreement can activate it. And as I said one rep goes to the hospital, the other one goes to the MACE team. If it's multiple hospitals involved, it's a region wide incident we will bring in more of the MACE team and split up the requirements or resources. So that's the

contact number. Normet who used to be here they now consolidated with Suburban out of Long Island but they still keep some of the Normet, they maintain this phone and that's how we activate it.

This is one of the forms that we use. You go down the list we can find out what beds you have available, med surg, burns, others. And then when we start sending them, like we work with Frank with the Port Authority and the air show we are there in the morning we call the hospitals. What is your status? What is going on? And then in the afternoon if something happens we can tell the squad, hey, this hospital can take this type of patient, all right? It takes the burden off the county OEM, you know, we know who to talk to, generally we talk right to the ERs, or to the nursing supervisors to find out what is your bed availability. And we can say, you know, take the patients to these facilities.

Here we are at the NDMS exercise. Got all the information, this is when they flew

in a lot of patients and we had all kinds of ambulances there and designating where the patients should go. So we do the different training exercises, definitely the hospitals have to participate into a year. We just did a big one for the region in the beginning of May. Two hospitals evacuated, Nyack and Good Sam, and, you know, again calling around finding out what patients could go where and we could start moving them, some of the nursing homes got involved with shipping patients also. So different training exercises we have been into. You know, big program with West Point. One of the cofounders of Normet was the emergency manager there so whenever they have exercises we are over there all the time working with those folks and they just had a real big one in April.

So this is our different folks, different training programs. We have been at Indian Point working with their emergency management programs. This is the NDMS exercise where they flew in this plane and

simulated patients and we would have to assign them to different appropriate facilities and the check ins and what have you. The three people in the middle you know, one is the cochair, myself, and the other gentleman is from West Point and he was one of the driving forces of developing this program.

Real world exercises. You know, a fire at Sound Shore. They had a boiler let go so we got involved with that, getting them extra supplies and moving patients around. Exercise at St. Luke's. Again, mass cal at Keller. This one, fire at New Windsor. I happened to be in that area when the page went out so I went right to St. Luke's so I was in their command center and we had everything sent up to go and no patients showed up. They didn't start showing up until later that evening. They all had some issues about, you know, saying yes, yes, I'm hurt type of thing. But when they started having respiratory problems that's when St. Luke's start seeing a lot of different

patients. But initially we were setup, we did make initial calls out to some of the local hospitals, this is what is going on if something did happen. But really it was a nice exercise to get, but in the end we really didn't get to do much.

So what have we done? All right, the '15 an exercise at Port Authority, exercise at Westchester County Airport. And Westchester County Airport has mandated that the MACE team be an active part of any of their exercises. There is some issues with Westchester County OEM, but they put into their program that the MACE team will be an active part of it. It turned out when they had their big exercise -- not the most recent, but the one before -- when the county OEM started going to the State for their bed numbers they are still waiting for it. Where the MACE team had all the bed numbers in a half hour, said, okay, here's where your patients can go.

The air show, that's an actual, mass cal. An actual, like I mentioned, White

Plains needed hospital beds so got involved with that getting them extra beds. Again, the air show in '17. Chemical plant in '17. The surgery exercise that the state did. Again, mass cal Westchester Airport. The Port Authority exercise with New Windsor EMS. The air show. And we are scheduled to do the air show again this year. Rockland County, I mentioned how they needed IG for their measles and within 15 minutes we satisfied -- answered that request. And Orange County and the most recent one was the 24th of May when they needed again. The Westchester County Airport I mentioned, you know, where we got involved in that.

The biggest issue that we are finding and Dr. Larsen can talk to this -- is burn beds. When we were looking at setting this up there is only 10 burn beds in this region. How do we disperse burn patients? One of the things we are looking at is putting together a call down list for all the different burn beds that are available. That's one of the additions we found we needed to add to this

program.

We do generate a report, it goes to all the hospital. It goes to Suburban, Normet and they pass it onto those folks.

And we have been asked to present this to joint commission meetings. Joint commission puts out a pamphlet or book on emergency management, we were on the cover of that particular document about it. And it's recognized as a way to do things in developing coalitions. And that's the big thing right now in all of healthcare, developing coalitions, working together.

So where we are, we want to get out to all the hospitals. We do have emergency managers from different hospitals, but when we call a lot of people go uh, what's the MACE team? We would like to get on the emergency manager's calendar, the CEO's calendar and present, hey, this is the MACE Team, this is what we can do for you.

All right, Westchester Airport, like I mentioned, we are involved with that. Orange County, we are part of their plan now, if

they see more than 25 patients we get the call to come in and assist. Long-term care, that's where we are headed with this right now. I'm getting a lot of requests from those folks to come in and work with them. And then definitely EMS, you know, I'm the lonely EMS rep at all these meetings and I'm always fighting for -- John, you are there you are part of it. EMS just like we are talking here, we are the stepchild. How do we get EMS involved in this stuff where we belong?

So questions, comments?

DR. LARSEN: Well, I have a couple comments. One, this MACE thing I think is absolutely the most cohesive thing that we have in the Hudson Valley that is an ongoing -- the folks, you know -- and these are a lot of the emergency medicine managers, emergency preparedness managers at the various hospitals have been very dedicated about it, taking this very seriously, they put themselves on-call, it's all volunteer. But they have been there every time something has

gone down where someone knew to reach out to MACE. So, you know, I'm just a really strong supporter of it. Because of all the entities I have seen over the years to try to come up with some kind of cohesive system to respond to a wide area disaster or something effecting a hospital, these folks have done it. And the other thing is that, you know, as we are all under some Empire now of various -- whether, you know, Montefiore, or whatever, Westchester Medical Center, whatever it is, they have brought across the board that kind of cooperation, which I think is also pretty good. So the people haven't broken down into just the silos of their particular, you know, hospital organization.

One thing I would put out a pitch here for is, in addition to the two folks who are always on we've tried to have a physician advisor on board for them to consult with. And I'm on for a lot of that, but it would be great if we had a lot more docs who would be willing -- like I said, I've probably been called once in this whole time. It's not

like you will get a lot of calls, but sometimes they need some expertise on a particular thing. And this is the perfect body of folks to do it. So I'm urging all the docs who are here to think about signing up to take a month of MACE call.

DR. MURPHY: You can put me on, Rich. Put me in Rich.

MR. PARRISH: Got you.

DR. LARSEN: So anyway, whatever a month you are going to be here and you know you are here and not off on vacation or something like that, put yourself in and, you know, just remember that you maybe getting a call from this entity named MACE and, you know, just be really familiar with it.

So that's one thing and, like I said, for me in terms of this is sort of a response system for the National Disaster Medical System. All -- I would bet that the vast majority of all your hospitals are NDMS hospitals. In other words, those hospitals in case of a national crisis are supposed to accept a certain number of patients that

would be brought in. And so right out there on those runways is probably the most common way that -- for instance, this is what happened in Hurricane Katrina. That all of a sudden we had three to four thousand patients that we were flying out of the New Orleans International Airport that went all over the country and all of sudden they were landing at airports all over the country and they had to be distributed out to hospitals and so on. This is the agency that is going to put that together and make it a coordinated effort. And this is why, you know, you can see some of those practice exercises. So from a national point of view and from the fact that your hospitals are -- you know, I would bet that the vast majority of the hospitals here in the Hudson Valley are under the NDMS contract and so they would be the receiving agencies.

So it's -- really incumbent on us to play an active role and support this entity. It is, like I said, what I have seen the most organized ongoing effort to do -- bring the

forces to together and have some kind of an emergency response on an area wide basis. So as physicians please sign up to an adviser for at least a month. Get to know about MACE.

Can we get this protocol -- can we get this Power Point out to -- you know, that would be good. Because this is your sort of basic tool of knowledge and what it is.

DR. MURPHY: We can attach it to the minutes today and make sure it goes out to everybody and we can distribute --

MR. PARRISH: Yeah --

DR. MURPHY: As long as you are okay with that Rich?

MR. PARRISH: Yeah, there is a lot of stuff blocked out in there, a lot of different pictures and all. But NDMS this showed the big plane, Mike, remember Desert Storm? We were putting the ambulances on-call for that and that would be the ideal thing for the MACE team. They would be there, okay, here is who has got beds available, things like that. The hardest set

of beds to fill are psych beds.

DR. MURPHY: That's every day of the week.

MR. PARRISH: Nobody wants -- there is very limited. In fact, a couple years ago we were one of the evacuating hospitals for the surg exercise and our psychs, wound up sending them to some hospital in the Bronx, nobody around here could take them. It's a good way to get a handle on what is available and distributing the patients appropriately.

DR. MURPHY: Excellent. Thank you, Rich. So everybody reach out to Rich if you are interested and I really appreciate the presentation.

MR. PARRISH: Thank you. And while I got the floor I have some other things.

DR. MURPHY: Yeah, go.

MR. PARRISH: We had the election of officers and I got elected a President again, Dave is my new Vice-President, Denise is our treasurer, and Nick Triano (sic) is staying on as secretary.

Some of the things we want to look at is

our committees, need to get more active. When you look at the protocol committee, doing a great job, the training committee. The transportation committee, that poor guy was recruiter, oh, nothing happens. It's the busiest year we have had with transfers. All right? The State EMS, the REMAC are all good things. But our public information committee isn't doing a thing. We need to come up with some type of newsletter. We need to get information out to everybody, you know, what is happening with the protocols. How do we get it out there? You know --

DR. MURPHY: Probably since Mr. Work, right?

MR. PARRISH: Yeah.

DR. MURPHY: He used to be the one to publicize all of our stuff in both directions from a political perspective and just --

MR. PARRISH: Yeah. And nobody has come forward to take that position. Now, our policy and procedure, the gentleman passed away. We need a new person to take that over. EPCR, you know, we are looking at

that, community paramedic medicine. Awards, once a year we get all active in awards. You know, we need to do a better job of recognizing people not one week out of the year, it's got to be fifty-two weeks of the year. All right, so if you are a member of the council you are supposed to be on a committee and that's one of the things we will be looking at to try and get everybody involved in that.

County EMS councils leave a lot to be desired. Some of them are very active, others don't do a thing. Glad to see that the protocol committee is reaching out to the coordinators, hopefully they are going to get involved because the protocol roll out is going to be a big problem. We need to get it out to everybody.

One of the things we are looking is when we get these committees more active is doing a conference call monthly, not waiting every quarter to, hey, what are you doing? Keep their feet to the fire and keep things moving.

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DR. MURPHY: If you did that by phone it might be easier to facilitate and people could just call in.

MR. PARRISH: Yeah, no, we are not looking at coming here. We are looking at conference call, web X, something like that --

DR. MURPHY: Yeah, because it used to be hard for people to jump out of their other jobs.

MR. PARRISH: Yeah. And one of the thoughts is restructuring the council. You know, we need to bring in nonEMS, nonmedical. We need input from civilians about the medical community, EMS, what they do. We have asked at the last meeting that the councils go back and look at their membership and possibly bring in nonEMS folks at least one from each council so those folks on board. The bylaws committee has accepted to revisit the bylaws and make some changes along those areas. All right, the office is looking at, as Mike said earlier, the constant contact e-mail list, looking at Grey

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Goose, which is redoing our portal, we have some issues with portal, Grey Goose --

DR. MURPHY: Not the vodka.

MR. PARRISH: Yeah, not the vodka. And this here is -- I'm glad that Mike brought up the issues with BLS, the BLS protocol committee, a lot of provider issues. We address ALS issues here, we do very little addressing BLS issues. And the BLS folks look at us as the police, not as a resource. When they hear from the region it's usually hey, you guys did something you shouldn't have done. We need to change that image. We need to, you know, hey, guys come on board, we need to work with you. All right? How do we stop this I'm not moving the patient until ALS shows up. All right? BLS is the first level of care and if ALS is not available the next ALS is the hospital, not sitting there waiting for an ALS unit to come out of another county and sit there 45 minutes to an hour, even an hour and a half. How do we do that?

Staffing issues, leadership training.

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We need to put a program together for the BLS folks. How do you effectively lead an agency? Standard of care, that's one of the things that the REMAC -- how many of our BLS agencies are following albuterol, EpiPen, Narcan, glucometry? They are not using it and they are supposed to be.

We talked about the Hospital Hub and hopefully we will see some of that coming out.

Those are things that we see -- we had an Executive Committee meeting and that's where a lot of stuff came from. These are things we see and the big thing is we have to address our BLS. Our BLS folks need attention.

DR. MURPHY: No question there.

MR. PARRISH: Thank you.

DR. MURPHY: Thanks, Rich. And congratulations, I didn't know you were President again.

That brings us to the end of new business. Open forum.

DR. LARSEN: Okay, this can go under

open forum. One of the things, just going back to stroke, is, you know, what prehospital evaluation tool are we going to use? Because everyone is throwing -- you know there is LAM's, there's Cincinnati Stroke Scale, you know there is Fast ED. So I don't know, I think one of the things as we move towards some type of destination system we probably want to have a good prehospital stroke scale. So I would just like to throw that out for people's thoughts.

DR. PAPISH: I thought we tabled it because they are going to come out with --

DR. LARSEN: We are going to wait --

DR. MURPHY: Yeah, then we could all be the same hopefully, so we are waiting to see which one they are going to pick. I still think it's going to be Cincinnati. But we were hoping something was going to come forward maybe more towards Fast and all those things. So we are not sure so we are waiting for them to bring it together and we will all disseminate it on the same page and not have to be redundant.

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DR. PAPISH: The question is should we have a timeline as to how long we are going to wait? I mean, my understanding is it was supposed to be within the year something was going to come out. And, you know, if we are here next year discussing which tool, maybe we should then act.

DR. MURPHY: Right. Mike, I think it will be soon, right?

MR. BENENATI: Most of the information we got from Bill from the State, it appears to be moving very fast. The manual is out and so I think that you are going to see this process move along very quickly.

DR. MURPHY: I think so. There are no guarantees in life but it seems like this one is a hot button item and they are on edge to get it out.

MR. HUGHES: We have a call every month and it's Wednesday this week --

DR. MURPHY: Ask them for the update.

MR. HUGHES: Yeah, with Ryan Greenberg, the Director of EMS up in Albany. So it's all of the program agencies are contacted and

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on the call and that's where a lot of this information comes from so we will see what we can get out of them this time.

DR. PAPISH: It would seem like if we made a whole big hoopla and decided on --

(The speaker cannot be heard.)

DR. MURPHY: It would be a pain in the neck.

DR. LARSEN: Just looking at the studies and the predictive value of each one of these tools seems to be pretty damn close. I mean, in terms of -- just tell me -- just tell me what you are going to use so we can all train to it --

(Everyone is speaking at once.)

DR. MURPHY: Pretty much what came out of the protocol committee was Fast ED, right?

MR. BENENATI: Because that's what REMO used and the only reason is because it's an easy app --

(Everyone is speaking at once.)

DR. MURPHY: Yeah, why reinvent the wheel? The only problem is we wanted to make sure that is what the State is going to --

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MR. JENSEN: I did make a suggestion to Dr. Papish through the Twiage app we mimic something to have Twiage be able to do that processing.

DR. PAPISH: Like I said, they will gladly insert whatever tool we end up picking because they have a vested interest in it.

DR. MURPHY: Any --

MR. HUGHES: One of the issues with the Fast ED is that it's not an option when you are doing EPCR so you have to put it into the other column and it's not counted the same way. But I think they are going to modify that if that's the one they go with.

DR. MURPHY: Anything else?

Okay, I'll ask for a motion for adjournment. I got the words out this time.

DR. VOHRA: Motion.

DR. MURPHY: And a second?

DR. BUTTERFASS: Second.

DR. MURPHY: Thank you, guys. I appreciate everybody coming, have a great week. Happy Monday.

(Time noted: 10:36 a.m.)

THE FOREGOING IS CERTIFIED to be a true and correct transcription of the original Stenographic minutes to the best of my ability.

Yvette Arnold