



# W e s t c h e s t e r R E M A C

## General Meeting Minutes - March 15, 2010

**Date:** March 15, 2010  
**Time:** 9:00 AM  
**Location:** Westchester County Department of Emergency Services  
**Chairman:** Dr. Nicholas DeRobertis, MD

### MEMBERS

Dr. Mark Silberman  
Dr. Ron Nutovits  
Dr. Carlos Flores  
Dr. Paul Koltovich  
Dr. Robert Marcus  
Dr. Emil Nigro  
Dr. Joseph Ponticiello  
Dr. Richard Marino  
Dr. Nicholas DeRobertis  
Dr. David Goldwag  
Dr. Tim Haydock

### AFFILIATION:

Dobbs Ferry Community Hospital  
Hudson Valley Hospital Center  
Lawrence Hospital  
Mt. Vernon Hospital  
Northern Westchester Hospital  
Phelps Memorial Hospital Center  
Sound Shore Medical Center  
St. John's Riverside Hospital  
St. Joseph's Medical Center  
Westchester Medical Center  
White Plains Medical Center

### ATTENDANCE

Present  
Present  
Present  
Excused  
Excused  
Excused  
Present  
Excused  
Present  
Present  
Present

### NON-VOTING MEMBERS

VACANT  
Dr. Joli Yuknek  
Dr. Richard Gallager  
Ray Cordi  
Roland Faucher  
Chief Anthony Chiarlitti  
VACANT  
VACANT

Medical Specialty (Trauma)  
Medical Specialty (Pediatrics)/WPHC  
Medical Specialty (Psychiatry) / WMC  
EMS – Proprietary  
EMS – Voluntary / MVFAVAC  
Police / Pleasantville PD  
Fire - Career  
Fire - Volunteer

VACANT  
Present  
Absent  
Present  
Present  
Present  
VACANT  
VACANT

### GUESTS

Joe Bilotto  
Jeff Casas  
Richard Robinson  
Donald Cottle  
Dr. Erik Larsen  
Daniel Olmoz

Harrison EMS  
Port Chester Rye Rye Brook EMS  
NYSDOH, BEMS  
Westchester EMS  
White Plains Hospital Center  
WCDES

## MEETING

The meeting was called to order at 9:06 AM by Chair Dr. Nicholas DeRobertis. It was determined that a quorum was present.

The minutes from the January meeting were disseminated to the members electronically and were approved as written.

## SEMAG

Dr. Haydock reported on the following: *SEMAG met on the 24th of February and there are a couple of things that came up that were relatively new. One was a new Triage category that New York City put into their disaster mix, pre-hospital disaster mix, which is an orange category. This did generate a certain amount of discussion because this was a departure from the nationally accepted standard of the old colors. Red, yellow, green and black. And, I'm not saying whether I'm pro or con, it's an interesting concept in that what they feel they are identifying with this particular category is people that they're potentially sick that fall outside the category. Or might get misplaced in a group that would be one of the greens. And, these are people that are saying, for example, someone who has a lot of co-morbidities who is in a traumatic event. Because most of these triage categories are based on usually traumatic scenarios. But somebody who might have medical co-morbidities with medical problems who really needs to be more like a red or a yellow, but might fall into the green category. And so they put this forward, and it was approved by SEMAG.*

*Now, there is a certain amount of talk or there is some extensive discussion on the safety of the EMS personnel taking care of patients, and taking care of patients in moving ambulances. The primary issue is unrestrained pre-hospital providers, and all of us know that when you're back there and you're taking care of patients it's kind of hard to be*



# W e s t c h e s t e r R E M A C

## General Meeting Minutes - March 15, 2010

restrained. So there was some discussion about how you encourage people who are in the moving vehicle, in the back of the bus to be seat belted, and to avoid doing things that are not necessary in transport. But, also to define categories of interventions where it's realistic and reasonable for a pre-hospital provider to get out of the restrained seat and take care of the patients such as, of course, airway management and things like that. Now, the obvious alternative to this would be nothing, to stop, which certainly doesn't make a lot of sense necessarily, or to take advantage of technology that prevents you from having to get out of your seats such as routine automatic vital sign measurements en route. And, of course, one topic that came up, which I always love, was the trauma discussion about what do you do starting IVs in trauma patients who would perhaps benefit from intravenous solutions in transport. And the traditional thinking is to start a line en route. So anyway, the discussion flipped back to, "Well, we'll just wait at the scene and start the lines," which sort of goes against the whole concept of load and go and the benefit, whether there are any scientific benefits of doing this in the field for the patients there is a certain body of literature that suggested it's better just to go. What the group is going to do is try to define the procedures that are clear, get out of seat, un-strap yourself and take care of patient, minimize those. And that list will be coming out and discussed further at the next meeting.

Okay, then one of the other large topics that was discussed was pre-hospital hypothermia, hypothermia centers and interventional management potentially of hypothermic arrests that come into emergency departments. And once again the bus is being driven by New York City on this where they are aggressively promoting pre-hospital cooling using 1.8, I think, degrees centigrade fluids with the initiation of rapid infusion of liters of normal saline to just start to cool patients down. A couple of points on this is that I think the feeling is, is that cooling of patients in arrests with return of circulation, the standard of care at this point seems to be to cool these people. You have better outcomes. I think there is a body of evidence out there that suggests this, and certainly we've had some success, I think in Westchester County at certain institutions with cooling patients in the hospital. This is an attempt to extrapolate this benefit of this to initiating it in the field even given the transport times in these patients those arrests is not a long transport. Typically, these are done in patients who have return of spontaneous circulation. But that being said, New York City is looking to even start this on people before they have return of spontaneous vital signs, and that's a little bit more controversial. But in any case, what they're doing there is they put out this protocol where they're going to cool people in the field. They will only go to cardiac arrest centers, meaning centers that can provide cooling for patients who have return of spontaneous circulation after cardiac arrest. And they're not just limiting it to the defib arrests, which has been traditionally been the thinking. They aren't doing any resuscitation absent of the trauma and they're including the trauma patients at this point. It's an interesting protocol and something we probably need to be looking at here at least encouraging the hospitals to use this technology for cooling, most of which is fairly simple. Most of the places that I'm familiar with are using the non-interventional cooling devices, which seem to work quite well to initially cool people. So that was approved.

And there is an attempt by the SEMAC to get a letter from I think it's DOH that excludes the potential penalty of taking these people to the cath lab, i.e., someone who has already a cardiac arrest, they've been resuscitated and they've been cooled. And now you're going to take them to the cath lab. That's going to be a statistically dicey patient potentially for their interventional cardiologist, and may ruin their statistics which sounds like that's not what we're all about, about statistics. But if these people have bad statistics, it doesn't matter what the reason is, they're published in the record and anyone can review these and they can be considered below standard based on their failure rate or complication rate. So there is an attempt to have this category excluded from the database as a potential penalty if there's a complication.

Ketamine is still being considered for field use, and there was some discussion about budget, which is just the same discussion.

And there was also a discussion that there has been some consideration of consolidation of departments, and lumping EMS into Homeland Services, but I think that's probably not going to happen.

There are some discussions of the possible closure of hospitals throughout the state vis-à-vis certainly St. Vincent's in the City potentially closing, which is a big, big deal. The economics of health care is getting to the point where a place like St. Vincent's would close, which is a major trauma center, a major community hospital, a major tertiary center in a very densely populated part of New York City. The fact that this would even be considered or even be allowed is a disturbing situation.

### **SUBCOMMITTEES/TAG Reports**

**PARAMEDIC PROTOCOLS** – D. Olmoz reported on behalf of Dr. Cordi: Specifically, I think the major issue that has come up with protocol is that if you will recall going back to the last meeting, they had requested that the Regional EMS Council consider developing an operations based committee to assist them. Since they were



# W e s t c h e s t e r R E M A C

## General Meeting Minutes - March 15, 2010

receiving requests to get involved with issues that after beginning the original review, it seemed that they were more operationally based than protocol driven or patient care related. So the Regional Council did make that motion and it was approved at the last meeting, and that committee is due to meet next Monday. It will be their initial meeting. So they will be working pretty much side-by-side with protocol so that operational issues can be looked at, and new protocols, policies and procedures and what-not can be developed accordingly. Outside of that, the main work task right now is they're initiating the next revision of the Advanced Life Support Protocols beginning with the introduction section. So that's underway.

Dr. DeRobertis added - *All right, and I think one of the things that they were asked to investigate, too, is patient contact, the definition of that which I think is going to be somewhat difficult. But they're going to try to at least give us an idea of how we should consider that.*

**EVALUATION** –Dr. Haydock reported there was one case that was brought to the attention of the Regional office that was not found to meet the Evaluation Committee review process.

**QUALITY IMPROVEMENT** – D. Olmoz reported on behalf of Dr. Yuknek: *The Quality Improvement Committee is engaged in revising the Quality Improvement Guidelines, and as you'll notice there's a recurring theme where all of our major documents are currently under revision. So there is a huge amount of work before some of these standing committees. But, I think for good reason it's been a number of years since a lot of these documents have been looked at and modified. And the Committee members have been asked to expedite their return of comments so that we can move that project forward.*

Dr. DeRobertis added - *And I think one of the things we're trying to look for, too is just to sort of get a brief summary, too, of our QI Plan itself as something a little more palatable itself for the EMS agencies to read and use. So once we get that done, we'll certainly get that out to the agencies itself for comment.*

**STEMI TAG** – Dr. Goldwag reported the following: *I think the thing that is most important is that this just really has to be driven by the Medical Directors of the ALS Units. They need to know their STEMI centers and their geographic areas in detail. And again, we recommended having two, one for the primary geographic area and then a backup for traffic situations etc.*

D. Olmoz added - *to this date we have not received any formal agreements. We did receive one from a BLS agency, but we moved to clarify that really the only agencies that are being asked to engage in this collaborative agreement are the paramedic agencies. However, a good question was raised and that was that some of these paramedic agencies are intercepting with the BLS ambulances, which are physically doing the transportation of these patients. And they may at times go outside of their region, and it was suggested that this information be made available to those agencies as well. And I believe that that's what we're going to be working towards and the information, the original announcement and packet was distributed to all EMS agencies, hospitals and the Regional Council as a whole so that everybody could start to at least review that material. There were also some concerns about turnaround times. And, how that may be looked upon if an agency feels that they are going to be unduly burdened by traveling far outside of their service area to deliver this patient to the STEMI center. And how that may impact their ability to service their contracted or their primary territory. And would it be appropriate if the medical director and paramedic agency decided or elected not to transport patients to STEMI centers on behalf of serving their own primary territory expeditiously, which is an interesting concept.*

Dr. Goldwag responded - *I think that's up to the medical director. If a medical director of an ALS unit feels that the number of STEMI patients are going to be diverted would adversely affect the response time, that's something they could bring back to this committee. I can't imagine that there are more than a handful of cases that really wouldn't stress things. But theoretically, it is certainly possible they're going to be driving further. But all of these agencies are currently doing that for trauma patients, which is a very, very common reason to go to a specialty designation hospital. And so I think as Dan is saying that this is going to be a much, much, much lower volume of cases. So I think it's just really education and working with the people to make them understand that it won't happen that often.*

Dr. Haydock commented as follows - *One point I should also mention in regard to the STEMI destination procedure that we have. I think Nick you had asked me, or someone had asked me to explore what the State's position was on having this diversion from STEMI patients to STEMI centers in Westchester County because I think the Hudson Valley Region is having some issues with that. And whether they were allowed to do this without getting a protocol approved. And the answer to that question is if you don't present it as a protocol, but you*



# W e s t c h e s t e r R E M A C

## General Meeting Minutes - March 15, 2010

---

*present it as a procedure based on medical direction, you are not changing the protocol per se. You are just having a little procedural modification. And this has been done and that's what New York City did and certainly there's a precedent that we could do that.*

**INTERFACILITY TRANSPORT TAG – No report**

### **SPECIAL COMMITTEES**

**HUDSON VALLEY / WESTCHESTER HELICOPTER COMMITTEE –** D. Olmoz reported on behalf of Dr. Stuhlmiller: *We met on Thursday and that Committee is also jointly reviewing and revising the Helicopter Utilization Guidelines. And, once again, the thought process is to streamline the document and kind of simplify procedures. And, I don't believe there were any incident reports. There is a reoccurring discussion about communications. The Committee has made a recommendation that Lifecom, which is the nationally based dispatching entity, that Lifecom should be dispatching all of the air medical services in the regions. As you may know, currently there is a separate dispatching system in place for the New York State Police helicopters, and, that's being looked at to see whether or not that concept can come to fruition.*

**HUDSON VALLEY REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC) – No report**

**DIVERSION REPORT -** D. Olmoz reported that a report was created by Katherine O'Connor and was distributed to REMAC for review. Dr. DeRobertis asked if there were any related questions. None were voiced.

### **NOTICES OF INTENT**

**PAD –** Child Rehab of White Plains, Town of Greenburgh

**APPLICATIONS FOR SPECIAL PERMISSIONS (i.e. Albuterol, Mark I, EMTD) – None**

### **OLD BUSINESS**

D Olmoz commented as follows - *One item that I did want to bring up was regarding the CME and Credentialing Procedures. We attempted to get some participation on the Credentialing Committee as it was I guess put together back in 2003. I'm only recently finding out that some of the people that were originally on that Committee were unaware that they were participating on that Committee. So we put out an announcement just last week just asking everybody that was supposed to be the Committee to reconfirm if they were able to participate. And we certainly can use some additional input. We would like to branch this out a little bit to get minimally some of the other course sponsors involved. Specifically, I think one of the key players that should be involved with the process is the Paramedic Program at Westchester Community College. And I just wanted to kind of run that by the body to make sure that everybody is okay with that. We already have one course sponsor representative from Phelps and that's Jeff Meade, and he's very willing to participate. And he's come up with a number of great ideas, and we would like to again move that process forward as well. So if anybody else is interested, please put your name forward. Again, just to kind of comfort everybody to a certain extent, a number of these committees are attempting to meet through electronic means, and conference calling because we realize the lack of time that everybody has to commit to physically meeting face-to-face.*

### **NEW BUSINESS**

Dr. DeRobertis commented as follows - *Not much else, but we certainly downsized at least a number of these meetings for the year. So what is going to be really of importance itself is obviously these TAG meetings.*

*Because obviously a lot of the stuff that we're going to be discussing itself is going to be coming from the TAG or our meetings themselves or the committees. So it's just really imperative for us to obviously meet electronically or*



# W e s t c h e s t e r R E M A C

## General Meeting Minutes - March 15, 2010

---

*to meet physically itself for these meeting to obviously to try to decide on some of these topics that are being pushed there. I think it's just imperative. So for those who are on those committees please make a real effort to get there or to electronically give some feedback. I mean, Dan is working feverishly himself obviously on the computer itself to give us a lot of emails with a lot of responses that he's looking for, and I don't think a lot of times he gets any response at all. And, I think that is not really something that we should promote because obviously it's not going to bring anything to the table except for what Dan works at. So I think I really want to emphasize to everybody to please be active in those committees. There is a lot of good stuff that needs to be done there. There is a lot of stuff that has to be revised. Because the only things we've done is the bodies themselves who actually volunteer for these committees and actually meet either electronically or physically so that we can have something to discuss here.*

*D. Olmoz added - I think a great move that the State, and I don't know if you're aware, but recently the new officers were put in place on the State EMS Council. And SEMSCO Chair, Bob Delagi who is from Suffolk County EMS had made a suggestion, since all of the committees at the State level are having the same issues that we are regarding participation and what-not. And they made a recommendation that all the committee chairs go back to their individual committees. And, put together some work plans and some time lines to re-look at all of the work that has been designated to the committee over the past several months to determine and establish goals to see if there is even something that can be achieved with the work that is being assigned to them. And each committee chair is on a regular basis asked to put together a report so that that information can be followed. I think it would be a great move for us to do that for our Regional Council in a REMAC as well. So that information continues to flow. As it currently stands, I'm going to try to keep everybody informed, but although I would love to be the chief decision maker for this body, I don't believe everybody else would agree with that. And, you know, the reality is that there are certain interpretations that come into play when it's left to one person's hands. So I would suggest that in the coming days that everybody tries to at least voice their opinions and get a little bit more involved with that.*

There was a brief discussion regarding the credentialing process for medical control physicians. Clarification was made that the materials were available on the [wremasco.org](http://wremasco.org) website. It was suggested that the Credentialing Committee work on improving the process. Concern was voiced over the specific terms of credentials and the process to maintain them. A request was made that a list of medical control physicians and their credential status along with the responsibilities for maintaining credentials be distributed to the ED Directors for review.

Dr. Larsen mentioned a study that challenges the notion of transporting trauma patients to a local hospital if the Golden hour can not be adhered to. The REMAC members were referred to the March issue of Annals of Emergency Medicine for the article.

**NEXT MEETING** –The next meeting is scheduled for **Monday, May 17, 2010** at 9:00am.

Session was adjourned at 10:20am.

Respectfully submitted by D. Olmoz