5/13/2026 - Medical Standards - Saratoga Springs

NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS

DATE: May 13, 2026

TIME: 8:06 a.m. to 10:04 a.m.

CHAIR: DR. JEFFREY RABRICH

LOCATION: 24 Gideon Putnam Road
Saratoga Springs, New York

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2 **APPEARANCES:**
ELIZABETH MCGOWN
3 RYAN GREENBERG
MARK HENNESSEY
4 DOUGLAS FISH
THERESA ALLEN
5 MERRY RUDINGER
ARTHUR COOPER
6 MAIA DORSETT
MICHAEL DAILEY
7 JASON WINSLOW
DAVID KUGLER
8
BRIAN CLEMENCY
JONATHAN BERKOWITZ
9
KIRBY BLACK
10 MICHELE (MICKEY) FORNESS
NAVEEN SETH
11 DANIEL OLSSON
DAVID VIOLANTE
12 GEORGE STATHIDIS
PETER BRODIE
13 DONALD HUDSON
ERIN REESE
14 DAVID STALERNO
MARK PAPISH
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STEVEN KROLL
JON WASHKO
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JERRY RUBANO
MEGAN WILLIAMS
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MICHAEL REDLENER
18 STEPHANIE SHULMAN
TIMOTHY EGAN
19 AL KIM
SCOTT CLARK
20 STEPHEN CADY
CHAD SMITH
21 ANDREW KNOELL
JERROLD GELBARD
22 CARL GANDOLFO
DONALD DUVALL
23
STEVE MEEHAN
GREGORY GILL
24
SAMUEL TINELLI
25 CHRISTOPHER SMITH

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2 **APPEARANCES:** (Cont'g.)
JENNIFER GOLDMAN
3 MICHELE MILLER-MCEVOY
CARLA SIMPSON
4 SALLY DRESLIN
AMY EISENHAUER
5 MICHAEL BENENATI
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2 (The meeting commenced at 8:06 a.m.)
3 **DR. RABRICH:** I'm going to call this
4 meeting to order of the Med Standards Committee. The
5 attendance will be going around. Please sign in on
6 the attendance sheet. And we're going to start with
7 some old business. So, the first item is an update
8 on the blood implementation on where the regs are at
9 and where we're at with blood. So, I don't know. Do
10 you want to speak to that or someone else? Blood
11 update.
12 **DIRECTOR GREENBERG:** Oh, yeah, Sure.
13 Jumping right into things here. Okay. There's
14 another mic there too, so that way everybody has a
15 mic. All right. So, blood update. Actually excited
16 on this one. For starters, thank you for everybody
17 on this panel who was a part of it and helping
18 drafting the regs. The regs have left the division
19 and are now in the approval process. So, we are
20 hoping for that to come out for public comment period
21 my hope sometime probably late summer is, you know,
22 by -- goes through the process.
23 It will -- just a reminder on what
24 that public pre -- comment period looks like. It is
25 sixty days on the first one, it will come back. If

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2 there is no substantive changes, then it will move
3 forward. If there are substantive changes that come
4 back, then it has to go back up for public comment
5 period, which is another forty-five days. So, going
6 through that entire process, if it only needs one
7 public comment period, I would say it's probably end
8 of the year. If it needs two, it might be end of the
9 year, beginning of next year, that really just falls
10 into the responses.
11 Particularly for everybody on this
12 group, I would highly recommend if you read them and
13 you find that they look good, positive public comment
14 is as valuable as productive public comment. So, by
15 all means, please feel free to read it when it does
16 come out and things like that. And the other thing
17 that is there is the -- and one that has come up for
18 a couple of people in here is related to what used to
19 be called the ambulance transfusion services, which
20 will now in the future be the interfacility blood
21 administration services. That is in that same reg
22 set.
23 However, we do have a couple of
24 deserts around the state, and so we have worked on
25 some provisions with legal to get a few additional

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2 agencies approved during this interim because of
3 where we are on the steps and the other processes.
4 So, in the next couple of weeks, we'll be working on
5 that one. So, they'll go through the same process
6 that they will after. They'll get a temporary
7 interfacility blood administration ability. And then
8 when the regs fully come out, they will resubmit
9 everything, it'll be reviewed and then keep going.
10 A reminder for anybody who is an
11 ambulance transfusion service today, you still are.
12 So if you were approved through Wadsworth, it never
13 went away. However, when the new regs come out, you
14 might have to just re-up your application, but it
15 would never -- it -- it wouldn't go away. It just is
16 updating all the documentation and everything with
17 it.
18 **DR. RABRICH:** Thank you. Do you -- so
19 for current A.T.S. providers --
20 **DIRECTOR GREENBERG:** Yes.
21 **DR. RABRICH:** -- do you anticipate a
22 big change for them, or is it just like some minor
23 paperwork update? So they'll still be -- they'll
24 just change the name of it.
25 **DIRECTOR GREENBERG:** Yeah.

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2 **DR. RABRICH:** They'll still be
3 approved, but they may have to update some --
4 **DIRECTOR GREENBERG:** Almost no change.
5 They'll just essentially resubmit a new packet and
6 continue on their way.
7 **DR. RABRICH:** Okay. And then the
8 couple that you mentioned that are kind of hanging
9 out there, they'll be reviewed for a temporary?
10 **DIRECTOR GREENBERG:** Yeah. So there's
11 been four or five that have reached out that have
12 identified the need that we've spoken to the local
13 hospitals as well. The hospital has confirmed that
14 there's, you know, a real challenge in some of it.
15 The need has been met, but it's been met by a nurse
16 going with the ambulance crew. So it's not that the
17 need isn't being met today. It's that the extent of
18 what needs to occur in that process --
19 **DR. RABRICH:** Right.
20 **DIRECTOR GREENBERG:** -- has been a lot.
21 So, we're just working on trying to do that. That
22 hopefully also would allow those patients to be
23 transferred sooner because if that hospital is
24 sending a nurse, it sometimes is a situation where
25 they need to wait longer or wait for a shift change

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2 or wait for something else and just working on that.
3 **DR. RABRICH:** Thank you.
4 **DIRECTOR GREENBERG:** Yeah.
5 **DR. RABRICH:** Any questions around the
6 -- the blood regs? Comments? So just -- just to
7 reiterate what the director said, any -- any -- if
8 you review them, positive comments are important as
9 well, right? The -- the -- the more substantive
10 comments there are that are -- require additional
11 rounds will just delay things. So if you review them
12 and they look good, please put positive comments
13 there.
14 Next is our clinical data integrity
15 tag. I don't know, is -- yeah. Would you like to
16 give us an update on the clinical data integrity
17 work?
18 **MR. VIOLANTE:** Yes, absolutely. Thank
19 you. David Violante here. And so we've been chasing
20 the data for a little bit of time now trying to
21 figure out where and how it gets to where it how it
22 gets to. And we've come up with a good process of --
23 of how we believe this occurs and wanted to share it
24 in a -- in a very easy way, and give you all some
25 ideas of how we're trying to move forward with this

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2 as well.
3 Next slide. So here we've got our
4 practitioner out in the field doing his or her work
5 and creating an E.P.C.R. and that E.P.C.R. then goes
6 to vendors and agency admins. Now, both of those
7 groups in this box have the ability potentially to
8 change the data in the P.C.R. And so vendors have
9 specific data that's in their coded specific ways.
10 And in some of those vendor systems,
11 agencies can change what that data looks like in
12 coding, and in some of them they cannot. And so of
13 course in those that don't have the ability, it's
14 great because the data's homogenized in -- in a
15 better way. But for those that can, you'll see what
16 happens.
17 And so that data is -- is hopefully
18 NEMSIS data and NEMSIS gets its data from a few
19 different places. For impressions, it's the I.C.D.
20 ten codes. For procedures, it's SNOMED codes. For
21 medications, it's R.X. Norm codes. And for locations
22 and demographics, it's all through Mr. Zip. Thank
23 you, Mr. Zip.
24 Next please. So all of that data then
25 goes into the ImageTrend Elite site on -- on the

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2 state bridge. And in some cases, it will go to the
3 regions after that. In a few cases, it goes to the
4 region first and then it goes into the elite site.
5 But in any event, that data that all comes in goes to
6 the elite site and typically out to the regions and
7 the next square that comes up there. Thank you.
8 And then from there at the regional
9 level of all the regions, they have the ability to
10 look at the data in a run chart and do quality
11 improvement. And so that data comes out in -- in a
12 variety of ways to them. They can parse it, they can
13 look through it and -- and -- and however they need
14 to for all the different things that they want to
15 look at and come up then with change decisions based
16 on that data and get back to what's going to happen
17 out on the street for practitioners and with
18 agencies.
19 So, this is the usual flow that we've
20 found out and where these codes come from and all
21 that jazz. Next slide. So, when we look at the data
22 on the state bridge, there's a few different pieces
23 here to look at. The first is, that on the left-hand
24 side there's different codes and values and then
25 where the red arrow is labels. The codes cannot be

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2 changed, the labels can. So, if we wanted to look at
3 a particular code and it comes up first on the list,
4 but we want to call it something other than what the
5 -- the value is, we can change that. Next slide.
6 So, if we look at this here, the code
7 for the SNOMED value here for this first one is what
8 it is for twelve lead E.K.G.s, and the label on the
9 right says twelve lead E.K.G.s. And so there's
10 others. There's four leads, there's A.E.D.s, there's
11 all kinds of other things that are here, but the code
12 is the thing that doesn't change although the label
13 possibly could, depending on the vendor. Next slide.
14 So if we look at these codes, we have
15 just hundreds potentially of codes out there in data
16 sets with similar sounding values and we can change
17 the labels on them. And for a lot of these things,
18 agencies can just choose and sometimes they typically
19 do, the first one on the list because it's the first
20 one on the list that must be the right one, and we'll
21 call it DuoNeb. And so that's what goes into the
22 P.C.R. But when we send the code out, seventy-two
23 thirteen for the first one, great, if that's what
24 everybody is using or that's the thing that we're
25 looking for. But if we start using different codes

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2 and labeling them differently, then we come up with a
3 problem in terms of looking at the data. The data's
4 not going to show us what we think it is showing us,
5 and this is something that we found with the I-gel
6 program in a variety of things being coded
7 differently. Next slide.
8 So when this data gets sent out, it's
9 the code that gets sent, not the label. So, if
10 you've called the label one thing expecting the code
11 to be that thing and it's not, guess what everybody
12 else sees? The other thing. And so this is the code
13 for twelve lead E.K.G.s, and you can see that it's an
14 E-procedures code, the code shows up there and that's
15 what gets sent out by X.M.L. file to the state.
16 Also, some hospitals now are just
17 taking the X.M.L. downloads for patient data that
18 comes in from the pre-hospital care providers and
19 they don't even see the P.C.R. anymore, so they don't
20 see what you have called it. They just see the codes
21 that are occurring. Next slide.
22 So, if we've all used the same code as
23 -- as we started this process here, this was our
24 initial thoughts, use the same code. Seventy-two
25 thirteen is DuoNeb, all the agencies are using that

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2 code, we can now see there's four uses of it. If
3 agencies are using different codes, then we see that
4 perhaps DuoNeb is actually used once in reality for
5 documentation purposes, but in all actuality, it has
6 been used four times. And so that data is just not
7 appropriate data that we're looking at.
8 So, one of our initial solutions is
9 looking at -- next slide, a defined list of codes.
10 And so for medications in the protocols, R.X. Norm
11 codes. And so if you're going to use Albuterol in
12 this concentration, this is the code. If you're
13 doing an intubation where you're going to use SNOMED
14 codes and that intubation is this code. And then
15 primary impressions using I.C.D. ten codes and for
16 whatever that impression is, it's this code. We had
17 a great suggestion yesterday that potentially we put
18 the codes for the procedures and medications directly
19 into the protocols in some way, so that when you're
20 doing that thing, this code is the thing that shows
21 up. And so we are looking at that as another option.
22 And then we thought -- and I'm going
23 to turn this over to Maia here, well, we can't just
24 go changing all of these codes, you know, willy-nilly
25 and -- and make sure they're all working and just

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2 change a whole batch of everything and all these
3 different areas at once. We've got to do it a P.D --
4 P.D.S.A. cycle for it. So Maia, I'm going to turn
5 that over to you for this piece.
6 **DR. DORSETT:** Yeah, so to -- what we
7 went through is we got essentially all the data of
8 every code that's been used for medications,
9 procedures and impressions in New York State for a
10 year and came up with a defined list. The problem
11 instead of saying like everybody must use this, is
12 that you have to remember that we are one state
13 amongst many, and others have the same issue. And if
14 other states like California came up with their
15 defined procedures list, which we tried to match, and
16 other states come up with their defined procedures
17 list and then there's currently thirteen vendors
18 working within New York State, it's a -- it's a messy
19 thing to say like, we're going to do it our way and
20 then everybody has to -- to subsequently change.
21 And so, in quality improvement before
22 you make a big change, right, you test small and say,
23 are we going in the right direction? Because I began
24 to get nervous that if we said these are the codes
25 that required, we were going to actually take a mess

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2 and make it a bigger mess without actually developing
3 a process on how to do that.
4 And so we came up with the idea that
5 we do a quality improvement project specifically on
6 data integrity now that we kind of understand the
7 problem and we choose a medication that we know is
8 represented multiple ways like Epinephrine and
9 cardiac arrest. A procedure that's in many different
10 ways like compressions or C.P.R. and all those
11 different ways, a bag mask, ventilation, things that
12 are both at the A.L.S. and the -- and the B.L.S.
13 level and say what would it take to make it so that
14 that shows up correctly in the state database for
15 everybody in New York State because that's a defined
16 problem that you can measure over time.
17 If you think about what are the
18 different ways that you can fix this problem and
19 imagine, right, there's two components. There's --
20 you can make it so that all the inputs are the same
21 so that when people have their E.P.C.R., we're
22 saying, like, these are the export codes that you
23 must use. That is actually problematic given the
24 number -- the ways E.P.C.R.s work across different
25 states. And also, it's problematic because people

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2 get their E.P.C.R. and let's be real, like, I didn't
3 understand any of this. Like when it happened, I was
4 like -- when I finally was like, oh, it's a mapping
5 problem. We can't expect every single agency person
6 to actually set this up correctly, and you're going
7 to constantly be chasing your tail.
8 So the other option is having it so
9 that on the back ends we say we translate those codes
10 into the code that we are looking for so that when we
11 write our reports, we can look at it. And I'm going
12 to turn over to Jill to talk about that, but I'm
13 going to give like a -- a clinical example on a -- a
14 regular like a couple quality measures that are
15 national quality measures.
16 Let's say I want to say what
17 percentage of altered mental status has a blood
18 glucose check, or what percentage of seizure patients
19 have a blood glucose check. There's lots of
20 different ways that that is documented. I don't know
21 there's like ten or twelve different ways to say I
22 checked a blood glucose and actually sometimes
23 whether or not I checked a blood glucose is that a
24 number appeared because I can't actually check a
25 blood -- get the number without actually checking the

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2 blood sugar.
3 So you have to design things so that I
4 can actually answer that for the state. It's really
5 hard to answer that for the state. For are we using
6 capnography to confirm invasive airways? Currently,
7 the way that we actually have to write that report is
8 I have to search for each individual procedure code
9 and say contains. Like I can't actually say the text
10 of all the different invasive airways and select that
11 within a report. And so you constantly have to
12 update that as well as the medication. So it's a --
13 it's a real issue.
14 I think the solution is going to be
15 that the -- on the state end for most things, and
16 we'll talk about the exceptions that we translate
17 what the input is. So, I can say glucose this way
18 and it says this is glucose and it maps to that. I'm
19 going to turn over to Jill.
20 **MS. JILL:** Good morning. So, I sit on
21 clinical data tag for the defined list. And as we've
22 been going through this, one of the things that has
23 been rolling around in my head is that we are -- we
24 have to get nine hundred to a thousand agencies to
25 try and do this in addition to vendors and whatnot

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2 and that's a lot of work, right? We've been talking
3 about export codes. Really what I think where we
4 need to make the change is on importing. Thinking
5 about this from the I-gel project and whatnot, David
6 had said a while ago when they were doing the
7 reports, there was seventeen different codes coming
8 through. We have an issue on blood -- blood glucose
9 where there's twenty different codes coming through.
10 Rather than asking everybody to export
11 the same code, we can take those codes and have the
12 state import them as a particular code. So, we have
13 a list of procedures from the last year. We can kind
14 of put that list together. We take all twenty codes
15 for blood glucose and we just have the state say,
16 okay, it doesn't matter which code it is. It's
17 coming in as blood glucose, and that kind of
18 correlates it together.
19 The other thing that this would allow
20 us to do is it allows agencies to have some
21 differentiation on their end. We're not forcing
22 agencies or medical directors to comport with the
23 same procedures if they wanted to -- the example I
24 have in my region is vent. I have a couple of
25 residents who use a personal vent. I have a skilled

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2 nursing facility that is a step-down unit from -- for
3 vented patients who are either -- learning to live
4 chronically on it. And then I have my own ventilator
5 that we use on A.C.T. transports.
6 It is very important for me when my
7 providers document a venti -- ventilator use that I
8 can differ -- differentiate between the patient's own
9 ventilator, the facility ventilator that comes with
10 the respiratory therapist managing it, and then my
11 qualified ventilator paramedics. I don't know if the
12 state or data definite -- necessarily cares about
13 that, right? It's just a ventilator as far as
14 procedure goes. So this rather than having everybody
15 try and export and get everybody on the same page, it
16 would be easier for the state to say, these all code
17 -- these codes for this procedure import as just the
18 singular -- the singular procedure code. I don't
19 know if that's --
20 **DR. DORSETT:** Yeah. And the one
21 exception to this is that, so there are things that
22 we'd want to reach out to the agency and have them
23 change the -- their export. And this is sometimes if
24 you change the number on a procedure by one digit, it
25 comes out as something totally nuts. So, when we

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2 look through -- I looked all the data on procedures,
3 one of the procedures that was done, I don't know,
4 like eight hundred times was like a reduction of a
5 middle failings dislocation, like a third middle
6 failings dislocation reduction or something, and
7 you're like, that's not in scope of practice. It's
8 not like there's a rogue agency relocating fingers,
9 you know, that they're not supposed to be doing.
10 What it is is that there's a miss
11 code, but it allows you, right, if it doesn't -- if
12 you set up like, these are the things that we accept
13 and we can map it, and when you have an unmappable
14 code, it allows you to actually figure out what the
15 source is for that agency and say, hey, I think you
16 have a -- a mismap or a miss code, so that we can
17 actually improve the integrity of the data. So,
18 there is going to be some agency level like reach out
19 and quality improvement on this because there are
20 some things that are unmappable to an E.M.S.
21 procedure, but we don't -- right now, like, we don't
22 even catch those things. We just have, like, that
23 appearing. And if you look at the state data set,
24 like I could probably write a research paper on, you
25 know, finger dislocation and E.M.S., that would be

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2 total nonsense.
3 **MR. VIOLANTE:** So I think our -- our
4 approach to this is going to be several pronged. I
5 think we're going to look at -- at this method of
6 filtering the data at the state level and compiling
7 it down. Also, creating defined lists for agencies
8 to use so that those that can and will would do it.
9 And another option also is to provide these defined
10 list codes within the protocols as well to make it
11 easier for folks at the agencies to use the right
12 codes. And so stay tuned for more as we continue
13 through this process. We'll take any questions.
14 **DR. RABRICH:** Dr. Winslow?
15 **DR. WINSLOW:** Forgive me for being
16 captain obvious, but can't we just delete all the
17 codes we don't want?
18 **DR. DORSETT:** No, you can't do that.
19 So, you mean like at the agency level?
20 **DR. WINSLOW:** No. Can't we delete it
21 from the platforms so that there's no redundancy and
22 make it so that there are codes that we set as
23 opposed to the -- the ones that the vendor sets?
24 **DR. DORSETT:** Well, I don't know about
25 the platform that only works in New York State, but

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2 you can't do that.
3 **DR. WINSLOW:** Okay.
4 **DR. RABRICH:** Other questions or
5 comments?
6 **DIRECTOR GREENBERG:** So I think just on
7 that one, and Maia, correct -- correct me if I'm
8 wrong on this one, part of that is institutional
9 data. So if one institution and I think the -- the
10 Roman numeral four was an excellent example from
11 yesterday is, if the Roman numeral four was used in
12 order every time that they started an I.V., and now
13 all of a sudden you change the code and they go to do
14 any reporting in their own agency, they wouldn't have
15 all the accurate data from their data set, and so
16 that's why bringing it up and mapping it at our level
17 keeps their data contained and reporting the same way
18 it has been.
19 The one question I have to that is, as
20 they change to a new platform, so let's say someone
21 moves from image trend to E.S.O. or something else,
22 is that a point where we should be correcting the
23 information?
24 **DR. DORSETT:** I -- I think ideally,
25 right, we provide these so when Jill is going through

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2 getting onto image trend right now and she -- she's
3 like using all the kind of the defined procedure list
4 to make sure that the mapping is correct. But I
5 think if you're constantly -- you can make those
6 recommendations, but if you're constantly trying to
7 police every single agency as they're changing, like
8 you are going to be chasing your tail indefinitely
9 around bad -- bad data. And honestly, it should just
10 be like they can pick a glucose and it just appears
11 as a -- as a glucose.
12 The same thing like there's agency
13 level data that I might be interested in as a medical
14 director. So for example, at a state level, I don't
15 think we -- I mean, I think it's important that we
16 know whether or not we are giving epinephrine and
17 anaphylaxis, which is actually a -- a nationally
18 recommended measure for pediatrics, ideally at the
19 correct dose. But whether or not that comes as an
20 auto-injector, whether or not that comes as a check
21 inject, whether or not it comes as this other
22 formulary, those are all actually different R.X. Nome
23 -- Norm codes, and we can condense that.
24 But as a agency medical director or an
25 agency, I want to say like, how many times are we

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2 using an auto-injector versus this? Like I can still
3 answer those questions at an agency level. There are
4 things that when we made the recommended procedures
5 list, we actually went through and compared
6 everything. If there was a NEMSIS recommended code
7 for it, we use that. If California had picked a code
8 for that, we use that. Otherwise we pick the one
9 that was the most commonly used one.
10 There are some things that are not
11 part -- NEMSIS recommended codes don't actually get
12 updated. So there's no distinguishment between
13 indirect laryngoscopy, like video laryngoscopy, and
14 direct laryngoscopy. I think actually as a system,
15 that's actually an important thing to say, are our
16 systems turning over to video laryngoscopy? What is
17 the impact on metrics around airway management in New
18 York State? So, like, I think there's a process
19 where we say like, these are the codes. And like we
20 -- when we made our defined recommended list, I kept
21 those actually as separate.
22 Like, I think indirect laryngoscopy
23 should be a separate -- a separate code that we're
24 able to actually measure at a -- at a State level,
25 which means that there's still iterative processing

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2 every two years where we look at that and say, as
3 practice changes, are these codes reflecting the
4 questions that we want to be able to answer? But it
5 should be like the minimum information and as simple
6 as possible for the questions we want to answer.
7 **DR. RABRICH:** Thanks. Any other
8 comments or questions on this topic?
9 **MR. STATHIDIS:** Yeah. George
10 Stathidis, New York State Department of Health. I --
11 I just want to say that this is something that I
12 think we can explore. I know that we've talked about
13 sharing some data so that we can identify some
14 specific codes that we can use to test and see how
15 this works. I -- I -- I think that this would be the
16 same, right? We would want to explore this to -- to
17 make sure that this is something that the state can
18 do, that we can do it accurately and that we can
19 really reflect the care that's being provided in any
20 data that we would be transforming. So, it would be
21 a process that we would need to explore, and happy to
22 work with you.
23 I just wanted to say, I think that we
24 should probably start small with this if we're going
25 to do anything because it could put a lot of the data

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2 that we have at risk, right? And -- and by that I
3 mean we could possibly risk doing something that
4 makes, you know, the data inaccurate if we are
5 transforming such a large volume of data, right?
6 Over four million records per year. So, my only
7 caution is that we -- we do this -- you know,
8 approach this carefully and that we really think
9 about what steps we need to do and -- and start on a
10 smaller scale to make sure that we can do it
11 accurately.
12 **DR. DORSETT:** Yeah. I -- I completely
13 agree. I think we pick a medication, a procedure,
14 right? And you can literally transform it and you
15 collect, say, we're going to flip the switch and we
16 are going to collect information for three days,
17 right? That's a -- and see what is the -- what is
18 the impact on that. The good thing about New York
19 State is that we run lots of calls. And so, if you
20 pick something that is common enough and messy enough
21 to start with, you will have enough information to
22 actually learn the consequences and the unintended
23 consequences. And if it works, you can spread from
24 there.
25 And I think Jon Washko made this

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2 excellent suggestion about, like, thinking about the
3 relationship with the protocols, right? Like, I also
4 don't think you do one test and say, oh, this is the
5 solution. Let's implement it all. I think we slowly
6 would say, if this is the solution, and no first
7 solution is ever the correct solution. Like, there
8 will be failure initially, so you're going to fail
9 small, is we slowly, like, march out by things that
10 are within the -- within the protocols, and study
11 each one of those individually.
12 But I think the operational
13 definitions of the quality measures are actually
14 pretty straightforward, which is the proportion of
15 the things in your state registry that are called
16 that code out of all the things that could possibly
17 be called it, and that's something that you can
18 completely track over time because that's data that
19 you can pull out of your system because you can pull,
20 like, what are all the procedure codes and -- and map
21 those -- and map those things, which is what we
22 essentially did manually for a year of data.
23 **MR. STATHIDIS:** Use A.I. Done.
24 **MR. HUDSON:** And George, to your
25 point, I think we're -- we're going to be at that

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2 point because, Peter, correct me if I'm wrong, the
3 defined lists for hospitals, we're implementing that.
4 Correct?
5 **MR. BRODIE:** I'm sorry, I didn't hear.
6 **MR. HUDSON:** I know you weren't
7 listening, that's all right. Let me get closer to
8 the microphone. We're -- we're implementing the
9 defined list for hospitals finally?
10 **MR. BRODIE:** Yes.
11 **MR. HUDSON:** Okay. So I -- I would
12 suggest that's the perfect test bed because it's a
13 fairly static list, and what that means is why we're
14 doing that is we've now been for years chasing where
15 our patients are going and -- and I'll use my region
16 as the example, but I know it extrapolates across the
17 state. So, I have thirteen hospitals. When I run by
18 name, there's hundreds of them because some people
19 list St. Joe's as S-A-I-N-T capital, which is
20 different than lowercase, which is different than
21 S.T. period, which is different than St. If we do it
22 by code, many of them still have the old three-digit
23 codes that was talked about yesterday, which is going
24 away, right? Rather than the H designation with the
25 zeros that they're supposed to be using.

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2 So this is part of the problem we've
3 been chasing and eye gel uncovered it, and we keep
4 seeing it occurring over and over and this is the
5 resolution or the attempted resolution to try and fix
6 that is -- I think the other thing we need to
7 acknowledge is we have thousands of E.M.S. agencies,
8 not all of them have a Jill, right? So many of them
9 -- well, I would like to steal her too, but I can't -
10 - I don't have that type of budget, you know. I
11 couldn't pay her for what she's doing because it's --
12 it's phenomenal, and many people in this room also.
13 So that being said, I would speculate
14 a fair amount of agencies are buying a platform and
15 assuming it works the way it's supposed to. And we
16 know that's just not been the case because different
17 people are doing different things and then there's
18 customizations which, you know, picks a piece of the
19 spider web that has ramifications five, ten strands
20 down, a -- and we continue to chase that. So, I
21 think this is a -- a valuable and hopefully realistic
22 resolution to try and fix that.
23 **DR. RABRICH:** Thanks. And -- and to
24 your point, Don, this -- this is why this all
25 started, right? We're recognizing when we do pilot

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2 studies that to get good data, right, to make
3 meaningful decisions about the care we're providing,
4 this is the crucial first step. And so I want to
5 thank you guys for the work that you've done already,
6 and I think this is a -- a huge step forward in
7 trying to clean up some of the data problems we've
8 had and get meaningful data that we can use
9 clinically moving forward.
10 So, I believe your presentation will
11 be available to others. We're not going to have you
12 repeat it two more times today, but we will make it
13 available, and thank you for your work on that.
14 Sorry, Dr. Dailey.
15 **DR. DAILEY:** So it -- it's funny
16 because I -- I take myself back to the days when we
17 used to key punch all of those paper P.C.R.s, right?
18 So, the key punching of paper P.C.R.s was actually
19 that opportunity to make sure that the data that was
20 going in was the same everywhere. But at the time we
21 had a fantastic partnership with SUNY Public Health
22 through this group. So, is it possible for us to
23 somehow resurrect the partnership that we had with
24 SUNY Public Health and potentially get some of the
25 really mutually useful opportunities for research,

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2 for quality data? Four hundred data points a year is
3 -- or sorry, four million data points a year is
4 important, but not if the data's inaccessible and
5 confounding. So, can we find a way to make that live
6 again?
7 **DIRECTOR GREENBERG:** Happy to look into
8 that. I don't -- I don't remember the days of key
9 punching. So, it predate -- it predates my -- I --
10 I'm not that young, but I -- I don't remember that
11 one. I remember paper and I enjoyed paper P.C.R.s,
12 but we weren't key punching.
13 **DR. DAILEY:** It -- it almost predates
14 the director who predates you. But -- but the
15 reality is we pre -- we did key punch data from COVID
16 because all of the COVID folks, right, the -- the
17 COVID ambulances were working on paper. So you know,
18 some of that still exists, but the important part
19 here is SUNY Public Health.
20 **MR. HENNESSEY:** Yeah. So we have --
21 we have an -- the department has an active
22 relationship with -- with SUNY Public Health -- SUNY
23 Albany Public Health, I think is what you meant,
24 right? We have a lot of wonderful state university
25 campuses, I want to specify which one we're talking

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2 about. So just to follow up on what Ryan is saying,
3 we can definitely look into that, and -- and get back
4 to you all.
5 But yeah, there's an existing
6 relationship, so let us take a look into it. And,
7 you know, anything we can do to improve the analysis
8 and understanding of what we're getting in through
9 our P.C.R.s is something that we think is, you know,
10 hugely valuable. So, let us look into it.
11 **DR. RABRICH:** Thanks. Dr. Winslow?
12 **DR. WINSLOW:** Yeah, just -- just one
13 final comment. Sometimes it has to do with when
14 you're doing a project to educate the providers on
15 how to document it so you get the map that you're
16 looking for.
17 **DR. RABRICH:** Yes.
18 **DR. WINSLOW:** And that's a key to
19 success.
20 **DR. RABRICH:** Thanks.
21 **MS. JILL:** So, I just wanted to take
22 the opportunity to mention also that the P.C.R., as
23 far as an agency perspective goes, we're using that
24 P.C.R. as -- for multiple reasons: for data
25 collection, for E.R. physicians or whatnot. This is

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2 part of my role at my agency where I view my -- my
3 job sometimes like a lens -- like the old lens master
4 kind of thing, where I'm looking through the billing
5 aspect, I'm looking through liability, I'm looking
6 through provider documentation, all of these kind of
7 things. And I just want to make sure that we -- like
8 I'm all for data collection, but we also need to make
9 sure that we don't inhibit the other purposes that
10 that P.C.R. serves, including sometimes billing or
11 liability, right?
12 The -- the -- the reason for the chart
13 is why today, why now on the billing side somebody
14 took an ambulance, right? And in a way we need to
15 make sure that our providers aren't inundated with
16 too many changes or whatnot, so that they don't get
17 bored with the chart and just kind of fill it out to
18 its basic minimum because at some point, that chart
19 follows the patient and can be financial patient
20 care, right? You don't want somebody who doesn't
21 prove medical necessity and has an issue with
22 insurance. That's just one thing I think that in --
23 the agencies consider. Then there's the liability
24 concern, you know, what happens -- whether it's legal
25 or whatnot, then da -- and data and all of these

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2 things.
3 So, that is another reason to take
4 some of these things slow because it might be a good
5 idea for data reasons, but a change might be a
6 problem on another level.
7 **DR. RABRICH:** All good points, all
8 important, and I think that's why the plan to go slow
9 with small tests to change and then, you know, give
10 out kind of bite size information instead of making
11 major changes at once will be helpful. We're going
12 to move on, but did you have one more?
13 **DR. DAILEY:** No, I'll be historical
14 again. So a number of years ago, when we were still
15 using paper P.C.R.s, and you know, granite tablets,
16 there was a request and a mandate from the state that
17 the last four digits of the social security number be
18 included on every P.C.R. They didn't tell anybody
19 why. They just said, you must include this. So, of
20 the P.C.R.s that were being completed, about seventy
21 percent ended up having the last four of either four
22 zeros or four X's, right?
23 The reason for that though was to
24 create a unique identifier based on date, patient's
25 initials, and the last four that could then merge

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2 with Sparks data, and there was a lot of -- a lot of
3 angst and gashing of teeth around the idea that, oh,
4 we're going to match all of these patients, right?
5 No matter what, billing will always be the number one
6 reason we're doing all of these things in spite of
7 all of our best wishes, right? No money, no mission,
8 right? All of these systems were built around moving
9 the money.
10 If we can get good data out of it,
11 it's secondary. But making sure that the clinicians
12 who are at the point of the spear know exactly why
13 we're doing the things that we -- we do and asking --
14 and making those asks is incredibly important to make
15 sure that it all follows through. So lots of
16 different masters here, but we can make it. We can
17 get there.
18 **DR. RABRICH:** Thank you. So, thank
19 you all. Great discussion. We're going to move on
20 to our next topic. However, I was remiss and jumped
21 right in to start the meeting. So, we have a couple
22 of guests joining us today that I didn't get the
23 opportunity to introduce. So, you already heard from
24 Mark some comments earlier, but if you want to --
25 Mark, go ahead and say anything.

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2 **MR. HENNESSEY:** No. I'm just happy to
3 be here today. I don't really have that much else to
4 -- to add to that. You know, one of the things that
5 Dr. McDonald has strongly committed to is that we're
6 going to have representation here to help with what's
7 going on with the State Emergent Medical Services
8 Council and also the SEMAC, and so myself and I'll
9 just semi introduce Dr. Fish, who's our deputy
10 commissioner who's with us here today as well, are
11 here to make sure that you all get the support you
12 need for success.
13 **DR. RABRICH:** Thank you. We
14 appreciate it. Dr. Fish.
15 **DR. FISH:** Good morning, everyone.
16 Doug Fish. I'm the Deputy Commissioner for the
17 Office of Healthcare Delivery. And just so you kind
18 of understand the organizational chart because it's a
19 little complicated, and it has changed in the past
20 two years.
21 So, we have an Office of Healthcare
22 Delivery that includes the Office of Primary Care
23 Health Systems Management that -- where Mark is the
24 director now, and this includes the Division of
25 Emergency Medical Services. Our office also includes

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2 the Office of Aging and Long-term Care, so we work
3 closely with our colleagues in the long-term care
4 space. It also includes our Office of Health
5 Facilities Management.
6 You may or may not be aware that the
7 State actually operates for veterans' homes across
8 the State. Batavia, Oxford and Central New York,
9 Montrose, Downstate and St. Albans in Queens as well
10 as the Helen Hayes Rehabilitation Hospital. And then
11 as part of this transformation and organization, we
12 moved out two separate offices from the Office of
13 Primary Care Health System Management because they
14 were more practitioner facing, and that is the Office
15 of Professional Medical Conduct, which oversees
16 conduct for physicians, physician assistants. We
17 don't license them. That's still done by State
18 education, but oversees physician conduct and
19 physician assistant, and then our Bureau of Narcotic
20 Enforcement because they're really kind of more
21 practitioner facing.
22 And so that was kind of the -- the
23 genesis of that to try to bring us all kind of back
24 together. Previously pre-COVID, long-term care and
25 acute care hospital, E.M.S. had all been part of the

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2 same -- same entity, same office, and then were split
3 out during COVID.
4 But, glad to be here. I feel like
5 I've been here because I always check in regularly
6 with -- with Ryan and -- and Steve and Mark, and
7 knowing many of you and just want to thank you for,
8 one, all the hard work that you do. You have a lot
9 of committees, you have a lot of good work. I review
10 and see all of those materials ahead of the meeting,
11 and so know that you put a lot into it and just thank
12 you for what you do to keep New Yorkers safe and
13 services available. So, thank you.
14 **DR. RABRICH:** Thank you. We're glad -
15 - glad you could join us today. All right. Is there
16 someone -- is a representative here from the
17 specialty care transport tag that could -- oh,
18 perfect. That could give us an update on kind of
19 where you're at with your work?
20 **MS. REESE:** Yep, absolutely. Erin
21 Reese, I've been chairing the specialty care
22 transport tag. For anyone that's not familiar, the
23 tag has been meeting since last summer. And since
24 our last update in December, we've continued to meet
25 monthly. Just going to give a brief update of -- of

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2 where we're at.
3 We currently have two subgroups that
4 are working. One is on governance led by Aiden
5 O'Connor, and guidelines and framework led by Dr.
6 Berkowitz. Governance group has been focused on
7 establishing resources related to data, governance
8 foundation for the tags work. They've been
9 identifying and meeting with key stakeholders and
10 working to gain that information.
11 The guidelines and framework group has
12 been working to develop and identify best practice
13 framework or toolkit to support agencies outlining
14 components of an S.E.T. program that can be used in
15 building or strengthening an S.E.T. program. Goal
16 being to have a product that's scalable based on
17 geographical area but consistent in the foundation of
18 the program.
19 Additionally, the tag collectively has
20 finalized two survey instruments to gauge the S.E.T.
21 landscape throughout the state. One survey is
22 specific to agencies, and the other is specific to
23 providers to determine their involvement and also
24 confidence in performing specialty care transports.
25 Both have been submitted to the state for the -- to

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2 start the approval process and build out, and we're
3 targeting ideally a late summer release if things go
4 as planned.
5 So, distribution would be to all
6 agencies and all paramedics within the State. Each
7 is designed to be a max of a seven to ten minute
8 completion depending on level of S.E.T. involvement.
9 And once released, we'd certainly appreciate any
10 assistance from this body to encourage participation
11 with that.
12 Additionally, I just want to thank
13 everybody that's been working on the -- this tag was
14 a -- we have a large group and a lot of great
15 participation and we'll continue to -- continue to
16 work. So, that's where we're at the moment.
17 **DR. RABRICH:** Thank you -- thank you.
18 Thanks Erin. Thanks to the -- the -- the tag. Are
19 there questions for the tag or any comments people
20 want to make or anything specific you'd like to know
21 from them or them to work on? All right. Well, we
22 appreciate the good work. I feel like it's long
23 overdue. It's an area that, you know, needed to be
24 looked at for a while, and it'll be great to have
25 your -- your feedback on that. So thank you.

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2 All right. We had previously had
3 discussions about R.S.I. training, credentialing,
4 should there be some sort of minimum standards. And
5 there's been good discussions at training and ed on
6 this as well and there's been some work done so I
7 don't know if Dr. Winslow or Mr. Hudson, if you guys
8 want to comment on -- I -- I feel like a lot's
9 happened since the last meeting, so.
10 **DR. WINSLOW:** Yes, thank you. So, we
11 had a meeting with ten state council members
12 representing the regional R.S.I. programs throughout
13 the state. And after reviewing what each regional
14 REMAC performs, there was no consensus on a minimum
15 standard across the state. They're very different
16 from region to region, and there was unanimous
17 support by the members to have this left to regional
18 REMACs to decide how to handle in each region.
19 **DR. RABRICH:** Thanks. Don, you want
20 to add anything?
21 **MR. HUDSON:** Yeah, I would mimic that
22 in our discussions. It's clear that each region is
23 rightfully doing its own thing based on its geography
24 and other variables as we know exist. Additionally,
25 I think it's more important that the SEMAC OMED

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2 standards acknowledge that regional authority and
3 codify that that needs to exist, you know, thereby
4 giving the region its due.
5 **DR. RABRICH:** Thanks. Yeah, and I
6 think what we learned is that each region does have a
7 pretty robust plan for their region. And how they --
8 **MR. HUDSON:** Which obviously includes,
9 you know, on go -- not only initial, but ongoing —-
10 **DR. RABRICH:** Yeah.
11 **MR. HUDSON:** -- education and
12 continuing education and quality. So that -- that's
13 all important to be codified.
14 **DR. RABRICH:** Thanks. Any comments or
15 questions on that? All right. There was one other
16 item of old business that people wanted to discuss,
17 and if we can circle back to the kind of B.L.S.F.R.
18 I-gel topic for a second. I know there was some
19 thoughts on this and there was some questions about
20 equipment lists and so forth. So I know Dr. Dorsett,
21 you wanted to make some comments?
22 **DR. DORSETT:** Yeah. So, coming back
23 because when the -- the B.L.S. I-gel policy was
24 released, remind everybody B.L.S.F.R.s were
25 specifically excluded with the logic that they can't

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2 -- that we're not regulating them even though they're
3 in the protocols and their scope of practices in
4 there, but also the equipment. But the new part
5 eight hundred regulations came out and part eight
6 hundred twenty-four F says that basic life support
7 agencies are not required to comply unless they
8 voluntarily participate in an educational program,
9 pilot program, or demonstration program as defined by
10 the department.
11 The only education program I can think
12 of that they participate in is the C.M.E.
13 recertification program, which to participate in
14 C.M.E. recertification, they also have to do
15 electronic P.C.R.s and submit their data to the
16 state. So, could we say that a B.L.S.F.R. who
17 participates in C.M.E. recertification is eligible
18 for B.L.S. I-gel?
19 **DR. RABRICH:** It's an interesting
20 question. And I -- I know -- look, I think from a --
21 from a medical point of view, we all thought, right,
22 if you're a B.L.S.F.R. and you're the first one there
23 and it's going to be, well, like it makes sense,
24 right? For, if they're trained to the E.M.T. level
25 to do this. But the issue had been regulation and so

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2 forth. So it's an interesting point within the reg -
3 - I don't know, you know, if you want to comment or
4 you want to take it into consideration or what your
5 thoughts are.
6 **DIRECTOR GREENBERG:** I'm happy to take
7 that into consideration is to -- you know, it is
8 checking a lot of boxes of where the concerns are for
9 it in oversight and kind of anybody being out there
10 with it. So, I would say, you know, happy to look
11 into that between now and the next SEMAC's meeting on
12 -- on that bucket of people.
13 **DR. DORSETT:** And the reason I really
14 encourage it is as a system design when I think about
15 in my system and there's going to be, right, it's an
16 -- it's an optional thing. But in my system when I
17 think about system design, this is who I wanted it
18 for. Like this is the exact population that I
19 wanted. And honestly, what I care about most is
20 access to capnography to assure effective ventilation
21 because if a B.L.S.F.R. is on scene before, and we
22 know whether or not there's an I-gel or it's face
23 mask ventilation, like the -- the use of capnography
24 for anybody who's ventilating a patient in cardiac
25 arrest I think is a -- is a quality issue.

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2 And so I -- I strongly urge that, you
3 know, I think all the safeguards are in place. It's
4 an optional thing. It's -- if it's trained or
5 equipped, but I think if a system looks at the -- at
6 their own system and says, there is an opportunity to
7 improve the quality of care for these patients, that
8 they should be able to do it because I don't think
9 that there's anything -- any reason not to when I
10 look at both like the regs and education.
11 **DR. RABRICH:** Thanks. Dr. Dailey.
12 **DR. DAILEY:** So, I think about this a
13 little bit differently, not in terms of the patients,
14 but in terms of the process. The department has
15 never before set themselves in a position where they
16 made the determination of what an individual agency
17 was going to do outside of controlled substances.
18 This has always been something that's been determined
19 on a regional level when there are agency upgrades.
20 And quite frankly, I appreciate some of the
21 expansions of -- of the department and their
22 influence over individual systems.
23 But I'm really troubled by the process
24 of how this works, because what it's doing is
25 paperwork's being done, it's being sent to the state,

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2 it's being sent back to the regions, everybody's
3 weighing in on this, and I'm not sure that it's
4 making for better medical care, but it is making for
5 incredibly more bureaucratic process. And quite
6 frankly, it is overstepping the regional
7 establishment of systems.
8 I think this falls to the REMACS. I
9 don't think this is something that should have been
10 done at the state level. I don't think the state
11 should be involved in -- in determining which agency
12 is going to be most capable of providing an
13 individual level of care, because that's something
14 that the regions themselves will have a better
15 understanding of. And to echo Maia, this is
16 something that belongs with those patients who are
17 being cared for by those -- by those providers, who
18 have added this to their armamentarium because of
19 local needs.
20 If I did not mention the Cohoes Fire
21 Department, who has been waiting to do this since it
22 was first discussed in the Hudson Valley, and has
23 been managing cardiac arrest while waiting for a
24 commercial ambulance partner to come for a long time,
25 and has grave concerns about their patient care, I

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2 would be remiss.
3 So, on behalf of Dr. Rushgow (phonetic
4 spelling) that mention has been made. But at the end
5 of the day, I don't think the department has a place
6 in this. I think the department's place was to say
7 B.L.S.F.R., B.L.S., I-gel, okay, then leave it to the
8 regions.
9 **DR. RABRICH:** Thank you.
10 **DIRECTOR GREENBERG:** So I mean, I think
11 it's also important to understand that it --
12 B.L.S.F.R.s are an important part of the system, and
13 then we also believe that they should become even
14 more ingrained in the system, including codified in -
15 -- in more ways than what they are today. And I
16 believe if we make them more codified, then they
17 truly become even more part of the region and part of
18 the REMAC. As a reminder, the REMAC and the REMSCO's
19 authority falls under Article Thirty and the same is
20 in what we govern.
21 And so our goal is the bigger goal,
22 not just for the I-gels, and I think we have a -- you
23 know, could have possibly a short term solution for
24 the I-gels, but the long term is to bring those
25 B.L.S. agencies into fully be integrated into Article

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2 Thirty so that the REMAC and the REMSCOs have that
3 additional oversight and regional authority over
4 them, which right now they're very limited in what
5 they're stated and how they're out there. And the
6 regions and the REMAC are based on Article Thirty.
7 So we want to codify that as the
8 system has grown over time and as the system has
9 continued to evolve with different layers of what's
10 ability, including things like Cohoes who -- having
11 an I-gel, I would love to see have an ambulance too,
12 but that's another story, in order to be able to best
13 serve their patients.
14 **DR. RABRICH:** Thanks. Dr. Winslow?
15 **DR. WINSLOW:** And I'll -- I'll take a
16 bit of the opposite approach here. When you read the
17 B.L.S. I-gel implementation policy statement, the
18 Commissioner of Health delegated to the REMACS a lot
19 of authority, which the REMACS appreciate the ability
20 to review the training programs, as well as the
21 manifest of providers, as well as the choice of the -
22 - of the selection of the agent -- of the device
23 itself. So I -- I do want to appreciate that.
24 And the REMACS in my region were very
25 happily surprised to be able to have some authority

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2 and participation in this. So, we wanted to say from
3 our region, thank you. I do think though that the
4 B.L.S.F.R. issue does need to be clarified because
5 that is a potential benefit to the system.
6 **DR. RABRICH:** Thanks. Sorry. Okay.
7 **MR. VIOLANTE:** I'm on your left, not
8 your right.
9 **DR. RABRICH:** Yeah, yeah.
10 **MR. VIOLANTE:** Yeah. I -- I -- I
11 would encourage Maia's approach as well as a method
12 that is currently being employed to allow B.L.S.F.R.s
13 to use I-gel because they currently have all of the
14 other B.L.S. adjuncts at their disposal, and this is
15 yet another one that can make a -- a truly impactful,
16 you know, ability on a patient. And so I think that
17 is a -- a -- a wonderful way to go as we continue to
18 work through the state bringing B.L.S.F.R.s into the
19 fold in some as -- as they would like to, so.
20 Especially since we have these other adjuncts that
21 are currently being used in this way, it makes it
22 easy to add this one in that particular same way.
23 **DR. RABRICH:** Thanks. And I think the
24 consensus here, what you're hearing is that, you
25 know, this is a key procedure that we would like

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2 B.L.S.F.R., who could be most impactful with this
3 device because they're there first, you know, that
4 from a medical point of view, it makes a lot of
5 sense. It's, you know, how do we -- how can we most
6 expeditiously get to a place where we can allow this,
7 and I think Maia brings up an interesting point that
8 maybe that's a -- a pathway.
9 **MR. HUDSON:** Can I suggest that in
10 this instance, it might just be a mentality shift.
11 Would this be a political, medical and bureaucratic
12 win to say the state's not going to tell you what you
13 can't do, we're going to allow the region to tell you
14 what you can do. They're New York State E.M.T.s.
15 The protocol says E.M.T.s can use supraglottic
16 airways as endorsed by their region if trained and
17 equipped. It seems like all of this is done. I'm
18 not saying look the other way, I'm just saying if we
19 all agree this is a win for patients, let's not let
20 the bureaucracy stand in the way of that.
21 **DR. RABRICH:** Well said. I think
22 that's the point everyone's trying to make, yes. Any
23 other comments? Good. Okay. Thank you all for the
24 feedback. I think you -- you bring up an interesting
25 pathway potentially, Maia, and I know that, you know,

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2 it'll be reviewed.
3 We're going to move on to new
4 business. The first thing on our new business agenda
5 is the collaborative protocol for 2026. This has
6 been out there for a while. We first discussed it at
7 the December meeting. Unfortunately, we didn't have
8 a February meeting but people have reviewed it. In
9 the interim, some little tweaks and language stuff,
10 and you know, no matter how many times you read it,
11 someone always finds something else. So we've --
12 it's been cleaned up somewhat. It's been posted on
13 Boardable with the change log, so I don't know.
14 I will open it up for discussion. I
15 know there was some commentary or some questions
16 around the neonatal resuscitation and some of the
17 language and some recent changes. So, I don't know,
18 if our E.M.S.C. colleagues, you know, want to comment
19 on that piece.
20 **DR. COOPER:** Thank you, Dr. Riber.
21 The -- Dr. Rabrich. The E.M.S.C. committee met on
22 Monday, two days ago in this very room, and reviewed
23 the -- several items. I'll have a fuller report at
24 SEMAC, but of -- of relevance this morning,
25 specifically with respect to the collaborative

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2 protocols. We were informed, and of course, noted
3 that the -- that an -- an attachment to the protocols
4 was the pediatric ambulance reference card that we
5 make available to every ambulance in New York State
6 and is periodically updated.
7 Every time the New Heart Association
8 standards become available, we noted that there were
9 three changes that needed to be made, and I believe
10 Theresa may have the motion that we made available to
11 project on the screen. But very briefly, the three
12 key changes were, Heart Association has eliminated
13 the two-finger approach to C.P.R. because it's been
14 found that it's not all that effective in terms of,
15 you know, the -- ensuring adequate chest compression.
16 That -- that even for neonates, a single hand should
17 be used for the chest compression to assure adequate
18 depth of compression.
19 And at last, the Heart Association has
20 shifted the -- the ventilatory rate from forty to
21 sixty to thirty to sixty. So these -- those three
22 changes were -- were discussed and approved by the
23 E.M.S.C. committee, you know, via motion. And it's
24 our -- you know, we respectfully request that -- that
25 the -- that the collaborative protocols -- that the

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2 attachment to the collaborative protocols be updated
3 in accordance with the New Heart Association
4 standards as I've just discussed. And I think there
5 you can see projected on the screen the actual
6 changes that need to be made.
7 There was further discussion about the
8 -- the draft neonatal resuscitation protocol. And
9 frankly, very few of our members had actually seen
10 that protocol prior to our meeting on Monday, but we
11 did note a -- a couple of issues. There was first an
12 issue about, you know, the directions regarding
13 management of a nuchal cord, which were raised as
14 potentially problematic. And there was also an issue
15 regarding -- oh, help me, Maia. I'm -- I'm having a
16 little senior moment here. Excuse me.
17 **DR. DORSETT:** Yeah. So I -- I think
18 the -- for the O.B. protocols, I think that that's
19 something for future I think -- for revisions. The
20 one thing is in the neonatal resuscitation, O.B.
21 newborn care. There's a statement that says, it's
22 meant to be algorithmic, but it says initiate chest
23 compressions of heart rate is less than sixty.
24 **DR. COOPER:** Right. Thank you. Yes.
25 **DR. DORSETT:** Oh, that's very close.

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2 If heart rate is less than sixty at any time, and
3 really in neonatal resuscitation, it's heart rate
4 less than sixty after thirty seconds of effective
5 ventilations. If it's possible to make -- that is
6 like the only change, and then you would change the
7 ventilatory rate to match the A.H.A. thirty to sixty.
8 I -- I don't think that they're that substantive in
9 the way that the protocols are used.
10 **DR. RABRICH:** Yeah. And I think in --
11 in talking with the protocol writers that -- that was
12 their intent, but it didn't come across clearly in
13 the language the way it was written. So, I certainly
14 think that can be clarified because that was their
15 intent of the protocol was to -- to follow those
16 guidelines, but it just doesn't read correctly, so.
17 **DR. COOPER:** So forgive my senior
18 moment but yes, those are -- those are the two
19 issues. That's -- the nuchal cord issue is really
20 more as -- as Maia points out, part of the O.B.
21 protocol.
22 **DR. RABRICH:** Yes.
23 **DR. COOPER:** But the neonatal resus is
24 the change in the ventilatory rate, you know, and --
25 **DR. RABRICH:** And the reference.

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2 **DR. COOPER:** -- for -- for an out of
3 hospital birth, right? That's what we're talking
4 about. That patient is going to get thirty seconds
5 of ventilation at thirty to sixty --
6 **DR. RABRICH:** Right.
7 **DR. COOPER:** -- before chest
8 compressions are initiated if the heart rate is less
9 than sixty.
10 **DR. RABRICH:** Right. Is there any
11 discussion on that or does anyone have an issue with
12 clarifying that to make sure it correctly matches the
13 A.H.A. guidelines? I don't think -- I don't -- I see
14 several representatives of the collaborative group
15 here as well. No -- no one seems to have -- okay.
16 So, that will be adopted in the thing. This motion
17 that was made, I think -- I guess we could take a
18 vote to see if -- I mean, you're going to bring this
19 up at SEMAC, correct?
20 **DR. COOPER:** I am, but --
21 **DR. RABRICH:** Would you like this
22 committee to vote on it and endorse it as well?
23 **DR. COOPER:** -- sure.
24 **DR. RABRICH:** Okay.
25 **DR. COOPER:** I think that would be

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2 helpful if we voted both on the -- the -- the --
3 suggestions to the neonatal protocol as well as the
4 pediatric, the -- the newborn resuscitation triangle,
5 right?
6 **DR. RABRICH:** Okay. Yep. So this
7 come -- this is already a seconded motion from
8 E.M.S.C. or -- okay.
9 **DR. COOPER:** We can certainly consider
10 it that way, yes.
11 **DR. RABRICH:** Okay. So, all those in
12 favor of supporting these changes and moving at
13 SEMAC, raise your hand please. Any opposed? Any
14 abstentions? No. So unanimously --
15 **DR. COOPER:** Thank you so much.
16 **DR. RABRICH:** -- agreed and will be
17 incorporated in the collaborative protocol.
18 **DR. COOPER:** I know our group will be
19 very pleased. Thank you so much.
20 **DR. RABRICH:** Thank you. Are there
21 any other discussion items or questions or concerns
22 regarding the collaborative protocol before we -- we
23 vote on those? People have had a long time to review
24 these. And just to point on the O.B., it -- several
25 people are aware of some of the need and that is an

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2 area that's going to be looked at in the next round
3 of protocol to see how we can improve those
4 protocols.
5 As far as the rollout for these
6 protocols, normally we're on a July cycle because we
7 didn't have the meeting in February and we're
8 approving it now, in order to give our colleagues in
9 the education side this time to ensure that
10 everyone's properly trained on the protocols, the
11 thought was to move the implementation date for this
12 cycle to August 1 from July 1. Discussion on that.
13 Any concerns or?
14 **MR. HUDSON:** Do you need a motion?
15 **DR. RABRICH:** I don't think so. Do
16 we?
17 **MR. HUDSON:** Do it.
18 **DR. RABRICH:** We'll -- we'll add it to
19 the pro -- so the -- the motion would be to approve
20 the collaborative with an effective rollout date of -
21 - and I can't make a motion someone else have to do
22 this, of August 1st and then it would go to SEMAC.
23 So, if you'd like to.
24 **MR. HUDSON:** Don Hudson, what you
25 said.

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2 **DR. RABRICH:** Thank you. Second.
3 **DR. DAILEY:** Second.
4 **DR. RABRICH:** All right. All in
5 favor? Any opposed? Any abstentions? Okay. So,
6 the collaborative with the changes that were
7 discussed is approved and will go to SEMAC later.
8 You wanted to say something?
9 **DR. DAILEY:** Look, the difference
10 between July 1st and August 1st because it's in the
11 middle of the summer probably doesn't make a damn bad
12 difference, Jeff.
13 **DR. RABRICH:** I know.
14 **DR. DAILEY:** Right?
15 **DR. RABRICH:** We're just giving people
16 time if they need it.
17 **DR. DAILEY:** I would say if you're
18 going to delay it at all, just make it September 1st.
19 But at the end of the day, the substantive changes
20 that we have in this protocol --
21 **DR. RABRICH:** It's not all we have.
22 **DR. DAILEY:** -- in this set are not
23 particularly in -- aggressive, so I don't think it
24 really matters.
25 **DR. RABRICH:** You may want to -- you

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2 may want to make that amendment when it comes up at
3 SEMAC, Mike. All right. The next item is the -- the
4 New York City protocols. There are two New York City
5 protocols that were sent for review. One was from
6 November and one was from January.
7 So we'll start with the November one,
8 which basically amends their AFib protocol. It
9 changes the initial synchronized cardioversion to two
10 hundred instead of a hundred. And then in their O.B.
11 emergencies, it -- it adds clarification under key
12 points to treat -- don't delay treating seizures.
13 There was a thought there that while people were
14 getting mag, that they were neglecting to go with a
15 benzo as for an actively seasoned patient. So that
16 was amended, as well as some changes to the
17 definitions for preeclampsia, and extending it to --
18 consider it six weeks postpartum instead of a month.
19 So -- and then on their -- other
20 changes in their protocols were just -- that's it for
21 that one. So any -- any comments or discussion on
22 this? Motion to approve this protocol? Motion
23 second? Second. All in favor of these protocols?
24 Any abstentions? Opposed? Yes, sir.
25 **DIRECTOR GREENBERG:** Just some

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2 discussions, if you don't mind --
3 **DR. RABRICH:** Yeah.
4 **DIRECTOR GREENBERG:** -- that -- can
5 you just put it based on the date that it was
6 submitted or some --
7 **DR. RABRICH:** Yes. Yes.
8 **DIRECTOR GREENBERG:** -- something that
9 just shows which or where it state --
10 **DR. RABRICH:** This is the one
11 submitted November twenty -- yeah --
12 **DIRECTOR GREENBERG:** Thank you.
13 **DR. RABRICH:** -- yeah, November 26th.
14 I said we would start with the November ones. Yeah.
15 Now we're going to move to the ones that were
16 submitted January 21st, which include the traumatic
17 cardiac arrest, anaphylaxis, and asthma protocols.
18 So in this one, traumatic cardiac
19 arrest, basically some clarification around not
20 delaying transport, re -- reorganization of some of
21 the steps in the protocol, and then a note that if
22 the cause of cardiac arrest is suspected to be
23 secondary to medical condition that's non-traumatic,
24 a reminder to treat appropriately that way. The
25 anaphylaxis protocol, they updated the Epinephrine

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2 dose to be a maximum of point five milligrams, not
3 point three milligrams, consistent with other
4 guidelines.
5 And then for asthma and wheezing,
6 again, some clarification for adult and pediatric --
7 pediatric patients with previously prescribed
8 Albuterol. And same thing, I did a paramedic step to
9 indicate -- to differentiate that the patient has a
10 previously prescribed Albuterol, not a history of
11 using it in the past. I think it's just -- just some
12 clarifications that they're actively taking that
13 medication.
14 And then a elimination of one of the
15 key points about history of Albuterol use. And those
16 are it. It's most -- mostly very little dosing
17 changes, other than the Epinephrine of max of point
18 five instead of point three. It's -- otherwise it's
19 all changes to language in the notes. So again, this
20 is the January submission, traumatic cardiac arrest,
21 anaphylaxis, and asthma.
22 Any comments on this or discussion?
23 All right. Motion to approve. Motion second?
24 Second. Okay. All in favor? Any opposed? Any
25 abstentions? Okay. This is good.

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2 Next item, there was a request
3 forwarded by the Westchester REMAC regarding re-
4 adding Furosemide as a medical control option to the
5 protocol, where it would -- it would be inserted
6 under medical control options, Furosemide
7 administered twenty to eighty I.V., monitor patients.
8 I -- we --- we -- I think most of us recall why this
9 discussion happened initially and why it was removed
10 initially. I will note that the intent of this
11 change is for them to allow a community paramedicine
12 program to administer Furosemide.
13 Now I'm not sure that this is the
14 venue that this needs to happen in because if it's a
15 community paramedicine program with a patient-
16 specific order, with a patient that's being followed
17 by a physician as part of a community paramedicine
18 program, I -- I'm not sure if this is the way to do
19 it or if it's on the formulary it can just be given,
20 but I open it up to discussion.
21 **DR. DAILEY:** So just to -- as
22 highlight, you're absolutely right, this is designed
23 around community paramedicine. However, the concern
24 is that it is not on the formulary and therefore
25 cannot be carried by that agency without -- without

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2 some other patient-specific order. Frankly, I think
3 that if we can add it to the formulary, allow them to
4 use it in a community paramedicine approach, it
5 doesn't have to be in the protocols.
6 And quite frankly, community
7 paramedicine interventions probably are something we
8 should look at on a regional basis, because there
9 will be such differences with them, and then perhaps
10 discuss some of them here, but the idea that -- that
11 this needs to be on every ambulance in -- in
12 Westchester was not an intent that was brought to me
13 as part of this. This is literally just to put it in
14 the formulary, so they can carry it on their truck,
15 so if somebody says please give this person some
16 Lasix, they can.
17 **DR. RABRICH:** Yeah. I think that
18 interpretation is correct. Dr. Clemency?
19 **DR. CLEMENCY:** Yeah, I -- I agree.
20 This does not belong in the primary protocols. As
21 the community paramedicine programs continue to grow,
22 we may want to consider a single protocol for the
23 community paramedicine stuff that augments the other
24 protocols. I don't think we're ready for that yet,
25 but I think that's probably --

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2 **DR. RABRICH:** Yeah --
3 **DR. CLEMENCY:** -- something to
4 consider in the future.
5 **DR. RABRICH:** -- I appreciate that.
6 Although, I do think if you've seen one community
7 paramedicine program, you've seen one community
8 paramedicine program, so -- which is part of the
9 challenge, right? So -- other comments on this?
10 Okay. So, would someone like to make a motion to add
11 it to the formulary but not change the protocol? Is
12 that your motion? Is there --
13 **DR. CLEMENCY:** What -- what --
14 **DR. RABRICH:** -- so you say the
15 motion, yeah.
16 **DR. CLEMENCY:** Yes. Please -- please
17 add Lasix Furosemide to the formulary.
18 **DR. RABRICH:** Okay.
19 **DR. DAILEY:** Second.
20 **DR. RABRICH:** Second. Other
21 discussion?
22 **MR. HUDSON:** Just to clarify --
23 **DR. RABRICH:** Yes.
24 **MR. HUDSON:** -- I don't know off the
25 top of my head in the formulary if we have the double

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2 dagger if you're trained and equipped, but could we
3 denote somehow that it is not absolutely required? I
4 think there'd be a lot of misinterpretation of
5 another unfunded mandate, how dare they type of
6 situation.
7 **DR. RABRICH:** Yeah. I -- yes. So it
8 -- so the way it reads is to re-add Furosemide Lasix
9 to the formulary, if available, trained, and
10 equipped?
11 **DR. DAILEY:** With a note that says not
12 required.
13 **DR. RABRICH:** Not required. Okay.
14 And I believe there was a second for that motion.
15 Any other discussion on that motion? Okay. All in
16 favor of adding it to the formulary? Anyone opposed?
17 Any abstentions? All right. The motion carries
18 unanimously. It passes. Thank you for that.
19 **MS. MCGOWN:** But we could add it to
20 this round of protocol so it's good for us.
21 **DR. RABRICH:** Well, it won't be in the
22 protocol --
23 **MS. MCGOWN:** Yes.
24 **DR. RABRICH:** -- but it could be added
25 to -- the formulary update can -- can occur.

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2 **MS. MCGOWN:** Add it to the formulary
3 document, in the protocol document.
4 **DR. RABRICH:** Yes --
5 **DR. DAILEY:** Yeah.
6 **DR. RABRICH:** -- it will be re-added.
7 Yes, it will be added to that.
8 **MS. MCGOWN:** Yeah.
9 **DR. DAILEY:** For this update.
10 **DR. RABRICH:** For this update, it will
11 be added, not required, to the formulary. All right.
12 Next on our agenda, the -- the issue of a couple of
13 the -- the air medical protocols have come forward
14 for review and some questions have come up about kind
15 of process around that, so I don't know if you want
16 to speak to air medical and where we're at and --
17 **DIRECTOR GREENBERG:** Yeah. Sure. So
18 there's been a number of air medical protocol packets
19 that have been submitted in -- in the past year.
20 They're very large protocol sets. They are not a
21 collaborative protocol set. They're individual to
22 each of the different flight programs. So you know,
23 they become a little bit more cumbersome to
24 individually look at them, so then we send them up
25 for the approval process and they take longer than

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2 some of the other parts of the process in the
3 approval process, particularly if there are specific
4 things in it that might be unique to the air medical
5 components and stuff like that.
6 So the packets that have been -- have
7 been set up, the ones that were submitted are up for
8 approval at the moment, but they -- we understand
9 they are taking longer than, you know, what some may
10 want them to take for changes. We did have, I think,
11 a, you know, a good meeting recently with all the
12 medical directors of the different air medical
13 programs -- I feel like I have to move my mic now.
14 So we did have a good meeting with
15 them about talking about, you know, what is -- what
16 does the future just look like in order to expedite
17 this process? Is there an opportunity here to --
18 similar to what we've done with the rest of the state
19 and the collaborative protocols, to have a
20 collaborative air medical protocol set that might
21 have some smaller uniqueness per program, similar to
22 what we see some smaller uniqueness in N.Y.P.D. or
23 F.D.N.Y. with some of our Haz-Tac and Haz-Mat
24 programs and things like that.
25 But that, you know, the overall

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2 medicine, the overall work that is done by them is,
3 you know, done in that collaborative effort with the
4 collaborative protocol set. And let me preface that,
5 significantly we're talking about, you know, well,
6 just on that collaborative approach. So we had that
7 meeting that is, you know, separate from those
8 documents that we received going up through the
9 approval process and things of that nature, and then,
10 you know, kind of trying to look at the future in --
11 in expediting things, you know, through this
12 initiative.
13 We did meet with -- we invited all the
14 air medical programs to the table, and most of which
15 did -- were able to attend for -- for that call, and
16 then you know, hopefully we'll have a follow-up call
17 for that, you know, in the near future on it.
18 **DR. RABRICH:** Thank you.
19 **DIRECTOR GREENBERG:** These mics aren't
20 --
21 **DR. RABRICH:** Yes.
22 **DIRECTOR GREENBERG:** -- as good as the
23 last ones, I apologize.
24 **DR. RABRICH:** Questions, comments,
25 concerns regarding air medical protocols or the

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2 process? Dr. Stalerno?
3 **MDR. STALERNO:** Yes, I'm David
4 Stalerno. I'm Medical Director for Air Methods,
5 LifeNet, New York. Just on behalf of all the five
6 air ambulance services that have bases in New York,
7 we -- we request that as we work through and discuss
8 and decide upon and agreed upon new process, that the
9 current process just be followed back from zero five
10 zero three policy statement, which is air medical
11 services protocol approval and credentialing of
12 flight personnel. Just that that process be followed
13 currently while we partner with and -- and agree to a
14 new process. And so that would -- that's our
15 request.
16 **DIRECTOR GREENBERG:** Understood. And
17 that process is still being followed today. So where
18 they're submitted to the region, only the region
19 where the primary -- they don't have to submit to --
20 so for LifeNet, you don't have to submit to each
21 region that you operate in, you submit to one, I
22 believe yours is REMO, and then REMO sends those
23 packets up to the state for approval. And they go
24 through the same process that the collaborative
25 protocols go through, the unified protocols for New

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2 York City go through and everything else. And that's
3 what they're going through right now. So, they're in
4 that approval process and is going through that above
5 us.
6 **DR. STALERNO:** And the step is here
7 for this body next to approve --
8 **DR. RABRICH:** Yes.
9 **DR. STALERNO:** -- and then go to
10 SEMAC. And that's what we're requesting.
11 **DIRECTOR GREENBERG:** Yep, and so they
12 -- they'll come to this body once they go through
13 that initial part, absolutely.
14 **DR. RABRICH:** Yeah. So to clarify, I
15 think they're -- they're in departmental review still
16 prior to coming to here for a vote is -- I don't know
17 that that was made clear, but --
18 **DIRECTOR GREENBERG:** Sorry. Thank
19 you.
20 **DR. RABRICH:** -- that's -- that's
21 where it's at.
22 **DIRECTOR GREENBERG:** Yeah.
23 **DR. RABRICH:** All right. Any other
24 comments on that? I think -- I think we do have a --
25 a good plan for moving forward as to how to kind of

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2 make this process a little bit better, so we'll see
3 on that.
4 The next item on our agenda was the
5 use of pelvic binders. This question had come up,
6 there was an N.A.M.S.P. position statement on this,
7 or I believe there's been some discussion at STAC
8 also around this. So just not that we're changing
9 any protocol right now about anything, but just as a
10 discussion amongst this group for, you know, some
11 thoughts on, you know, is this an area we should look
12 at? Is it a training issue? Is it the, you know,
13 the devices we shouldn't be using anymore? But just
14 wanted to get some initial thoughts on this and maybe
15 some direction of, you know, kind of where we want to
16 send it for review, you know, moving forward.
17 So I don't know. I think -- Dr.
18 Dailey, I think you might have been the one who
19 initially brought this to my attention.
20 **DR. DAILEY:** No.
21 **DR. RABRICH:** No, you weren't? Okay.
22 Was there discussion at STAC on this?
23 **DR. DAILEY:** There has been some,
24 there's been nothing definitive.
25 **DR. RABRICH:** Okay.

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2 **DR. DAILEY:** I think it's just one of
3 those things to keep on your -- on the -- on the
4 radar and for us to continue to -- to consider. If
5 you truly do have an open-book pelvic fracture, a
6 pelvic binder can indeed help, but the opportunity
7 for that to be placed based on your physical exam and
8 -- and concerns is unlikely.
9 **DR. RABRICH:** Okay.
10 **DR. DAILEY:** The more likely thing is
11 that you're going to have a sheer injury or a
12 hemipelvis fracture that ultimately will be made
13 worse with a -- with a pelvic binder. So, it's
14 really challenging without radiographic evidence.
15 **DR. RABRICH:** It is. And I think some
16 of the information that -- that seems to be out there
17 too is that -- that they're often misapplied or not
18 correctly applied. So I -- I do think, Don, maybe
19 this is something for Training and Ed to discuss.
20 **MR. HUDSON:** Yeah. So the new
21 T.E.C.C. guidelines were just published. I'm sure in
22 the next protocol review, as we do with any national
23 changes, we'll look at what if any changes
24 educationally or procedurally need to be made.
25 **DR. RABRICH:** Thanks. Maia, did you

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2 have a comment or -- no? Okay. Along with that is
3 the kind of the -- the mounting discussion about
4 rigid cervical collars and what's next for -- for
5 collars. And I think that's also something that will
6 be discussed and followed as additional guidelines
7 come out.
8 **MR. HUDSON:** Do you have the -- the
9 PowerPoint for that, for the rigid cervical collars?
10 **DIRECTOR GREENBERG:** I'm not seeing
11 it.
12 **DR. RABRICH:** I don't have it. We can
13 put it up. Yeah. And if --
14 **DR. DAILEY:** Yeah.
15 **DR. RABRICH:** -- if you want to
16 discuss it, Mike, yeah.
17 **DR. DAILEY:** Well, we can discuss it,
18 either one, but I mean, it probably makes more sense
19 to have a --
20 **DR. RABRICH:** Yeah. We --
21 **DR. DAILEY:** -- a discussion here.
22 **DR. RABRICH:** -- yeah.
23 **DR. DAILEY:** Yeah.
24 **DR. RABRICH:** Yeah. I don't know if
25 you want to introduce it or -- or talk about the --

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2 **DR. DAILEY:** Sure. So for -- for
3 those of you that have been awake, there's been a
4 drastic push back across the country and the idea of
5 rigid cervical collars. I don't necessarily agree
6 with Dr. Ben Abo (phonetic spelling) that cervical
7 collars cause cancer, which is what he is suggesting.
8 **MS. MCGOWN:** He was stealing a line.
9 **DR. DAILEY:** I am --
10 **DR. RABRICH:** Only in sharks, to be
11 clear.
12 **DR. DAILEY:** -- very clear that
13 surgical collars that are -- cervical collars that
14 are put on incorrectly do cause harm. Very
15 frequently we see in our trauma bay field clinicians
16 doing a fantastic job of caring for a patient,
17 limiting their spinal motion. And then the first
18 thing that happens when they arrive in the trauma bay
19 is a rigid extrication collar is placed on that
20 patient, putting them in an anatomically incorrect
21 position, making them extremely uncomfortable and
22 causing respiratory distress.
23 So, I think we need to bring some
24 common sense to this. So, this was a group of people
25 working together through the STAC. This was actually

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2 originally going to be discussed by the STAC and then
3 brought here. However, we didn't have a STAC
4 meeting. The STAC meeting is in two weeks, I think,
5 and we will be discussing the same presentation
6 there. So, I thought I would bring it here first.
7 If you'll note that -- that -- notes
8 to slide reviewers that there are some abbreviations
9 that are used here. There's a very specific request
10 from the Department of Health that you not use any
11 abbreviations in any presentations that will be made
12 to the public. I then went on to my D.O.H. login and
13 the entire page where you log in to the Department of
14 Health H.C.S. website is abbreviations. And I just
15 found that very -- very entertaining.
16 So, if we can keep on going from here.
17 So, NEXUS which all of you will know and is in here
18 just to make sure that we can review it with the
19 surgeons at STAC. You know, the things we live for -
20 -
21 **DR. RABRICH:** Just a comment first.
22 This slide, it doesn't read correctly. It says which
23 patients did not require cert -- cervical spine
24 imaging. I thought it was a collar originally.
25 **DR. DAILEY:** No. No.

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2 **DR. RABRICH:** Yeah.
3 **DR. DAILEY:** If you remember, NEXUS
4 was about imaging --
5 **DR. RABRICH:** Yeah. Yeah.
6 **DR. DAILEY:** -- as were the Canadian
7 C-spine rules. All of this is about imaging, not
8 injuries.
9 **DR. RABRICH:** Right.
10 **DR. DAILEY:** And as a result, what
11 we're doing is we're taking an in-hospital --
12 **DR. RABRICH:** Right --
13 **DR. DAILEY:** -- study.
14 **DR. RABRICH:** -- but you're applying
15 it to --
16 **DR. DAILEY:** And we are applying it to
17 -- to pre-hospital care.
18 **COURT REPORTER:** -- to not imaging.
19 To --
20 **DR. DAILEY:** This started in -- in
21 Maine actually, from a United States perspective, it
22 has continued from there. So NEXUS was about who
23 does not require imaging, and it was people with this
24 set of criteria. If we can go to the next slide,
25 please. And the Canadian C-spine rules actually have

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2 a significant number of mechanistic criteria which
3 become concerning. You know, fall of greater than
4 three feet. Well, that -- that's challenging --
5 **DR. RABRICH:** Everybody.
6 **DR. DAILEY:** -- right? What -- what
7 does that really mean? Age greater than sixty five.
8 Again remember, this is all for imaging, not
9 necessarily for any type of stabilization. Continue.
10 And PECARN, which actually takes both of them and
11 combines them into something that is very, very
12 reasonable, which is level of consciousness of the
13 patient. Can you communicate with that patient? Is
14 there any abnormalities in their A.B.C.s? And are
15 there any focal neurologic deficits? Let me see.
16 Continue. So, this is the -- the paper that started
17 the bonfires.
18 **DR. RABRICH:** Yep.
19 **DR. DAILEY:** This paper was originally
20 going to be a collaborative physician paper from the
21 American College of Surgeons, ASAP -- Committee on
22 the -- sorry, A.C.S., Committee on Trauma, ASAP, and
23 the National Association of E.M.S. Physicians. It
24 ended up just being a literature review. We don't
25 believe we have any of the authors in here right now,

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2 but we certainly do have some of their partners,
3 which is great. This is a very interesting article.
4 If you have not read it, I recommend that everybody
5 go out and read it.
6 Next slide. Next slide. Sorry, I
7 thought we had -- had some highlighted things on that
8 last slide. But anyway, conclusion here based on
9 this paper, which is a very broad literature review,
10 is that there is nothing definitive that shows the
11 cervical collars make any difference whatsoever. In
12 fact, there is a significant amount of literature
13 that demonstrates that they cause some harm.
14 This was a -- a quite a comprehensive
15 paper. I do recommend, again as I said before, that
16 everybody read it so they have a good way to -- to
17 start to consider this. But the most important
18 question to me is, do we throw the baby out with the
19 bathwater? We certainly have done that in the past
20 with E.M.S. interventions, and I think it's important
21 for us to walk slowly on this one. There are systems
22 in Florida that actually have taken all cervical
23 collars out of E.M.S. They did that --
24 **DR. RABRICH:** That's because in
25 Florida it causes cancer, right?

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2 **DR. DAILEY:** It causes cancer in
3 Florida, exactly.
4 **DR. RABRICH:** Okay.
5 **DR. DAILEY:** Exactly.
6 **MR. CLEMENCY:** Only in Ben Abo's
7 agencies.
8 **DR. DAILEY:** I think Antey's (phonetic
9 spelling) also.
10 **MR. CLEMENCY:** Yeah, yeah.
11 **DR. DAILEY:** But -- but it's -- it's
12 hard to tell. So, recognizing the fact that many
13 people in Florida are actually originally from New
14 York --
15 **DR. RABRICH:** Uh-huh.
16 **DR. DAILEY:** -- right? That probably
17 --
18 **DR. RABRICH:** Yes.
19 **DR. DAILEY:** -- has some type of
20 concomitant issue here. I think what we do have to
21 do is look to see how we change our protocol here to
22 make it more reasonable, more patient-centric, and a
23 little bit easier to interpret. So, if we go to the
24 next slide, this is our current protocol. A little
25 challenging to read from up there, and I apologize.

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2 Quite frankly, this protocol is challenging to read -
3 -
4 **DR. RABRICH:** Yes.
5 **DR. DAILEY:** -- even if you have it --
6 **DR. RABRICH:** Even at a normal size,
7 yes.
8 **DR. DAILEY:** -- in your hand. Okay.
9 The thing that is -- is hardest to -- to recognize
10 here is that it basically says everybody needs a
11 cervical collar, and that's just not true. So, if we
12 go to the next slide, which is going to be a
13 suggestion, we highlight these as -- as we go, so
14 it'll take a couple clicks. Sorry, Theresa. So,
15 this is a proposed draft. I don't know that we blew
16 everything up on this one because the expectation was
17 it would be a little more visible.
18 **DIRECTOR GREENBERG:** Dr. Dailey, so
19 just for anybody that has all the docs that were
20 shared with them, this was shared --
21 **DR. RABRICH:** Uh-huh.
22 **DIRECTOR GREENBERG:** -- so if you
23 think you got a --
24 **DR. RABRICH:** Yeah.
25 **DIRECTOR GREENBERG:** -- docu -- a

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2 document in error because it said STAC across it,
3 that's this document, and –-
4 **DR. RABRICH:** Yes, it is there for
5 review.
6 **DIRECTOR GREENBERG:** -- it -- it was
7 sent there --
8 **DR. RABRICH:** Yeah.
9 **DIRECTOR GREENBERG:** -- correctly.
10 **DR. DAILEY:** So, our goal with this
11 document was to improve the way that we take care of
12 patients, the way that we were going to proceed with
13 this document and the order of meetings in February
14 was going to be STAC approving this, it then coming
15 here as an approved document to then guide our change
16 in care in the field, because I don't believe that
17 E.M.S. in any way, right, we cannot act without our
18 trauma colleagues --
19 **DR. RABRICH:** Uh-huh.
20 **DR. DAILEY:** -- agreeing, because the
21 last thing we want is a clinician to show up in a
22 trauma bay and get beat up by a trauma surgeon or a
23 trauma nurse. We need to make sure that we're all on
24 the exact same page with these.
25 **DR. RABRICH:** Yes.

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2 **DR. DAILEY:** Maia, you have that
3 pulled up in front of you.
4 **DR. DORSETT:** Yeah. Do you want me to
5 move here?
6 **DR. DAILEY:** Yeah. That would be
7 great. Thank you.
8 **DR. DORSETT:** Yeah.
9 **DR. DAILEY:** So, the draft itself --
10 woah sorry. You guys could not see that but it was
11 going -- getting big and small and big and small and
12 now it's better. So, the proposal that we have here
13 is, first, does the patient have a significant blunt
14 trauma, right? That's the entry criteria. We don't
15 define significant blunt trauma, that's the
16 individual clinician is looking at whatever happened.
17 Then the first question is, altered
18 mental status or intoxication, right, which comes
19 from both criteria. Cervical spine pain or
20 tenderness, abnormal neurologic exam, distracting
21 injury producing an unreliable exam. So, not
22 necessarily if they have a broken leg but they have a
23 broken leg and you don't think you can examine their
24 cervical spine.
25 And really importantly I think for our

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2 clinicians that are out there, paramedic or E.M.T.
3 concern for significant cervical spine injury, right.
4 Still clinician decision-making, most important
5 thing. If those are true, spinal motion should be
6 restricted and they can consider the use of an
7 appropriately sized cervical collar. That would be
8 one that's not here.
9 **DR. RABRICH:** Yes.
10 **DR. DAILEY:** It's not here.
11 **DR. RABRICH:** Have you ever seen an
12 appropriately sized cervical collar come in on a
13 patient?
14 **DR. DAILEY:** Twice, yeah. And -- and
15 not upside down.
16 **DR. RABRICH:** Yeah.
17 **DIRECTOR GREENBERG:** He was in the
18 field on both of those calls --
19 **DR. RABRICH:** Yes. Yes.
20 **DIRECTOR GREENBERG:** -- and that's why
21 they came in that way.
22 **DR. DAILEY:** That's right. So, with
23 that if none of those criteria are present then the
24 patients -- Maia, this is really hard to read up
25 here.

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2 **DR. DORSETT:** It's your slide on my
3 computer.
4 **DR. DAILEY:** I know. Well, somebody's
5 uploading it. So, without any of those findings they
6 should not get a cervical collar --
7 **DR. RABRICH:** Right.
8 **DR. DAILEY:** -- or any other
9 aggressive means to support it. The things that we
10 put at the bottom, all right, as key points, use with
11 caution in patients over the age of sixty-five and
12 consider elevating the head of the stretcher and some
13 -- some other little things like that. But the --
14 the important part here is the comment at the bottom:
15 lack of a cervical collar does not equal cervical
16 spine clearance. We're not making that medical
17 decision that the patient does not have a potential
18 fracture when we don't put a collar on them.
19 And that really adds to the -- to the
20 key here that we still have to take care of our
21 patients when we get them in the emergency department
22 regardless of what has happened pre-hospital. And
23 for those pre-hospital clinicians, they are taking
24 care of this patient, making good decisions in terms
25 of not increasing the injury with a collar but not

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2 having them move their head all over the --
3 **DR. RABRICH:** Yeah. Yeah.
4 **DR. DAILEY:** -- place either, which
5 most people don't do on a regular basis.
6 **DR. DORSETT:** Not when their neck's
7 broken.
8 **DR. DAILEY:** Not when their neck's
9 broken --
10 **DR. RABRICH:** Right.
11 **DR. DAILEY:** -- because people whose
12 necks are broken --
13 **DR. RABRICH:** Yes.
14 **DR. DAILEY:** -- don't move them. The
15 bottom line on -- on I think cervical fractures and
16 where we got with the -- with the members of the STAC
17 is the biggest fear to me isn't actually the patient
18 with the broken neck. The biggest fear and biggest
19 moment of concern to me is the patient with a broken
20 neck, an unstable cervical fracture, who I then
21 paralyze and intubate. That's a patient who has
22 spasm in the area of a fracture because for anybody
23 who's ever broken a bone, if you broke a bone you're
24 not moving that bone. You're not moving what's going
25 on around that because of the -- of the muscle spasm.

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2 I get concerned when there's going to
3 be chemical paralysis and then intubation, because
4 intubation no matter what you do, will manipulate
5 that cervical spine.
6 **DR. RABRICH:** Yeah.
7 **DR. DAILEY:** That is the point at
8 biggest risk. So those are the patients we have to
9 really be concerned about. But it doesn't
10 necessarily mean that we do this with them --
11 **DR. RABRICH:** Uh-huh.
12 **DR. DAILEY:** -- so.
13 **DR. RABRICH:** Thank you.
14 **DR. DORSETT:** I have --
15 **DR. RABRICH:** Maia.
16 **DR. DORSETT:** -- I have two points on
17 this. I think the first is I agree and I think we
18 learned that you can take away the backboard and
19 still maintain spinal motion restriction and think
20 about the -- the spine, which Ben Abo also stole
21 Brian Clemency's backboards cause cancer. The --
22 **DR. BERKOWITZ:** I appreciate you
23 amending the record to reflect that.
24 **DR. DORSETT:** -- thank you. The --
25 the second point is, emesis, these guidelines should

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2 be used with caution in patients over the age of
3 sixty-five. I think actually the population of
4 patients who has the greatest amount of harm from
5 cervical collars is geriatric patients. And they've
6 been harmed by systematically being excluded because
7 they were too high risk for most of the decision
8 rules. So, like everybody gets a C-spine C.T.,
9 everybody gets a cervical collar.
10 I work in actually a geriatric
11 certified E.D. I'm like the receiving agency for
12 every granny that falls down. And I agree, like they
13 are actually harder to fit for a cervical collar,
14 have greater risk of pressure sores, greater risk of
15 respiratory depression, literally get delirious from
16 being in the collar in a non-anatomic position. And
17 so like the one amendment is, I think we try and
18 protect older adults by being like, you're too high
19 risk.
20 I'm going to say, in a place that
21 takes care of a lot of geriatrics, we actually don't
22 image a lot of C-spines, like, the trauma center
23 does. And I don't think there's a bunch of
24 quadriplegic eighty-year-olds because I haven't
25 imaged them and put them in a cervical collar for six

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2 weeks to find, like, the incidental, like, crack
3 that's actually not an unstable fracture in their
4 spine because there's other considerations.
5 So, I would actually suggest that we
6 remove that line and have people use clinician
7 judgment to say if somebody has a bunch of neck pain
8 and they smack their head and they did one of these
9 and they say it hurts, then you can consider how you
10 mobilize it. The one -- this was not a position
11 statement from N.A.M.S.P. The N.A.M.S.P. actually
12 does have a board-approved position statement on
13 spinal trauma that's specifically and geriatric
14 trauma, that actually both specifically call out
15 using alternative methods for geriatric patients for
16 minimizing spinal motion restriction. Because if
17 somebody has found a C-collar that fits an eighty-
18 five-year-old with kyphosis, please let me know
19 because I have not found one that exists.
20 **DR. DAILEY:** So actually one
21 clarification for Dr. Dorsett is that it says use
22 with caution on patients over the age of sixty-five,
23 but that takes you back up above which says, you can
24 consider, but you don't have to, right? And I think
25 that that not having to is really important. We're

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2 going to see that push continuing to grow and making
3 sure that we remain really focused on the patient and
4 we're -- how we're taking care of that patient is
5 going to be the key here.
6 **DR. RABRICH:** Thanks. Dr. Berkowitz
7 and Dr. Winslow.
8 **DR. BERKOWITZ:** Yeah. So, very
9 supportive of this initiative. One thing I think
10 it's really important is that, you know, the guidance
11 should be very clear because we really want to avoid
12 a situation where a crew brings in a patient to the
13 hospital and someone in the hospital says, why don't
14 they have a collar? And that -- that -- I've seen
15 that friction happen a lot, and that -- that is --
16 that is -- that is a problem that we should make sure
17 we're addressing with this. And that's why it needs
18 to be clear so they can say, I'm following our
19 protocol, and -- and -- and you know, if you have a
20 problem talk to Mike Dailey.
21 **DR. RABRICH:** All right.
22 **DR. BERKOWITZ:** All right.
23 **DR. RABRICH:** Or -- or talk to your
24 trauma surgeon who, you know, STAC approved it as
25 well, so. Dr. Winslow?

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2 **DR. WINSLOW:** And can I also just ask
3 that E.M.S.C look at this for children? We know
4 they're even harder than our elders to examine and --
5 and there's nothing like tying down a four-year-old -
6 -
7 **DR. RABRICH:** Yeah.
8 **DR. WINSLOW:** -- with a collar that
9 doesn't fit.
10 **DR. RABRICH:** Absolutely.
11 **DR. DAILEY:** They are a patient
12 population that would do this the entire time.
13 **DR. RABRICH:** Yes, if they could.
14 **DR. DAILEY:** I was going to say that
15 that's actually exactly why we pulled PECARN in --
16 **DR. RABRICH:** Yeah.
17 **DR. DAILEY:** -- as we -- as we started
18 focusing on this. My goal today is actually for us
19 to review this new protocol, approve this new
20 protocol, and then have it go to discussion at STAC
21 in two weeks as an approved protocol from SEMAC.
22 **DIRECTOR GREENBERG:** Approved protocol
23 to go into this year's -- right. I'm just trying to
24 make sure I'm tracking completely.
25 **DR. DAILEY:** Sorry. Be -- because --

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2 **DIRECTOR GREENBERG:** Thank you.
3 **DR. DAILEY:** -- of our change in dates
4 --
5 **DIRECTOR GREENBERG:** Sure.
6 **DR. DAILEY:** -- it's a little bit more
7 complicated. I just want to make sure that -- and
8 frankly, if we approve this and it gets -- it at --
9 gets added in August or September, I think that would
10 be perfect. And I would -- I would say do that
11 because this is going to continue to advance care.
12 And I don't think this is actually going to be the
13 thing that will require the most education for the
14 update. There's nothing else in -- in these
15 protocols that require that much -- that much
16 education.
17 But we can put this together
18 relatively easily and get that done. But I
19 absolutely don't think, even if we pass this at the
20 SEMAC and say this advances into the protocols, I
21 don't think we can put it in the protocols unless we
22 also have the endorsement of the STAC.
23 **DR. RABRICH:** Yeah.
24 **DIRECTOR GREENBERG:** Sure.
25 **DR. RABRICH:** Which will delay that a

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2 little bit. And then the question is -- and then I'm
3 sure Training and Ed is going to have comments
4 because it sounds like this has been an area of
5 confusion in the past and we'll need more clarity.
6 So, I feel like we may be rushing it a little bit to
7 get it this protocol cycle, but maybe we could.
8 **DIRECTOR GREENBERG:** So, two things on
9 it and really, I'd leave it on this body on the
10 decision of when you wanted to go in. I will say if
11 you do put in, the September date probably is more
12 realistic to make sure the message is out there and
13 communicated and distributed.
14 If you add a camera to the protocol,
15 the distribution gets much faster. No, nothing?
16 Thank you. The -- so with this protocol if it goes
17 in though, STAC is in two weeks, so that's pretty
18 quick, but E.M.S.C. doesn't meet until the fall. And
19 is this something that is waiting for E.M.S.C. or
20 not? And -- and just because you're talking about
21 all the different groups that you want including in
22 it. I just want to make sure whatever decision you
23 make has that in mind as well.
24 **DR. RABRICH:** Dr. Cooper.
25 **DR. COOPER:** Thank you, Dr. Rabrich.

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2 E.M.S.C. of course did not discuss this at its
3 meeting two days ago. And in terms of obtaining a
4 formal, you know, endorsement from E.M.S.C. that
5 would have to wait until September. However -- and I
6 will -- even though I'm not authorized to speak for
7 the trauma surgeons, I am a trauma surgeon.
8 **DIRECTOR GREENBERG:** And the Chair of
9 the committee.
10 **DR. COOPER:** Yeah, that's right.
11 Well, not of the STAC, but the E.M.S.C. But you
12 know, both groups are comprised of mostly reasonable
13 people. And I think -- I think that -- that this --
14 this protocol will probably enjoy some, you know,
15 some interesting discussion. But in the end I
16 imagine that no one will have any objection.
17 That said -- that having been said, I
18 think Director Ryan Greenberg's suggestion that we
19 may consider delaying this until September is a good
20 one so we can get all the appropriate bodies
21 involved, you know, to endorse, not to mention the
22 fact that it'll give -- it'll give Training and
23 Education an opportunity to come up with a, you know,
24 a perfect, you know, teaching instrument that -- that
25 can be used to, you know, assist us in getting the

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2 word out there to our -- our pre-hospital colleagues.
3 Thank you.
4 **DR. RABRICH:** Thanks. Don, any input
5 from Training and Ed on?
6 **MR. HUDSON:** Yeah. So I think -- the
7 first two things. The first thing would be, you
8 know, a -- a paradigm shift from assuming that
9 everyone gets a collar to the assumption should be
10 many people will not get a collar. A collar is a
11 specific treatment for a very specific injury, all
12 our traction splints, right? You ask any provider
13 for decades how many times you use a traction splint
14 and we know the answer, simply because A, either that
15 injury doesn't present as often as the textbooks
16 would have suggested and or they're virtually never
17 isolated that you break the largest bone in your body
18 and it's the only thing that hurts.
19 That being said, just for STAC, would
20 it be worthy of -- across the literature there seems
21 to be a discrepancy of when we say cervical collars
22 or they say cervical collars, are they specifically
23 discussing our rigid plastic E.M.S. extrication
24 collars versus the semi-rigid, i.e. Philadelphia
25 collars --

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2 **DR. RABRICH:** Yes.
3 **MR. HUDSON:** -- versus just the soft
4 padded that feels better --
5 **DR. RABRICH:** Uh-huh.
6 **MR. HUDSON:** -- only because, again,
7 my interpretation not being a physician or anything
8 else is that it seems to suggest that the rigid
9 E.M.S. extrication collar’s time has come, the
10 discussion would then focus around what other collar,
11 i.e. the orthopedic collars, Philadelphia's and
12 otherwise.
13 **DR. RABRICH:** Yes. And Miami, yeah,
14 yeah.
15 **MR. HUDSON:** And you know, just
16 functionally operationally if anyone's been tracking
17 the cost of an E.M.S. collar, they're becoming
18 exorbitantly expensive.
19 **DR. RABRICH:** Yeah.
20 **MR. HUDSON:** And we know this single
21 patient use and generally are off the patient before
22 we even have a signature. So you know, like many of
23 our other treatments through the years, I think this
24 is a very good time to reflect on what we've been
25 doing, why we've been doing it, and more importantly,

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2 what is the literature suggests we should be doing.
3 **DR. RABRICH:** Yeah. I think you make
4 an excellent point and specifically to that collar,
5 right, because you're right, we don't use those in
6 the hospital, right? And if they have a fraction, we
7 send them out. We're changing them to a different
8 collar. So I do think part of this is to look at
9 what collar should we actually be using and, you
10 know, I don't want to say we're just going to go back
11 to the Philadelphia collar of years ago but maybe I
12 don't --
13 **MR. HUDSON:** I mean quite honestly
14 that's where we started --
15 **DR. RABRICH:** Yeah.
16 **MR. HUDSON:** -- before the E.M.S.
17 stuff came along. And I think the literature
18 supported that --
19 **DR. RABRICH:** Yeah.
20 **MR. HUDSON:** -- that's probably the
21 thing we should be using. You know --
22 **DR. RABRICH:** Yeah.
23 **MR. HUDSON:** -- I'll just call
24 everyone's attention that it's a hard fact that the
25 pictures in our textbook for auto extrication are

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2 like 1974 Buicks and none of those cars exist. We
3 have crumple zones and airbags and better highway --
4 everything's been designed and changed around that,
5 yet we are still doing things like they did in '69
6 NASCAR. So maybe it's time to reevaluate that.
7 **DR. RABRICH:** Thanks. Dr. Cooper?
8 **DR. COOPER:** Thank you. You know, the
9 old French proverb reminds us that the more it
10 changes, the more it stays the same. And I believe
11 that probably somewhere in the musty-dusty department
12 files there may be a SEMAC advisory or that we wrote
13 probably twenty years ago sort of advocating
14 selective spinal immobilization based upon the main
15 experience.
16 It's interesting how perhaps little,
17 you know, has changed despite even twenty years ago
18 our advocating selective immobilization. But you
19 know, maybe this time around, maybe this time it'll
20 stick. I certainly hope so. Thank you.
21 **DR. RABRICH:** Thanks.
22 **MR. HUDSON:** Yeah. And just to give
23 everyone hope and then hopefully close the up -- the
24 topic. You know, it has gotten better. We don't see
25 the lines and lines of used backboards at trauma

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2 centers anymore, so you know, I would say maybe it's
3 time to reevaluate whether we have piles and piles of
4 used collars left.
5 **DR. RABRICH:** Dr. Clemency?
6 **DR. CLEMENCY:** So first
7 congratulations, Dr. Dailey. I think this represents
8 a kind of a common-sense approach to a very
9 contentious issue, so thank you for that. A couple
10 of questions and possibly suggestions, the first is
11 that last bullet of paramedic or E.M.T. concern for
12 significant spinal injury probably shouldn't be
13 subordinate to significant blunt trauma. It's
14 probably its own thing. If the paramedic thinks that
15 there's an injury des -- despite what the mechanism
16 was, you should probably be taking the steps you
17 need.
18 And my -- my other question is the
19 penultimate old bullet point which was a long spine
20 board, it's one of multiple modalities, blah, blah,
21 blah, blah. That was -- I think that was really key
22 to the de-implementation of backboards, but probably
23 it's a vestigial structure at this point, kind of
24 replaced by your new point about lack of cervical
25 collars. So I thought that was a great line when it

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2 was written because I wrote it. And now I think it's
3 probably time for it to sunset.
4 **DR. RABRICH:** So just to wrap this up,
5 I'm -- and I'm hearing that there are some -- there's
6 some feedback on maybe some changes document, there's
7 some feedback about maybe types of collar. I -- you
8 know, is this something we're ready to advance now,
9 or it sounds like maybe and then E.M.S..C's input.
10 It sounds like this should kind of wait a little bit,
11 but.
12 **DR. DAILEY:** I think there are times
13 where we can take something like this and allow it to
14 wait. And I think there are times where it probably
15 doesn't make any sense.
16 **DR. RABRICH:** Yeah.
17 **DR. DAILEY:** This one I think falls to
18 the it doesn't make any sense category because we
19 have E.M.S. clinicians who will be paying attention
20 to the national literature, who will be watching
21 what's happening in other places and need to be given
22 the opportunity to care for their patients as
23 optimally as possible. Our training here will --
24 will go forward. We will see people changing their
25 practice. We need to make sure those clinicians are

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2 -- are adequately supported.
3 No matter what else, as Brian said,
4 the idea that that clinician has an opinion about
5 what's happening is going to rule the day. Cervical
6 collars can still be used for those people who are
7 firm in their belief that, you know, if you fall
8 down, you know, this is the right treatment for you.
9 So I think this allows both people to
10 continue practicing the way they are, people to
11 change, to take better care of patients. It protects
12 our elderly patients. I'm troubled by that age over
13 sixty-five. I'm way too close to that and I want to
14 make sure that we're not going to end up with me
15 wandering out of here with a collar after I stubbed
16 my toe.
17 But I think the other thing too is
18 that it doesn't necessarily change what we're already
19 doing for children because most of our children that
20 fall down aren't getting collared anyway. And this
21 actually is empowering to the clinicians that are
22 taking care of those patients because we took PECARN
23 into -- into consideration as we went through this.
24 And PECARN basically is the other two sets of
25 guidelines combined in a common-sense approach. So I

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2 think that what we're doing here is advancing care of
3 patients, taking good care of our -- of our E.M.S.
4 clinicians, and ultimately, it's going to fall to us
5 to make sure that we're teaching our hospitals -- the
6 hospital side.
7 **DR. RABRICH:** All right.
8 **DR. CLEMENCY:** Yeah, I completely
9 agree with Dr. Dailey. I think -- you know, my
10 suggestions I don't think are substantive and I don't
11 think should slow down the process. This is going to
12 be a de-implementation, not an implementation --
13 **DR. RABRICH:** Uh-huh.
14 **DR. CLEMENCY:** -- so it's going to be
15 a slow simmer, right? This is even if we start the
16 September 1st which I hundred percent think we
17 should, it's not going to flip a switch that day.
18 It's going to take months to change hearts and minds
19 and slowly get people comfortable doing this.
20 **DR. RABRICH:** Yeah.
21 **DR. CLEMENCY:** So, I don't think we
22 should delay.
23 **DR. RABRICH:** Okay. So I'll ask this
24 since we don't currently have a motion on the table,
25 is there a motion that someone would like to make?

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2 **DR. WINSLOW:** Motion to approve.
3 **DR. RABRICH:** Is -- can you be a
4 little more specific?
5 **DR. WINSLOW:** I approve to Dr.
6 Clemency’s changes. Motion to approve changing the
7 current spinal motion restriction protocol to this
8 version that Dr. Clemency just edited, amended.
9 **DR. RABRICH:** Is there a second on
10 that motion? I see a second.
11 **DR. DORSETT:** Seconded.
12 **DR. RABRICH:** Okay. Is there any
13 further discussion on the motion?
14 **DR. WINSLOW:** I think it's a good
15 thing. It's going to end up being in the protocol
16 updates that we do, so I think moving it forward
17 makes sense even if later we kind of put the brakes
18 on it a little if you know what I mean, because I
19 have to do the protocol update anyway.
20 **DR. RABRICH:** Okay.
21 **DR. DORSETT:** I -- I think it also --
22 Brian's point is really clear that it -- it's part of
23 your protocol update ,but it's also like not just
24 part of your protocol update because if somebody
25 continues, I feel like the protocol updates have to

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2 be like we're actually -- these are the changes you
3 have to make based on the protocols.
4 **DR. RABRICH:** Yeah.
5 **DR. DORSETT:** If somebody kept
6 operating the way they're currently operating, it’d
7 be like grandma fell down, I suspect --
8 **DR. RABRICH:** Yeah.
9 **DR. DORSETT:** -- she has a spinal
10 injury. They're actually still within the protocol,
11 so you haven't put them in danger but it actually
12 allows education and change in practice serially over
13 time in a way that allows me to advance their
14 practice. So, because if I kept operating the same
15 way, I wouldn't be violating the protocol. I don't
16 think it has to be like part of the big update. And
17 I think it actually is a separate topic. I think
18 every time you're saying E.M.S. is, reminder E.M.S.
19 is not black and white thinking, it's clinical
20 decision-making. I know, I know.
21 I think it requires separate attention
22 to, like, how do you actually make those decisions.
23 And there's like a whole bunch of psychomotor stuff
24 about how do you actually minimize restriction --
25 actually minimize motion within a spine.

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2 **DR. RABRICH:** All right. So, let's
3 vote. I would also suggest that this be a September,
4 not August implementation to allow for -- but -- but
5 we'll make everything at SEMAC. We'll fix all that
6 and make everything in September.
7 **DR. DAILEY:** I would say in Sep -- you
8 know, September not August, but -- but the other
9 thing I was going to say is that this is something --
10 this -- this is a B.L.S. protocol. This is an
11 everybody protocol --
12 **DR. RABRICH:** Right.
13 **DR. DAILEY:** -- as opposed to the rest
14 that are collaborative changes.
15 **DR. RABRICH:** Yeah. Right.
16 **DR. DAILEY:** So this -- the training
17 needs to be on Vital Signs Academy so that everybody
18 can access the exact same set of a bulleted training
19 and that we don't end up with, you know, lots of
20 different versions of the same thing, because the
21 ideas behind this that are the most important thing.
22 And we can get those across better to everybody
23 through that platform. And yes Ryan, I’ll do it with
24 Dr. Rubano.
25 **MR. HUDSON:** Training and Ed welcomes

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2 that.
3 **DR. RABRICH:** Any comment or -- all
4 right. So, the motion is to approve what Dr. Dailey
5 submitted with the change Dr. Clemency made for
6 September 1 implementation and to send it to SEMAC.
7 All those in favor? Anyone opposed? Any
8 abstentions? All right. The motion carries
9 unanimously passed. Do you have a comment?
10 **MR. HUDSON:** And just then extend the
11 olive branch to both STAC and E.M.S. children for
12 further --
13 **DR. RABRICH:** Yes.
14 **MR. HUDSON:** -- input.
15 **DIRECTOR GREENBERG:** That's Don Hudson
16 chairing the committee for the training? No --
17 **MR. HUDSON:** For now.
18 **DIRECTOR GREENBERG:** -- what is --
19 what happens if you bring it to STAC and they feel
20 differently? I'm not saying they will or they won't
21 but just bring that up as a point.
22 **DR. DAILEY:** Quite frankly I think if
23 we bring it to STAC, STAC feels differently, STAC
24 shoots us down, then we do not implement it this
25 summer because we need to make sure that we are going

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2 in -- in --
3 **DR. RABRICH:** So --
4 **DR. DAILEY:** -- lockstep with them.
5 **DR. RABRICH:** -- so it sounds like we
6 need to amend what we did that, you know, pending
7 STAC approval, but if --
8 **DR. DAILEY:** We can do that at the
9 SEMAC also.
10 **DR. RABRICH:** -- okay. Please fix it
11 there. Dr. Cooper?
12 **DR. COOPER:** I think the major
13 concern, you know, of the trauma surgeons will be
14 that, you know, there's the occasional major trauma
15 patient, you know, who we all recognize is a major
16 trauma patient who might somehow fall through the
17 cracks. And I think to the extent that that issue
18 can be addressed --
19 **DR. RABRICH:** Yes.
20 **DR. COOPER:** -- at the STAC meeting, I
21 think will go a long way toward making sure that this
22 revised protocol is -- is properly endorsed. Thank
23 you.
24 **DR. RABRICH:** Yep. Thanks. We'll
25 look forward to STAC's feedback. And it sounds like

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2 that's a bit of a training issue. And yeah.
3 **DIRECTOR GREENBERG:** I would only ask
4 that when you do bring it to STAC that you express
5 that this is based on their approval or, you know,
6 discussion not that they feel like it's secondary and
7 whatever they say is automatic but that we express
8 that yes, we did it now because of timing and because
9 of weather not secondary to -- yeah, because of that.
10 **DR. RABRICH:** But it's pending there.
11 Yeah, they're reviewing. Yeah. Dr. Winslow, did you
12 want to talk about your Keppra pilot project?
13 **DR. WINSLOW:** Yeah. Thank you. So, I
14 put all the documents in Board-able in December
15 planning to present this in February, but we wanted
16 to do a pilot project and it's going to be a joint
17 project done by Nassau County REMAC and Suffolk
18 County REMAC, both REMACs met and approved. Could
19 you put up the protocol, please? I think it'll be
20 the next one. It would be to -- to add the use of
21 Keppra to refractory seizures. And so, the
22 management of the seizure will be the same administer
23 Benzodiazepines for a patient that has more than one
24 seizure, administer Keppra while addressing the
25 seizure as you normally would do it would with --

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2 with Midazolam.
3 So the background is there's two other
4 states that have been doing this for the last year,
5 New Jersey and Rhode Island. There are multiple
6 states that have it in inter-facility. Keppra is
7 inexpensive. It is safe in pregnancy. It is also
8 safe in children and is the medication of choice for
9 loading in the emergency department when you bring
10 these patients to the E.R. -- E.R. anyway.
11 In Suffolk County, we had discussion
12 amongst the four health care systems and got their
13 neurology departments all to agree that this would be
14 a good idea and supported by them. So, if you --
15 there was a -- there's one this is the way the
16 protocol is, correct? I think it's just one other
17 document. Just might make it easier to see it. It
18 just showed the collaborative protocol with the
19 adjusted addition of Keppra.
20 **DR. RABRICH:** Right.
21 **DR. WINSLOW:** I'd like to -- I'd like
22 to study this for a year with the idea being that if
23 it's very -- if it's useful, it would be an E.M.S.
24 agency option at the paramedic level if equipped and
25 trained, and then it can be brought to other regions.

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2 We also may consider putting it in protocol in the
3 next year if it's successful.
4 The protocol would -- would read that
5 you would manage seizures with Benzodiazepines and
6 then it would say for more than one seizure on the
7 alarm to administer Keppra, and the load is sixty
8 milligrams per kilogram, I.V. over three to five
9 minutes while addressing the seizure. And there were
10 three patient populations excluded: trauma patients,
11 patients with new onset seizures, and children and
12 pregnant women.
13 I think they will have use in those in
14 the future, but when we study things this is
15 traditionally how we've gotten them across to study
16 them and make sure that they're safe. And I think
17 that this would be a great project to do. When I
18 looked at the Suffolk County numbers, there would
19 have been eighty patients last year who would have
20 qualified for having had multiple seizures on the
21 alarm. Any questions?
22 **DR. RABRICH:** Thanks. Yes. Questions
23 or kind of Dr. Clemency you had. I -- I think
24 several regions are going to be interested in
25 participating with you.

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2 **DR. CLEMENCY:** Yeah. I -- so two
3 things. Yeah, I think other regions should be a lot
4 to say provided they're able to provide hospital
5 follow-up data. I think we should make sure that
6 we're really studying this if we're studying it. And
7 my second question is if we're only doing adults, why
8 not do a fix dose? Adding weight-based dosing to an
9 adult medication adds a kind of unnecessary cognitive
10 load, and so I would ask to consider a fixed dose for
11 adults.
12 **DR. WINSLOW:** Thank you. We chose the
13 dose and the neurology experts from the four health
14 care systems agreed that was the right dose. That
15 was the original question. Currently the dose is
16 twenty milligrams per kilogram on Rhode Island. They
17 felt that was low, so the dose is sixty milligrams
18 per kilogram.
19 **DR. RABRICH:** Other comments or
20 questions for that one?
21 **MS. MCGOWAN:** Could we please also
22 make sure that if you do it for more than your region
23 that we coordinate the codes that you're submitting
24 it with so we can see it across the, you know, easily
25 compare apples to apples when we write our P.C.R.s

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2 for that?
3 **DR. WINSLOW:** That would be my hope.
4 **MS. MCGOWAN:** Yeah, so.
5 **DR. WINSLOW:** I will tell you we
6 joined Suffolk and Nassau County on this is a great -
7 - as a great model. And the paramedic that put this
8 forward happens to be a member in an agency, one in
9 Nassau and one in Suffolk which is a -- a bonus.
10 **DR. DORSETT:** So, my question is like
11 the exclusion of groups. We're talking about this
12 like it's research. If it was a prospective research
13 study, we'd need an I.R.B. and patient consent. If
14 it's a pilot study for quality improvement around,
15 right, like it's not like a Keppra is an untested
16 treatment for seizures. Like, I don't get patient
17 consent to get Keppra and a seizing patient in the
18 emergency department. I'm not studying it, so I
19 don't understand why we're excluding people who are
20 pregnant or children or prisoners, like, it's not an
21 I.R.B. approved prospective research study. And we
22 have to be really careful because if that's -- if
23 it's a research question, you need a prospective
24 I.R.B.
25 **DR. WINSLOW:** So the reason we

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2 excluded trauma patients and new onset seizures was
3 that the advice of the neurologist, who both said
4 that the administration of Keppra before they had a
5 chance to -- to investigate the reason would be that
6 they wouldn't give it first. And the reason to
7 exclude pregnant patients and children, although it
8 is safe in both, was because that would be the
9 easiest thing for the paramedics administering it not
10 to worry about that population.
11 **DR. DORSETT:** I think you can say
12 adults and then pregnant women would be -- although
13 in pregnancy I would say there's a medical reason
14 which is if I'm pregnant and I'm seizing, I probably
15 should be getting Mag, not Keppra. So I -- I think
16 for these it's a really important that we're doing a
17 pilot study, we're talking if we're saying this is
18 people who we'd actually would exclude from the
19 protocol for this reason because one of the things
20 that you want to be checked for is protocol
21 adherence.
22 If there's harm to administering it
23 for a new onset seizure or if they're a pregnant
24 patient is getting Keppra instead of magnesium when
25 they should be getting magnesium, that is actually

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2 part of the thing that you want to understand about a
3 pilot of whether or not we can be discriminatory
4 enough in our administration pre-hospital to say that
5 we are actually making good choices about who gets
6 this medication versus another.
7 **DR. RABRICH:** Thank you. All right.
8 So, if you have -- anyone has additional feedback or
9 comments please send them to Dr. Winslow. You -- so
10 the next step would be for you to submit this as a
11 pilot proposal and it would go to the Commissioner
12 for review.
13 **DR. WINSLOW:** Yeah. I think I just
14 need SEMAC approval --
15 **DR. DORSETT:** Right.
16 **DR. WINSLOW:** -- so I don't plan to
17 bring it up.
18 **DR. DORSETT:** I think you do.
19 **DR. WINSLOW:** I don't.
20 **DR. RABRICH:** I mean you could bring
21 it up as informational and solicit feedback, but I
22 don't -- I think the Commissioner approves pilot
23 projects. I don't think it goes through like --
24 **DR. WINSLOW:** Can I just submit it
25 directly to the --

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2 **DIRECTOR GREENBERG:** You're welcome to
3 -- to have something that just shows support.
4 **DR. RABRICH:** Yeah, they can endorse
5 it. But yeah.
6 **DR. WINSLOW:** Yeah. I think I'd like
7 to do that. I'll bring it up at SEMAC with --
8 **DR. RABRICH:** Okay.
9 **DR. WINSLOW:** -- the idea being if I
10 could just get the SEMAC to support this.
11 **DR. RABRICH:** Sure.
12 **DR. WINSLOW:** Then we'll submit it to
13 -- to the Bureau and the Commissioner that way.
14 Thank you.
15 **DR. RABRICH:** Yeah. Yeah. Yeah. And
16 -- and I think if the Commissioner approves it once
17 that happens, I do think it would come back one more
18 time to SEMAC and SEMSCO for approval as an approved
19 pilot by the Commissioner, so.
20 **DR. WINSLOW:** With the protocol.
21 **DR. RABRICH:** Yeah. Yeah. All right.
22 Thank you. Any other business? Seeing none I will
23 entertain a motion to adjourn. So moved. Okay thank
24 you all.
25 (The meeting concluded at 10:04 a.m.)

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