9/16/2026 – Medical Standards Meeting – Troy, N.Y.

NEW YORK STATE
DEPARTMENT OF HEALTH
MEDICAL STANDARDS

DATE: September 16, 2026
TIME: 8:03 a.m. to 9:21 p.m.
CHAIR: Brian Walters, Acting Chair
LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

Reported by Daniel Christian

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APPEARANCES:

Albert Shih, Finger Lakes REMSCO
Arthur Cooper
Brian Clemency
Daniel Olsson
David Kugler
David Violante
Donald Doynow
Donald Duvall, Jr.
Donald Hudson
Doug Isaacs
George
George Stathidis
Jason Winslow
Jonathan Berkowtiz
Jonathan Washko
Kathleen Hallinan
Kirby Black
Maia Dorsett, Monroe Livingston REMSCO
Mark Hennessy, Deputy Director DOH
Michael McEvoy
Michele Forness
Ryan Greenberg, Director
Theresa Allen, Secretary
Tiffany Bombard
Timothy Egin

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(The meeting commenced at 8:03 a.m.)

CHAIR WALTERS: All right. If you can take your seats, I think we'll get started in the interest of everyone's time. As you can tell, I am not Dr. Raybridge. I am just standing in for today. I am not taking over as Chair of the Medical Standards Subcommittee. I would just like that to be clear and on the record, but I am happy to share in his absence. As we get started, just a reminder that the attendance sheet is circulating around, so make sure you sign in. And with that said, I think we'll move on to the first items on our agenda under old business. And that would be a blood implementation update to start. And George, would you mind giving an update for us, please?

DR. STATHIDIS: Good morning. Yeah, I'd love to kick off the meeting with a little update here. As I mentioned yesterday and in some of the committee meetings, the pre-hospital blood and what was formerly known as Ambulance Transfusion Service, we're going to have a new name for that, but it's the same thing. Those regulations are drafted. They're going through our approval process currently at the department. I don't have a date yet of when those re

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-- regulations, those proposed regulations will be posted. But I'm hearing that it's imminent.

When we have a date, we will share those -- we'll share that information on the public comment and where you can find the regulations to review for public comment and how to submit a public comment. We'll likely share those through Boardable and our regular listservs. And we'll also provide an update during our regular monthly call. So, hopefully we'll have more information to share and happy to take any questions on that.

COURT REPORTER: I'm sorry, George. Can you spell -- spell your last name for the record?

DR. STATHIDIS: Sure. Stathidis, S-T-A-T-H-I-D-I-S, common spelling.

CHAIR WALTERS: Thank you very much. Any questions for George about the blood implementation update? Very good, thank you. Next up is the clinic -- clinical data integrity technical advisory group. Dr. Dorsett, could you give a quick update for us, please?

DR. DORSETT: So at the last meeting, one of the things that we talked about is the group had come up with a set of defined procedures lists,

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medication codes, not quite impressions. And we wanted to test the idea that if we could actually change everything to the -- that code on import mapping to the state, and we wouldn't have to get everybody on the front end of every single little agency to use the same codes. The State has been busy with Schematron updates, so we haven't been able -- they have not been able to test that. But we've proposed testing that at the regional level for one of our regional repositories to say that we can change the import code, and then hopefully we can report out at the next meeting whether or not that results in better data quality.

CHAIR WALTERS: Great. Thank you very much. Then we'll continue moving on. Next is a specialty care transport TAG report. I don't know, I know Erin usually does the report, I don't think she's here today. And Dr. David sits on that TAG, but I know he can't be here this morning either. Is there anybody else from that TAG that could update us quickly?

DR. BERKOWITZ: I can give an update. So we've had -- you know, we've broken up into several work groups focusing on regulatory on -- on

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clinical, and we've made some progress. I don't have an update on the regulatory side. On the clinical side, we've prepared a -- a readiness tool with the -- the goal of being this is something that agencies can use to assess their readiness to provide the service.

And then we're in the process working with Dr. Kugler and others to create some template protocols that you know can be used voluntarily by agencies kind of as a -- as a -- as a starter point, so starter place. So we're making progress, and I'm sure Erin would have a much better report. But like you, happy to -- to fill in when needed.

CHAIR WALTERS: Excellent. Thank you very much. And is there a timeframe at all for the readiness tool, the template protocols and things?

DR. BERKOWITZ: Yeah. So we've distributed the readiness tool to a few agencies to take a look. And frankly, if there's anyone who would like to look at it, just contact me, and we're happy to share it with you. And the -- the protocol part, we're just starting working on now. The goal is to create something that would be -- that would not conflict with the collaboratives, so it would sit

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nicely on top. And so there's -- there's some work to be done there.

But I would hope to have something for this body to review, let's maybe say by the summer-ish would be a reasonable goal, not with the expectation -- I don't think -- I don't -- we -- we don't even know from the regulatory standpoint whether we could approve them. But these are -- these are templated protocols meant to be kind of ad -- adopted as -- as desired by agencies.

CHAIR WALTERS: Great. Thank you. Any questions or comments on specialty care transport TAG? Good. We're doing good so far. We're going to keep moving right along. Next is the Keppra pilot project proposal, an update on that. I know this has been discussed at the last couple of meetings, but I'll turn it over to you, Dr. Winslow, if you could say a few words.

DR. WINSLOW: Thanks. Yeah, so we're going to need to make a -- a final motion and approval at SEMAC. At the May SEMAC, we tabled the formal approval of it. I do want to thank our partners from Buffalo, Dr. Clemency and his I.T. team and data management team. Not only did we secure

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I.R.B. approval from Buffalo, but we also streamlined the mapping so that the data will be cleaner. So I just wanted to thank him and his team.

We have a proposed start date of January 1, pending final approval at SEMAC this afternoon and from the bureau. If anyone has any questions, they could email me directly, but we currently have Suffolk County, Nassau County and the Buffalo region participating with interest from REMO. And this will be offered to any region that wishes to participate.

CHAIR WALTERS: Thank you. I guess, Dr. Winslow, since we need to formally approve this pilot program, I know we've talked about it again, could you just remind the audience just some of the technical details of the pilot program and what it entails?

DR. WINSLOW: Yeah, it's meant for the status epi patient. Currently under protocol, Midazolam -- Midazolam and then, you know, consideration for Ketamine. I think that's caused a significant respiratory depression -- respiratory depression especially in the field or the back of an ambulance. So this would be Midazolam -- Midazolam,

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Keppra -- and would be the medicine that most emergency department physicians would load the patient with when they got to the E.R.

I did a data query of Suffolk, and there were seventy patients over a year that would have qualified. So I -- I think there will be some use in the larger systems, but it will be for the rare patient who has stat epi.

CHAIR WALTERS: Very good. Then I think that since we've talked about this and it's been circulated for a couple of meetings, the point that we're at is, if there's any further discussion on it, I'll entertain it now or I'll entertain a motion to approve this pilot program and move it forward.

DR. CLEMENCY: Just one word of clarification. First of all, thank you to -- to Dr. Winslow for all his hard work on that. I think this is going to be a really great project. The I.R.B. is not yet approved. We need approval from this body to then submit it to the I.R.B.

CHAIR WALTERS: Thank you, Dr. Clemency. Dr. Clemency, if it does pass here today, what is the timeframe for that I.R.B. approval,

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because Dr. Winslow suggested a January 1st start date. Is that reasonable?

MR. CLEMENCY: Yeah, I -- I think that -- I think that's reasonable. And it's a -- it's a data collection model. So yeah, that'll be fine. As long as we just will need some documentation from the State that it's approved to submit with our application.

CHAIR WALTERS: Very good. Is there then a motion to approve this pilot program and move it forward to the SEMSCO -- or to the SEMAC first? Excuse me. Dr. Bombard makes the motion. Is there a second?

DR. DORSETT: Second.

CHAIR WALTERS: Dr. Dorsett. Is there any further discussion on the -- the motion to approve the Keppra pilot project with a proposed start date of January 1st and move that forward to SEMAC this afternoon? I'm hearing no further discussion. We'll vote. Okay. So we do not need a roll call vote. So all in favor, raise your hands and say aye. Good. Any opposed? No opposed. Then the motion carries. Thank you.

Moving on then on the agenda, the next

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item is a collaborative protocol rollout update. I know there's been a couple of errors that are corrected. George, is that something that you're willing to speak about or?

MR. GEORGE: That would be me, (unintelligible) division. We have now rolled out the twenty-six-dot twos. The twenty-six-dot two has been updated to adjust for the clerical errors found in the original twenty-six dot zeros, and the oxytocin I.V. bolus option was removed in the twenty-six dot ones. Those have been released as of this past week and any pending reviews or discussions are ongoing.

CHAIR WALTERS: Great. And I saw that that's posted and I saw the notification go out recently. So, I think that that's excellent and we've fixed those and moving forward. Good.

We are just moving right through this agenda. I appreciate it, guys. Thank you. Make sure you tell Dr. Raybridge what a great job he did by the way, when he comes back. Next item on the agenda is going to be the E.M.T.C.C. sunset TAG. We have an update. David Violante, would you be willing to lead us?

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MR. VIOLANTE: Sure, thank you, mister assistant to the Chair.

CHAIR WALTERS: Thank you for making sure that wasn't assistant chair -- Assistant to the Chair, I appreciate the correct term.

MR. VIOLANTE: As you may all remember, the Commissioner couldn't sign off on our previous plan of sunsetting C.C.s because of some items, including short runways and potential for losing practitioners. He asked it to go back to committee. We created a representative TAG, including members from the SEMAC.

We have a pre -- preliminary path of consensus among all of us. We met with the Deputy Commissioner to put feelers out, make sure we're moving in the right direction and meeting the considerations of -- of the Commissioner. So as soon as we hear back from them, we'll solidify a solution among all of us and then present that finalized plan for a vote here in December. That may also possibly include some regulatory changes as a piece of it. The TAG is making great progress, so stay tuned for more.

CHAIR WALTERS: Great. I know this

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has been kind of an area of concern and discussion for -- well, I think as long as I've been on SEMAC. So, are there any questions or other thoughts about this? Or -- or David, is there a kind of proposed timeframe, timeline of how this would work or what that sunset would be? I know there's been a lot of consensus and discussions, but where do we see from here going forward?

MR. VIOLANTE: Well, we're waiting to hear back from the Commissioner on the direction we're heading. So, we're looking at potentially something that he would sign for, you know, some -- like a traditional eighteen-month sunset timeframe. But it's up in the air and we want to make sure that, you know, people are all coming to a center -- centerpiece with this.

CHAIR WALTERS: Great. Are there any questions or comments for David or on the E.M.T.C.C. sunset? All right. Then that concludes the old business and we'll take us right into our new business today.

That takes us to the discussion on codifying the protocol update process. This is something that I know we've discussed for a few years

in the collaborative protocol group and we've -- and we've had kind of this timeframe, which I thought we codified it at one time, but it appears we've never really put it into some type of either policy statement or put it into a section in the protocols. And so there's been some discussion about trying to actually make sure that's written somewhere and then that we stick to it. I know this year was a little bit different because of one of the weather cancellations in the last meetings, which set us back a few months.

But just to remind everyone, the process, as we discussed it previously, was that the collaborative working group would work over the -- the summer, fall time to look at new protocol updates and changes and things like that and that they would typically be brought and presented at the December meeting as suggested changes. Then they would come up again at the February meeting, which I believe is now going to be pushed back a little bit later, maybe to March going forward.

But nonetheless would be -- the first meeting of the year would be brought -- those same changes would come back for final approval. That

gives time in between for people to review, to digest, to look at any suggestions or errors and -- and things and work those out, approve those in March. And that would give plenty of time for those protocol updates to go to the commissioner and for Training Ed to look at it, for education from the division to look at those and then those to be rolled out on July 1st.

So that has been kind of the process going -- that we've put in place and we've tried to stick to. So the conversation has been, do we need to -- to make sure this is written somewhere and so that it is standardized and -- and make sure everybody follows it going forward. So I don't know if there's thoughts from the group on that. I'll stop for a second and -- I see Dr. Dorsett.

DR. DORSETT: No. No. I can --

CHAIR WALTERS: Okay. I thought -- I thought that -- I thought that hand was like, you're ready to talk, sorry.

DR. DORSETT: I -- I think the short answer is yes. I think everybody always wants to add kind of last-minute things. But I think we saw kind of the confusion that happened in this last group.

And when you're trying to implement protocols and provide the education, I think there has to be a standard process.

I think there also the benefit of having it written down somewhere. Once it's written down, it should also include how those protocol suggestions are made and who those protocols are sent out to. I know the education and training group has been asking for a while for, like, making sure that there is a point at which that is sent. And while they do have representatives to the collaborative protocols group, I think much like many things, unless something is written down with a checklist in the timeline, when things get busy or there's low bandwidth or complicated, they are less likely to happen that way, and I think we saw that.

There should also be, as we learned, it snows and it gets cold in Upstate New York in the winter, that there probably should be a written process for what happens if one of those meetings is unable to be had and a provision for how to actually keep to the schedule in that case.

CHAIR WALTERS: Don Hudson.

DR. HUDSON: Yeah, hi, Don Hudson. So

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you know, never being above stealing somebody's good idea, a bunch of guys got together in I believe Philadelphia just under two hundred and fifty years ago wrote a pretty good guidance document, and they saw fit to include how to change that document in that document rather than having to go look for it in some other policy or manual. And I think we've been pretty good as it -- based off the collaborative group and everyone else as far as keeping everything in one place, learning from some of the experiences in the past where things were all over the place.

So, what I'm suggesting is respectfully to this group and then to SEMAC is put the change prog -- process in the protocol manual as an addendum or an appendix and be done with it. I -- I thought this was done already, so.

CHAIR WALTERS: So your suggestion, Don, is to put the -- the timeline and who to submit changes to right in the protocol itself, correct, in the collaborative protocol?

MR. HUDSON: I also suggest, you know, based on our processes rather than going through, you know, regulatory oversight and policies and things like that, if it -- if it pertains to the protocols,

go through the protocol process and use that. It gives us a little bit more fluidity and -- and -- you know, a little bit more nimble rather than having to go back to the drawing board and through the bureaucratic processes that we know exist for policies and regulations and such.

CHAIR WALTERS: So, I guess the one question that came up in discussing this is that as we talk about this timeframe for protocols, are we talking about this is the timeframe for the collaborative protocol group, or is this the timeframe for all protocol updates and changes? And -- and I know that they're almost one in the same, right, the collaborative -- the -- the B.L.S. collaborative protocols are the State B.L.S. protocols.

But we do have areas in New York City, for example, that has separate protocols. And I don't know how that timeframe works or if that's something that we want to standardize amongst all the protocols, so everybody in the State is getting protocol changes at the same time. I don't know how logistically that would work for people in the New York City area and I'd be interested to hear from

someone about them, Dr. Isaacs or someone else.

DR. HUDSON: While Dr. Isaacs is compiling his thoughts, can I suggest that, you know, New York City maintains its -- maintain its autonomy for a reason. If we focus on the collaboratives and anyone else wants to follow suit, so be it.

CHAIR WALTERS: I'm fine either way. Just -- it's just a conversation point to -- to look at and discuss of -- of whether those things should be done at the same time and standardized. I -- I guess I'd also ask the, you know, the division of E.M.S., if -- if that, how that would work, those would be a lot of updating the pro -- collaborative protocols and rolling them out and looking at the education piece and that -- and the New York City unified protocols at the same time, does that take up a lot of band -- bandwidth, is that feasible or does that cause -- cause some logistical challenges on their end?

DR. ISAACS: Yeah. Good morning. Sorry for the delay in getting on the mic here. So yes, our goal is to once a year release July 1st protocols. Sometimes we have that active discussion at New York City REMAC. Sometimes adjusting that

date depends on when protocols got up here to the State and that approval process and public comment and what have you. So, but our goal is once a year, similar to dates here for the State protocols, July 1st.

DR. MCEVOY: I would just summarize also some discussion from the last meeting of the collaborative group. And that is that the collaborative is an assembly of regions who hold the statutory authority to make protocols, and those used to be eighteen different regions all making their own protocols. They collaboratively got together and put this group together that makes the protocols.

It is not the State. It is not this body. It is the regions that collaborate to put that together and then bring it here. And this group says, yes, we like this, we don't like this, tweak this, tweak that. And so, the collaborative probably is the best place to put the collaboratives process. And if the State wants to use another process, the State could make a policy for doing it a different way, but really that lives with the regions.

DR. DORSETT: Can -- can I follow up on that? To that end, I don't -- one of the issues

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that happened with this is that there was version control, right, there was changes in change log, and then things went and it came back from the State, and then things were different.

Why is the final document produced by the State if their collaborative protocol group is the one that's making the document for approval? Why does that need to be, because it just seems that there is a potential for error, right? There's somebody leading the charge around making this protocols, we review one document. Why does it actually go through a process where anybody tweaks anything after this body reviews and approves it?

DR. MCEVOY: That is a very good question.

MR. HENNESSY: Yeah, this is the part where I pull the microphone over. So, first of all, there was a question that was asked previously, which I wanted to answer, which is -- you raised, which was, you know, having kind of multiple processes or -- or having different procedures, and does that create more sort of bandwidth issue. Maybe it was asked over here, I'm sorry. And the answer to that is yes. So it's better when there's a clear process,

and I think that agrees with some of the points you raised earlier.

To the -- to the second question, which was about why does something go through a state process, you know, we have protocols that we maintain and make sure that they're available. So we use our resources to put those out there. I want to make sure that they meet whatever standards may exist at the state level as well. So, there is a group that does go through those protocols when they come to us. So that's the reason.

DR. BOMBARD: My understanding of the State law is that the protocols are written by the regions, not by the State. Is that correct?

MR. HENNESSY: The little light is on. I just can't see it, I'm sorry. So, that is true. But we have a process where it goes through us and we take a look at it. We have multiple groups that review it just to make sure that there's nothing that is problematic or conflicts with things that we've working on. So, we have standards that we have internally as well.

DR. BOMBARD: But the State has made content changes in the protocols. Is that correct?

Not just punctuation.

MR. HENNESSY: There have been circumstances in the past where we made changes, yes.

DR. BOMBARD: And those changes have not been run back by the regions by -- for approval, and it's the regions that create protocol.

MR. HENNESSY: So the --

DR. BOMBARD: By law.

MR. HENNESSY: I understand what you're saying.

DR. BOMBARD: Okay.

MR. HENNESSY: Okay. And we would probably want to walk through on an example-by-example basis and walk through the reasons why there may have been changes. Why it wouldn't have been passed back through the -- the collaborative group, I'd have to check into that to tell you the truth. But I -- I don't have a list of the individual changes that have been made at this time.

DR. BOMBARD: Nor do I -- and nor do --

MR. HENNESSY: Yeah. Totally fair. Yeah.

DR. BOMBARD: This isn't the place for

that anyway. That wasn't the point. But I think we need to work more collaboratively. The collaborative --

MR. HENNESSEY: Yeah, and I think that the --

DR. BOMBARD: -- well, we need to collaborate because at the end of the day, it's not the State's position to be changing content. And honestly, grammatically, we should probably collaborate as well.

DR. CLEMENCY: I -- I guess the -- the -- where -- where I'm uncertain is for protocols that are not the collaborative protocols, it doesn't sound like this level of review occurs. Like, New York State's -- New York City's protocols don't go through the same thing. And when we had -- when before we were part of the collaborative protocols, our -- our regional protocols did not go through that same system.

So I think -- I think the point here is, I think we should be encouraged to do the collaborative protocols, but I'm not sure why being part of the collaborative protocols then puts the region up for this other level of review that would

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not exist or doesn't seem to exist for agents, for regions that are not part of the collaborative system.

CHAIR WALTERS: I think someone over there --

MR. HENNESSY: You want me to answer it?

CHAIR WALTERS: I don't think it's addressed to me.

MR. HENNESSY: Okay.

CHAIR WALTERS: I think it's addressed to you.

MR. HENNESSY: No -- no, I just want to make sure. You're the Chair. I'm trying to follow direction, yeah. So, I think to the point that was raised earlier, there needs to be a clear process that everyone understands and is laid out. I think it should be written down, and it should be in front of all of you for consideration. So I think that that may help to resolve if there is any lack of linearity, I'm trying to think the right word, to how the process lays out right now. And we can do that. I mean, we can put something in front of you all.

CHAIR WALTERS: So, I think that my

perspective would be, the -- the whole goal of the collaborative protocols is to be as inclusive as possible to look at things across the state, to hear from all the stakeholders and then to put out a good product in the interest of quality patient care and serving our providers. There may be times where right in this process, one region or one agency or some person has a good point about why we should or shouldn't do something or should change something. But I think that we try to make that as transparent as possible and make sure that everybody, you know, is part of that discussion, understands the rationale, as opposed to one person making that decision or -- or not.

And I think the -- the question is not whether or not the State or the division should be involved, certainly, but -- but about changes being made without coming back for discussion and being part of that -- that process if I'm understanding.

Well, we're getting a little feedback, so I think that's -- that's the conversation that we're having. And did you have a comment?

MR. HENNESSY: No, I -- I totally agree with you. I mean, if -- if -- if some changes

are made, they should come back to you all. If that's not the case, then we should change that practice.

DR. WINSLOW: Maybe just to kind of close this out on a -- on a -- on a good note. So in 2023, Suffolk County was the last county to join the collaborative. And by far and wide, the providers in our region were very appreciative of it because many of them work in Nassau County as well.

So the whole point behind the collaborative did its job in linking two regions that often cohabitate. So, I -- I do -- I do appreciate the benefits of it. Having said that, you do need to draw a line in the sand when the collaborative protocols are updated each year for training and education, and if you keep changing the goalpost, it's hard to develop those materials to share with our constituent and providers.

DR. DORSETT: Can we make a motion?

CHAIR WALTERS: We certainly can.

DR. DORSETT: I -- I think we should make a motion that this group develop the process, a draft process, of what -- how this actually works. And then we put it for, and that that process will

later be documented as an appendix within the collaborative protocols themselves.

CHAIR WALTERS: And -- and I think I would just say based on Mike's comments earlier, that I think that because this is a group of regions, the collaborative protocols are a group of regions with statutory authority that probably -- the right place for that would be in the collaborative protocols, not a bureau policy statement because you know, other regions, New York City, for example, is welcome to do the -- follow the same timeline or to develop their own as a region which they have the authority to do. Is that what I'm hearing?

UNIDENTIFIED SPEAKER: Do we have a motion?

DR. BOMBARD: Second.

CHAIR WALTERS: Yeah. So, Dr. Dorsett, you made the motion. Who seconded it? I'm sorry. Dr. Bombard. And then any discussion?

DR. MCEVOY: I -- I would just point out that that has been done and approved by this group, approved by SEMAC, and approved by SEMSCO. So, if we could just pull it out, we got it.

DR. BOMBARD: So the only additional

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piece is to incorporate it within the protocol document.

DR. MCEVOY: Correct.

CHAIR WALTERS: And then, I'm not sure then if this would be to include it in the collaborative protocols if that is something that actually needs to be a motion here.

DR. HUDSON: Can I suggest that for the next, which would be right January would -- to be implemented in July I believe is the timeframe that we're on, that -- that just become part of that process for 2027? It's already done. You know, Mr. McEvoy put the nail -- hit the nail on the head. We can just dust it and tuck it in.

CHAIR WALTERS: And so -- so Don, what you're saying is to -- as part of the collaborative protocol ongoing review, put this piece in there for the next protocols that come forward at the next meeting for approval?

DR. HUDSON: Right. As we argue for months whether it should be a comma or a semicolon, tuck that into that conversation also, and then we can kill each other over it.

DR. MCEVOY: And I think Dr. Fullagar

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here who has involuntarily made the chair of the collaborative recently is more than happy to do that.

CHAIR WALTERS: Does Dr. Fullagar want to consent himself, or is Dr. McEvoy speaking for you? Perfect. Thank you. So -- so there was a -- a motion and a second. But do we need the motion, or is there -- do we want to withdraw the motion then?

DR. BOMBARD: I think the part of the motion that's still alive is that we do incorporate this within the protocol document. And so I think we have to vote on that, right, I think?

DR. EGIN: I would think you could make a friendly amendment to the motion and include it.

DR. BOMBARD: Okay.

DR. DORSETT: So, a friendly amendment would be to remove the first part about the process because it's already been done and keep that this lives within -- it gets added as an appendix to the collaborative protocol, which is where it lives.

CHAIR WALTERS: Dr. Cooper?

DR. COOPER: Good morning, everyone. This is an unusual motion only because it concerns an issue that we ourselves feel is not necessarily

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within our purview. So I think this is re -- this really needs to take the form of a recommendation to the collaborative group. I know that's Dr. Dorsett's and Dr. Bombard's intent, but I just think that needs to be clear. Thank you.

DR. HUDSON: And Dr. Cooper while I appreciate that, I believe it was the collaborative group that brought that process to here to SEMAC, to SEMSCO, with the intent of getting everyone collaboratively on board with one singular process, so that we didn't have things changing all the time and subsequent education that may or may not match, and one region is on board with a different set of protocols, right. We've come this far as a State. I think this is the next logical step and seems like such an easy lift. I think it just should be voted on if nothing else for the record so we can be done with it.

DR. DORSETT: Yeah, let's vote. If Don says it, we should do it.

DR. HUDSON: Motion to call to question.

CHAIR WALTERS: All right. There was a motion, a second, and a call to question. So, do

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you want to restate the motion for us, Dr. Dorsett?

DR. DORSETT: The motion is that the process that was codified by this group for which protocols are updated in New York State is added as an appendix within the collaborative protocols, which is where it lives, rather than any bureau policy.

CHAIR WALTERS: Thank you. And then, we will vote. This will be a show of hands and an aye. All those in favor, raise your hands and say aye. And, good. Any opposed? So, there is no opposition. Any abstentions? All right. Then it passes unanimously. Thank you very much. Last item --

DR. HUDSON: If I can, you said it was going so well too -- to many times, so now-

CHAIR WALTERS: Go ahead, Don.

DR. HUDSON: So, I brought this up and we discussed this in the past, and I'd just like to revisit it. If there's no requirement that the State maintain a set of protocols, is it also an opportunity here to have one book that providers and students and educators can look at, because we're constantly battling or -- or tackling the question about, when we do education, either initially a

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refresher or anything else, you know, which book? Is it the city one, is it the State one, is it the collaborative one, is it A.H.A.? Like, what are we doing tonight, you know.

And obviously that's an educational question, and eventually we quickly get all students to realize it's really all the same now, so stop it, right. The cover on the book doesn't matter, because the concepts are all the same. But I'm just saying only because isn't it -- isn't it more difficult than it needs to be to try and maintain two books that should look alike, but don't always do? Why is there a State B.L.S. protocol and then a statewide collaborative protocol in which the B.L.S. protocols are embedded?

DIRECTOR GREENBERG: Mr. Chair? May I?

CHAIR WALTERS: Please, Director.

MR. GREENBERG: Good morning, everyone. Thank you. I apologize for my timing. Again, kids are safely on the bus. Two working parents. Working on that.

The -- so, timely discussion. Love to have this discussion. The biggest thing that comes

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up with this one is technically there is, one, State B.L.S. protocol -- statewide, including New York City. And then New York City takes that and makes sure to conform to it and can make edits and things like that -- kind of the basis there.

Very open to possibly looking to combining that to where it sits in just a collaborative. And you know, Dr. Walters and the others who work on the collaborative team, this would help us, right? Like, we go through this as we do updates and, you know, do updates in the collaborative protocol as well as the B.L.S. protocols. If we only had to update one document, that would be easier.

The question then becomes, and kind of two questions have come up in the past. It would be a great discussion for this group. The first is, technically by state standards there's one B.L.S. protocol. And then we'd be merging it into collaborative and we'd have to say, okay, the collaborative B.L.S. portion is the collab -- is the State B.L.S. protocols. That would be okay. And that's fine.

The second component comes up to, from

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the B.L.S. side of things, obviously if we look at the collaborative protocols there are many more protocols in the collaborative protocols than there is in the B.L.S. protocols. And what is the adjustment? Maybe none. Two, our B.L.S. providers using that and adjusting to that and which protocol to find or when they're going through something or -- or things of that nature. Is that just an educational front? What timing do we need on that? And that has been a lot of what has leaned towards having the B.L.S. protocols remain separate.

But, open to change and open to discussion on what the best path forward is that in the future.

MR. HUDSON: So not to belabor, but you know educationally at least, when we have these discussions, either in E.M.T.s looking to -- you know, going to a E.M.T. level or E.M.T.s to go into the paramedic level -- and quite honestly now that I'm thinking of it, more specifically on the E.M.T. original level is, so when do I call for A.L.S. and why am I calling for them? Meaning what are they going to do differently when I -- when they get here. And when we show them the collaborative and say,

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well, here it is, from C.F.R. through paramedic with medical control, discretionary orders, specialty transfer, right; all the things in one place, they're like -- oh, so why don't we just use this.

And I would suggest to the group, you know, there's an opportunity here to change our thinking. I like -- probably I would assume most people in the room still think of these as books. They're digital references nowadays that don't exist in a singular book. You know, the State has provided mobile platform was -- really changed that. A student or provider, as intended, can go in one app that calls from one or multiple references and gives them the answer for this specific patient.

You know, my head is still stuck in, let me go to my office and get it off my shelf and I'll bring it in here and we can sit down with a highlighter and look at it. I'm old.

CHAIR WALTERS: So, I think just one point I want to clarify, Director Greenberg, is we've already voted here, right. And I believe the B.L.S. collaborative protocols are the State B.L.S. protocols, right? We've -- we've made that decision before?

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DIRECTOR GREENBERG: The standards that are set in the B.L.S., in the collaborative protocol at the B.L.S. level are what is used to develop and outline. So yes, they mirror each other. And when one is updated, the other one is updated.

DR. HUDSON: Then that's my point is, if the one book says look at the other book, why do we have two books?

DIRECTOR GREENBERG: One book for -- at -- at the provider level, one book doesn't say to look at the other book. If an E.M.T. opens up the B.L.S. protocols, it doesn't say refer to the collaborative protocols.

DR. HUDSON: And that's my point. It never should. Do away with the other book and let them have one reference. Just a suggestion.

MR. GREENBERG: And I guess the question is to the medical directors around the room. Do you feel that creates any issues or things of that nature? I think some of the barriers that we've had in the past, we can work around. So then the next question comes down to, do we feel from the provider point of view using it, and, you know, the -- the Chair is saying next to me as well.

You know, we'd have some, you know, just quickly on discussions -- this one, today with apps and things like that, I think more people won't look for a particular protocol as much as they type in an issue or something that's going along with it. So, thoughts?

DR. WINSLOW: So -- so in our region, there's a lot of mutual aid, there's a lot of providers on calls. It helps having one working document because it also allows the basic to see what the advanced life support provider would add when do they call for an A.L.S. intercept. So having one set of protocols works. In our region, we advise them to just read the collaborative advanced life support protocol and stop where appropriate.

DR. DORSETT: Yeah.

DR. HUDSON: And I mean, that was one of the intents behind one of the educational funding pilot programs was to sort of push that envelope for a basic E.M.T. to see what other quote unquote advanced life support options are available when they want to toy with upgrading. I think we're all -- we've come this far in every way possible educationally, protocol, medical oversight and

everything else. This is -- let's just do it.

DR. DORSETT: I would say that I think most providers think of protocols as an app, not a book, and they search for what they need specifically. I think one of the things to look into here is, if they're logged in in Muru, they only see their scope of practice. I think this is actually problematic. Like if you're logged in as a B.L.S. provider, you can only see B.L.S. protocols. So if that's used as a state protocol app, I think that's a disadvantage.

The other thing is, it -- it's not just like seeing what an A.L.S. provider can do. Should I upgrade? It's being an A.L.S. assist on the scene where the A.L.S. provider says, pull this up while I'm doing this other thing to look at a reference and double check in another mind.

So, I don't know the last time I actually looked at a book or pulled out a book. I think it's a search for an -- an app overall, and it doesn't matter how it lives. But I do think that there is value in any B.L.S. clinician being able to see what A.L.S. can do on scene so that they can both -- I think actually predominantly in that context, be

an assist.

You know, in our region like the -- the B.L.S. providers all have access to an app where they can pull up the dose, where they can scan the med, where they can do that to cognitively offload an A.L.S. provider who's trying to do a lot of things at once.

DIRECTOR GREENBERG: Mr. Chair?

CHAIR WALTERS: Please.

DIRECTOR GREENBERG: I think the recommendation I would have here, and kind of funny coming from Don Hudson, the -- the initial part -- if this is the direction that we think we want to go in, which again I will tell you from the Department's side of things is we're sitting here updating two different books, we literally were having this conversation recently. I would recommend that in December it goes to training and to make sure that they don't feel there's any educational components to it. And that -- I know, that's why I said it was funny, Don. And then from there, I believe in December, we'll hopefully be voting on the next set of protocol updates.

I would vote to sunset the B.L.S.

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protocol book on its own for July 1st and to incorporate that the B.L.S. -- statewide B.L.S. protocols are the B.L.S. protocols of the collaborative and will live within the collaborative document and will into effect on July 1st with the next protocol change.

DR. HUDSON: We'll get that done, look for it in December. Thank you.

CHAIR WALTERS: So, does -- so I understand the suggestion that that go to training and ed, but I -- I think the question here then, based on the discussion in the group I think everybody is in agreement about this. I think that should probably be a motion that goes forward to SEMAC if we're talking about moving -- right, making the collaborative B.L.S. protocols, these statewide B.L.S. protocols, and only having one document going forward on July 1st. I think that that would be the more appropriate way to handle it. Dr. Winslow?

DR. WINSLOW: It -- it could just be added to the next round of updates, which is going to begin very shortly. There's been a lot of change this year, and more confusion right now would be a bad thing. In my opinion, we should just bring this

up in December as part of the collaborative update for 2027, July 1, and remove the B.L.S. separate document and just live in the collaborative.

CHAIR WALTERS: But I think this goes beyond the collaborative protocol group, right, because this would be affecting a statewide B.L.S. protocol, a larger group. So, I think it -- kind of similar to the same discussion we had before that Dr. McEvoy brought up. I think that -- this -- this type of change would be more appropriate to be coming from Med Standards to the SEMAC to the SEMSCO and not just within the collaborative group itself.

DIRECTOR GREENBERG: I think if you were to move forward in that pathway, the motion doesn't change anything for today. It's just setting the gears and motion for the future, as well as then if there are any additional discussion points that happen at SEMAC with the full body and or at the SEMSCO with the full body, that it gives that opportunity for those to discuss as well.

DR. MCEVOY: And so -- I would make one other point, that -- that B.L.S. is a state function, B.L.S. protocols is a state function. A.L.S. protocols is a regional function. And so, we

want to be cautious not to blur those lines. I don't think that requires two separate books, but the -- the lines of authority are important.

DIRECTOR GREENBERG: And this has been one of those discussions from the past on why it has lived as two separate books, but yet has moved the needle when the collaborative protocols have updated.

DR. MCEVOY: Last thing we want to do is go back to having every region have its own protocols.

DIRECTOR GREENBERG: Sounds like a great idea. Is that a recommendation for one set of protocols for the State? I'm just checking, Dr. McEvoy.

CHAIR WALTERS: So, then is the -- the discussion and the feeling of the group that we hold off on making any voter determination until the December meeting or something that we --

DIRECTOR GREENBERG: I think -- I think your motion is just that, you know, it's just that. It's a motion to move something forward and to you know, have that start to occur in the December meeting. And then it opens that discussion for SEMAC, which might be a short discussion at SEMAC

based on here.

And then for that same discussion to occur at SEMSCO, which would line us up well to know -- you know, if SEMSCO comes back saying, no, we don't think this is a good idea, we want them separate, something else, I think that's important for this group to know as well as they, you know, work to move this forward. Not that they do a bunch of work to all of a sudden then have the SEMSCO say, no, this isn't good.

I mean, we can move it forward. Just -- you can move forward a motion that's a recommendation, too. And I think that will give you a discussion both at SEMAC and at SEMSCO without an issue.

DR. HUDSON: Can I suggest that -- sorry -- as -- as all the subcommittees are actually subcommittees of SEMSCO put -- this group should put it to SEMAC, if SEMAC sees fit to put it to SEMSCO and SEMSCO wants to send it back to T and E or any other subcommittee, that's their right. But let me suggest let's do it today.

CHAIR WALTERS: I would think that would be the correct order and process. So, then, is

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there a -- a motion? Anybody willing to make a motion here on this?

DR. HUDSON: I'll make a motion that Med Standards recommends for the State of New York to adopt the collaborative protocols not to replace but to no longer maintain a statewide B.L.S. protocol and adopt the collaboratives.

DIRECTOR GREENBERG: B.L.S, you mean, something that says B.L.S. in there.

DR. MCEVOY: Isn't there a motion on the floor already?

DIRECTOR GREENBERG: No. We just discussed about having a motion, but he was making a motion.

DR. MCEVOY: Okay.

DR. HUDSON: I -- I don't want to use the phrasing B.L.S. or A.L.S. because there's an active text going on right now amongst the training and education committee as we speak about, is that even an outdated concept. It stopped when we let E.M.T.s give aspirin. I mean, because if the delineation was, well, A.L.S. gives meds --

DIRECTOR GREENBERG: So put E.M.T.

DR. HUDSON: Why don't we just call

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them pre-hospital treatment protocols and be done with it? Why -- why drill down on stuff that probably is equally outdated? If we're talking about a statewide treatment protocol that encompasses B.L.S., A.L.S., and everything in between -- winner, winner, chicken dinner, I mean what's the holdup?

DIRECTOR GREENBERG: Your motion.

DR. HUDSON: Where are you at, Theresa? I see you looking. Start from fresh? Yeah, just strike the winner -- winner, chicken dinner thing. So, I make a motion that the State of New York no longer maintain a B.L.S. protocol and adopt the collaboratives. I'm open to accepting friendly amendments.

DR. DORSETT: Can I ask a question about balancing, like, the unintended consequences? We're doing that because the State has this extra authority around B.L.S. that Mike brought up. Would doing that give the State kind of more input into the collaborative protocol process because there isn't this separate thing, which is what we're trying to avoid? Sorry, but true.

That's my -- that's my worry, right, because once if we say it's merged, if they have to

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control one part of this pro -- have some control over the one part of this process, I'm like worried about the unintended consequence of where does that process now live.

CHAIR WALTERS: So, just as a point of order, there was a motion made, and so we need a second to continue discussion on the motion if someone would like to second Don Hudson's motion.

DR. WINSLOW: Second.

CHAIR WALTERS: Thank you, Dr. Winslow. Go ahead.

DR. MCEVOY: I would agree with Maia. I think that there needs to be a delineation, and saying -- this body has no authority to tell the State what to do with the B.L.S. protocols. We can make recommendations, but it's not our purview.

MR. WINSLOW: And if I may -- and that was the whole point behind having regional REMACs sticking to an advanced life support in the first place. And then the collaboratives connected A.L.S. from every region except for New York City. And the New York City ones, quite honestly, are very -- very similar. So, I don't want to single out New York City.

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But -- but having two documents becomes confusing to providers under which document I'm working on. So I -- I do think that there is no clear consensus on how to move forward on this. There's been multiple different -- I do think this in the interest of moving things forward should be discussed not only by the collaborative working group, but maybe we should even put like a group together to look at this issue to work collaboratively with the State, and I'd be happy to work in that group if that's what the group wants.

DIRECTOR GREENBERG: Higher powers? Sorry. No? Come on. You know, Maia, just to -- Dr. Dorsett, to -- to your point, kind of that component too has already kind of happened in the past years, right? So like the B.L.S. protocols that are out there, we align those with the collaborative protocols as they come out.

So I -- I don't, I understand where you're coming from on that. And I -- I think there's a discussion based on recent events, so, you know, how the collaborative protocols come forward and -- and working on -- on that component. But I don't see that -- I don't see us really changing that process.

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Like that -- we've -- that's been a process moving forward for I don't know how long the collaborative protocols has been going on.

But at least in the eight years I've been here, that we've kind of just aligned and said, okay, this is good medicine, let's change that at the same time at the advice of this group and then obviously the approval of the commissioner. But I understand where you're coming from that's --

DR. MCEVOY: This issue, I think is, I agree, is not easily solved here. I would make a motion to table this.

DR. HUDSON: I'll withdraw my motion.

CHAIR WALTERS: Okay. So, the motion is withdrawn. I think there was some –

DIRECTOR GREENBERG: All right. So much for SEMAC and SEMSCO discussion on that. Just so we're clear, Dr. Walters. What would be next steps on that one, and what can the -- the division do to help?

CHAIR WALTERS: So I think the -- the con -- based on conversation I think the appropriate place for this to go back would be to the collaborative working group for discussion as they're

looking at protocols and -- and that. And I do agree with what's been said, personally I think that it helps providers to look at the whole continuum of care and understand what those next -- next pieces are.

Like many medical directors here, I -- I also encourage my providers to look at the collaborative protocols for that re -- region -- for that reason, not the State B.L.S. protocols because they end at the B.L.S. level. But there are some issues, like Dr. Dorsett brought up with -- with Muru and being able to access those as a B.L.S. provider, which maybe we need to -- to look at how we can fix.

DIRECTOR GREENBERG: I definitely think the way that people interact with protocols today is different than probably the way that many of us who are E.M.S. providers -- you know, that are E.M.S. providers or were prior to becoming medical directors.

I mean, I can tell you, I used to be really excited. I used to take my protocol book when I first became -- and shrink it down to twenty five percent, make four of them and then bind them with a little twisty and it would stick in my side pocket.

And so, you know I literally had to flip to the page. My eyes were also better back then, so it was okay being smaller.

If you -- at your discretion, Mr. Chair, would you be willing to maybe get a show of hands because if people feel this is going in that direction, and that way the division would know what we can do to help facilitate that or not if we feel it's too early.

CHAIR WALTERS: A show of hands, it's going in what direction, I'm sorry?

DIRECTOR GREENBERG: To merge the B.L.S. If the medical directors around this table or the -- the committee members, not just medical directors, I apologize, believe that it should go to one set of protocols, B.L.S. and collaborative.

CHAIR WALTERS: Show of hands. Thank you.

DIRECTOR GREENBERG: Okay.

CHAIR WALTERS: I mean, just by the straw pool seems to be fifty-fifty.

DIRECTOR GREENBERG: Yeah.

CHAIR WALTERS: Roughly. So, I think the appropriate place then maybe is further

discussion. Since this originated from a discussion on the collaborative protocols and the State B.L.S. protocols, I think referring it back to the collaborative working group for discussion and then moving forward from there would be appropriate. And Dr. McEvoy says Dr. Fullager would be happy to do so.

DIRECTOR GREENBERG: I heard Dr. McEvoy was going to chair it, what?

CHAIR WALTERS: All right. And then the only other thing, and I don't want to belabor the discussion on -- on protocols, but just as I think as we've had this conversation and some discussions and some texts going around, I think Dr. Dorsett, you brought up the -- the question on if there is, you know, we -- we run into some weather-related issues. Sometimes there's cancellations of meetings, things like that, and what does that do to the process if we outline and codify the process. Right now, we're presenting suggested changes at the December meeting, but then we don't vote on them until the next meeting, the first meeting of the year. And there's probably very few changes in that -- that time period.

Is there -- and I'm not suggesting a

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motion or a vote here, but maybe in the collaborative group, maybe we look at, is there the option of, should we just be presenting those changes for vote in December, and then if a December meeting gets canceled, for instance, we still have that timeframe to approve them in the February, March meeting, whenever it is. Or if we do that, if we approve the changes, we still can because they're not being rolled out to July, we can still make tweaks and changes or additions at that following meeting. Is that something that we want to consider just to make sure we don't run into an issue like we did this year?

So, I don't know if there's thoughts on that. Again, that can be discussed in the collaborative group as we outline this process and include it in the protocols for the next update, but are there any thoughts from the group on that?

DR. HUDSON: So, I don't know if Ryan stares at me out of disdain or because he wants me to talk. So I'm --

DIRECTOR GREENBERG: I didn't even look in your direction this time.

DR. HUDSON: Yes, you do. You do, so.

I guess some homework to take back to the State itself is -- is there no allowance that in the event of this declared S]state of emergency, whether it be weather, pandemic, or otherwise, for a virtual option, so government doesn't stop if indeed we ever have to cancel a meeting again?

DIRECTOR GREENBERG: It's a much higher level. So -- so the -- the thought is that the --

DR. HUDSON: -- so the answer is yes and no. There is no -- there is no waiver to certain rules and -- and things like that, that it has to be public and everything else. Should something extreme happen, are there some extreme measures that can be taken, yes. I can tell you we haven't hit those probably since COVID and obviously COVID had the exemptions on some other things.

I think to Dr. Walter's point, you know, if these protocols come forward in December and they get voted on December and they get approved in December, that also allows us to put them up on the website in January. Let people see them, let people educate on them, let people do what needs to happen. And then if they notice that something, uh-oh,

something was off, something was wrong, which we had in this situation.

We had two different situations that came up. Thank you for that. You know some of the things that came up during education. And the reality is, it could happen, right, like we all look at things, but this was missed. When it's coming up before -- you know, in -- in a reasonable period of time, there's also then another meeting that anything can change, right? Maybe you implement something and say, you know, we were teaching this and it just didn't work out, that, we can go backwards and change it. You'd have that April meeting.

And if for some reason there is -- whether for some reason that it doesn't happen or even simple things, which, you know, Don, you're talking about, you know, weather. But we've had SEMAC meetings that got canceled because we didn't have quorum. So, it could be anything. And so I think the -- the precedent of voting on it December, we've got -- you know, the collaborative has looked at it, everybody here has looked at it. And we kind of just sit on it right now from one meeting to the next. I don't see a negative. They're not going

into effect. There's still another whole meeting before we would implement it or anything else. It just says, now they can be published online, because we won't publish a draft.

We won't publish something that you don't vote on. And if you're wondering why we don't publish it and why we currently don't do -- I go to the meeting materials, we'll list what they are. Anybody -- they're accessible to anybody -- anybody can call us and ask them for -- we'll send it to them. We don't post it online because otherwise what people do is they do a Google search, kind of to Dr. Dorsett's point of like, we look at everything in map. We also Google search every answer that I want. And all of a sudden, some draft policy comes up and someone reads it and says, oh, that must be the real one, that's in place today and then they take that as what it is. And so we don't -- we don't post draftings.

But if it's approved, we can post it. If it's approved, we'll put it up because that's what was approved, even if there's a modification for something at a later point in time.

DR. BOMBARD: We don't have a meeting

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until March. It looks like tentative State Council meeting dates next year. So, if we have a weather cancellation in December, then we're stuck till March?

DIRECTOR GREENBERG: Yes. Which is --

DR. BOMBARD: It seems bad. Can we just have a virtual meeting if we have weather in December?

DIRECTOR GREENBERG: No.

MR. HENNESSY: That's not -- that's not a -- that's not a SEMAC SEMSCO thing. That is a -- as State no open meetings law requirement. And there were circumstances, say during the COVID pandemic, where there were emergency allowances put in place to waive those -- those requirements. If we had an extended circumstance where something like that was to happen, there probably would be considerations like that. But what happened, I think with the last weather event is it was pretty sudden. There wasn't any time to do that kind of consideration, and so the cancellation took place. It is possible, hypothetically, that we could, provided we can kind of work with everyone here to achieve quorum, that we could do a different meeting

date.

There also would need to be some logistical work that would happen with the place where we host the meeting. So they're kind of open questions as to whether we could organize that. But I think -- I think one of our takeaways is if we miss a meeting, is there some way we can reschedule something like that? But I -- I cannot say today that we could offer to do a virtual meeting, for example, in a place of an open meeting. That's just not something that we're allowed to do.

DR. DORSETT: I think this gives a lot of food for thought. I think this needs to be taken back to the collaborative protocols group to get their input and whether or not this is feasible in their thoughts. So I -- I think this is a good thoughts to bring back, but I don't think we should take any actions on changing the entire schedule right now.

CHAIR WALTERS: I agree. I think it was just discussion in consideration. So any final thoughts before we move on? Great. Then next on the agenda is medical aid and dying and some guidance for E.M.S. providers. Director Greenberg, do you want to

speak on that?

DIRECTOR GREENBERG: Sure. We had a, you know, really good meeting with Dr. Dorsett and a number of other people, as well as Division of Legal Affairs and -- and many others on this one related to medical aid and dying. The guidance for E.M.S. has been completed as well as the most update, including a section on it related to medical aid and dying. We are waiting for that to come out.

It is -- it is with the department-wide medical aid and dying committee, as there are many different facets of this going on right now, and they are making sure that it is coming out streamlined for everybody involved. And -- and I say everyone, meaning hospitals and nursing homes and hospice care. And so, there has been lots of communications and things that are going through on that one.

So, I am hoping by the end of the month, you'll see both of those policy Statements up on our website. And we'll make sure to share that with everybody here.

CHAIR WALTERS: Okay. And I know a lot of regions and areas have already put out their

own guidance to providers on this and in the interim and that. Any -- any other thoughts on that? No? All right.

Then last, any of you who were at the committee meetings yesterday are going to be shocked to find out that the last item on the agenda is -- is the county comprehensive E.M.S. plans.

I think -- I think the conversation that I just wanted to bring up here and hear from the medical directors is, and I think that I take this for granted working for the county and -- and being involved like everybody here around the table with their agencies is probably involved in these plans and aware of these things, but from the group of physicians, are there suggestions of things that counties should be looking at from a medical director standpoint, from a quality oversight standpoint, for just -- just to ensure that there is discussion inclusions of -- of medical director involvement?

Is there anything here that we want to discuss as suggestions for those counties as they develop their plans or -- and or anything to bring forward to discuss at the SEMAC level? Dr. Winslow.

DR. WINSLOW: Yeah, I don't -- I don't

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want to take time up at SEMAC or -- or any other meeting. But one thing I would recommend the E.M.S. coordinators look at under the first section where they go over the demographics and geography is to allow for some description of the types of facilities to which the E.M.S. units transport their patients specific to their region. We have one trauma center, we have zero trauma centers, we have twelve trauma centers.

Just an example, we don't have a stroke center in our region. Because I think that the legislative body that reads it is going to need to be able to interpret long transport times in rural areas, especially when we have destination decision making. So if they could consider adding some of that facility specific detail, I think that would be very useful to the readers.

CHAIR WALTERS: So specifically, you're saying looking at facility details with regard to specialty centers, right --

DR. WINSLOW: Yeah.

CHAIR WALTERS: -- and --

DR. WINSLOW: Yeah.

CHAIR WALTERS: -- transport times.

DR. WINSLOW: Yeah. Stroke, STEMI, trauma.

CHAIR WALTERS: : Very good. Any other thoughts from the group?

DIRECTOR GREENBERG: Mr. Chair?

CHAIR WALTERS: : Yes.

DIRECTOR GREENBERG: Out of curiosity, how many of the E.M.S. medical physicians have been contacted by county E.M.S. coordinators or been asked, you know, to give their feedback or involvement? And is there anything, do you -- do you feel the need to, or is there anything that we can do to help facilitate that or someone?

CHAIR WALTERS: So I guess the question, just by a show of hands, how many of the physicians sitting around the table are already involved in their county comprehensive plans? I only saw three hands, so.

DIRECTOR GREENBERG: Four.

CHAIR WALTERS: Four, I'm sorry, four.

DIRECTOR GREENBERG: I think two of them are county E.M.S. medical directors.

DR. WINSLOW: Yeah, if I may, I would -- I would just urge the medical directors to reach

out to the E.M.S. coordinators to lend their guidance and assistance. I think that may be the right olive branch to extend.

DIRECTOR GREENBERG: I -- I think in this one, and I bring it to every committee, right, this is the last meeting before most of these plans are written. This plan is asking counties and the E.M.S. system as a whole to look at what their system will look like in the next two, five, ten years. And the models that have been there, many of them work, many of them are a little wobbly, and some might need a complete restructure.

A key component of that is strong medical direction. And so, I believe it's important in that process to have that input into the plan, to figure out or make recommendations on why anyone may feel, oh yes, this is, you know, this is what you need for medical direction, this is what you want from it. This is -- the barrier is -- and I don't know this to be true, I'm just putting out that the barrier is that it's not paid. They should, you know, pay a physician group and then we can all provide the coverage in some way. Whatever that might look like, now is the time to talk to your

county E.M.S. coordinator to discuss that being in there, so that it doesn't come out after and medical direction comes back and says, oh, well, this really would have benefited it if it said X or Y.

MS. DORSETT: So, I'm glad that this is being brought up here, but I think it's worth looking at the system design of how this data was collected, and there's a bunch of agency surveys. But I didn't see in the checklist that they had to reach out to the medical directors providing medical oversight in the county and ask their input specifically on this, which is probably why four of us got talked to.

DIRECTOR GREENBERG: Which is exactly the type of stuff that I want to come up here, so that, again, because we probably have twenty county E.M.S. coordinators around the room, like for them to hear, for them to -- to know what needs to happen in order for that to occur.

CHAIR WALTERS: And just -- I don't know the answer to this, so I'll ask. With some of the data collection, right, there's things that look at -- look at PSAPs, agency data, all those types of things. Is there, in any of those questions or data

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points, does it look at medical director involvement in the system? Yes?

DIRECTOR GREENBERG: Yes, it's one of the questions. Now, I will also tell you, it's a question, I think it's a yes or no question, I'd have to go back and look at the survey exactly. It's also up to the person who decides to answer the survey to answer on, right, what that involvement means. And I'm sure that's a little bit different in every agency.

So -- and this is with any -- you know, this is with any survey, but also particularly in this survey. You know, we have some of our county E.M.S. coordinators that have come back saying, hey, I know some of this data isn't right or is leaning more towards this side or leaning more towards that side. That is part of what they have to put together and discuss and -- and figure out.

But that's why we stress it. That's why it's been on every agenda for like -- you know, this meeting, is to make sure that these points are getting across the county E.M.S. coordinators that as they're writing these plans, that these things are taken into account.

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CHAIR WALTERS: So I -- I think everyone here agrees that E.M.S. medical directors should be involved in the development of these plans and -- and involved in the E.M.S. system. Is there any, other than reaching out to your E.M.S. coordinators or discussing that with the E.M.S. coordinators group for some inclusion and -- and for them to reach out to medical directors, is there any other action that anyone feels we need to take here from this body today?

All right. So the consensus is no, which takes us to the end of our agenda. So I will -- are there any other items to be brought before the committee? Yes, Dr. Winslow.

DR. WINSLOW: Yeah, I just wanted to give an update on the B.L.S.I.M. glucagon project. I didn't want to take up time at SEMAC, I thought I would just give you the numbers. So in July of 2025 under a pilot program, the ability of a B.L.S. E.M.T. basic provider to give intramuscular glucagon to a patient with a documented low blood sugar began. There are currently thirty-two E.M.S. agencies from Suffolk and Nassau counties, and I have had fifty-seven successful documented uses by B.L.S. providers

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where there was no A.L.S. provider available. I can further drill down into that and present it to the group in December, but I plan to ask the collaborative working group to add that for next year's update to add B.L.S. I.M glucagon to the basic E.M.T. skill set under protocol.

MS. DORSETT: I have -- it's technically old business, but I guess what's old is new again. At the last Med Standards, we were -- I brought up talking about I-Gels at the B.L.S. F.R. level and whether or not through the -- you know, the hold of C.M.E. recertification, we might be able to expand that policy statement to make it possible. I'm just wondering if there's any updates on that.

DIRECTOR GREENBERG: So if you don't mind, can I just answer one thing on there and then I'll answer -- here, I'll give you a quick answer. Yes. We think we have good progress. I think, yeah, you will see it in December for a pathway for the B.L.S. F.R.s to -- if not before December, for the B.L.S. F.R.s to be able to have I-Gel, so.

CHAIR WALTERS: Great. Thank you. And I'm -- I'm sorry, I just want to go back for a second Dr. Winslow because I -- I didn't mean to cut

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off your discussion. I thought Dr. Dorsett had something about that. That's okay, I don't know. But just with those fifty-seven successful usage, you said that was with no A.L.S. on scene, correct?

DR. WINSLOW: Correct.

CHAIR WALTERS: Okay. So -- so -- good uses.

DR. WINSLOW: Yeah.

CHAIR WALTERS: Or -- also valuable uses, right?

DR. WINSLOW: Yeah. And also self-reported by the agencies. They were happy to share the P.C.R. and the documentation because of the successful outcome. Now, I will do a further, deeper dive and find out if there were other uses that weren't reported, but -- but I can think of nothing better for a basic E.M.T. to be able to diagnose and treat hypoglycemia when there's no A.L.S. provider available. So I think it's a good option, especially for the -- for the B.L.S. provider.

CHAIR WALTERS: And -- and I know, without doing too much of a deep dive, do you have any data on what the average glucose level was or any -- were there any adverse effects?

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MR. WINSLOW: Yeah, it -- it takes about ten minutes to affect its change in a positive way, and it depends on how low the sugar was, whether it moves the needle a little or a lot.

CHAIR WALTERS: And any adverse outcomes or negative effects?

MR. WINSLOW: Not that I have seen. I will -- I will actually make a formal presentation in December if the group would like.

CHAIR WALTERS: Thank you very much.

MR. WASHKO: Just a quick comment on that unintended consequences. When an A.L.S. provider is on scene, would the protocol require the A.L.S. provider to give glucagon or would the B.L.S. provider still be allowed to give glucagon because you're going to shift an A.L.S. one to a B.L.S. rate if you allow glucagon to E.M.T.s, which is fine. I mean clearly it's appropriate, but it will have an impact on the ability to bill diabetics, especially the treat and release diabetics, you know, things like that from an A.L.S. one down to a B.L.S. rate.

So, just something to think about. And then if we can write it, if A.L.S. is on scene, only A.L.S. can give glucagon, that -- that might fix

it.

DR. WINSLOW: The other way we did it, Jonathan, was we made all the patients be transported. Nobody was allowed to be treated and released.

MR. WASHKO: Got it.

DR. WINSLOW: So if a B.L.S. provider gave glucagon, the patient must be transported.

MR. WASHKO: Okay.

DR. DORSETT: How do you do that, right, like if a patient -- if a patient --

CHAIR WALTERS: I get out my magic wand.

MS. DORSETT: -- right, like if a patient has decision making capacity, my protocol doesn't change whether or not they have decision making capacity to not be transported. So I mean, part of it is glucagon either doesn't work or it takes a really long time to work, so they're like already in your ambulance, which is probably the -- the solution, but.

CHAIR WALTERS: All right. Any other items to come before this committee before we adjourn?

DIRECTOR GREENBERG: So, just one thing, just a reminder, the B.L.S. I.M. glucagon is a commissioner pilot program. And before it would move to a formal protocol open statewide, that's not a pilot program, the commissioner would have to opine on that. So if there's data and different things that -- that maybe we can push forward and things like that, because the next step, and I know this has been a regional thing, might be a larger scale pilot program and then to expand to other things, or it might not be. But I think there were some questions even just from this group related to that and seeing the data and things might be with that next step.

CHAIR WALTERS: You can put it on December's agenda. We'll put it on the Med Standards agenda for December, yeah. And if there's no further items, then I'd entertain a motion to adjourn.

DR. DOYNOW: Sure. I'll make the motion.

CHAIR WALTERS: Dr. Doynow, second. Dr. Cooper, all in favor? Thank you, we're adjourned.

(The meeting adjourned at 9:21 a.m.)

STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 72, inclusive, is a true record prepared by Associated Reporters Int'l., Inc. from materials provided by me.

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