

5/7/2025 - Medical Standards - Saratoga Springs, NY
 NEW YORK STATE
 DEPARTMENT OF HEALTH

 MEDICAL STANDARDS

 DATE: May 7, 2025
 TIME: 8:05 a.m. to 10:06 a.m.

 CHAIR: DR. JEFFERY RABRICH, D.O.

 LOCATION: GIDEON PUTNAM RAND BALLROOM

 24 Gideon Putnam Road

 Saratoga Springs, New York

Reported by Danielle Christian

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 2 **APPEARANCES:**
 3 ALBERT SHIH
 4 AMANDA SHULTS
 5 AMY EISENHAUER
 6 ARTHUR COOPER
 7 DANIEL OLSSON
 8 DAVID VIOLANTE
 9 DONALD DOYNOW
 10 DONALD HUDSON
 11 DOUGLAS ISAACS
 12 GINA WIERZBOWSKI
 13 JASON WINSLOW
 14
 15 JERMEY WONG
 16 JONATHAN BERKOWITZ
 17
 18 KATHLEEN HALLINAN
 19 KIRBY BLACK
 20 LEAH SWEENEY
 21 LYNN FARRUGGIA
 22 MAIA DORSETT
 23 MATTHEW HARRIS
 24 MICHAEL DAILEY
 25 MICKEY FORNESS
 PAMELA MURPHY
 PETER BRODY
 RYAN GREENBERG
 TERESA HAMILTON

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 2 (The meeting commenced at 8:05 a.m.)
 3 **CHAIRMAN RABRICH:** Seats, please. I'm
 4 going to call the meeting of the May 7th Medical
 5 Standards Meeting Committee to order. I'm Dr. Jeff
 6 Rabrich. I'm the Chair of the committee. There --
 7 attendance will be going around. Please sign in to
 8 the meeting, and then we will start with some old
 9 business.
 10 So, an update on the collaborative
 11 protocol July rollout. I know that the protocols are
 12 posted on the Bureau website. I don't believe
 13 there's any issues with the July 1 implementation,
 14 but I don't know if there's Gina or someone else from
 15 the Bureau can speak to. Are we on track or?
 16 **DR. WIERZBOWSKI:** I'm sorry, Dr.
 17 Rabrich.
 18 **CHAIRMAN RABRICH:** That's okay.
 19 **DR. WIERZBOWSKI:** It's -- it's -- good
 20 morning to you.
 21 **CHAIRMAN RABRICH:** Good morning.
 22 **DR. WIERZBOWSKI:** What did -- what did
 23 you need to know?
 24 **CHAIRMAN RABRICH:** The July 1 protocol
 25 rollout. I know the protocols are posted on the

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 2 website.
 3 **DR. WIERZBOWSKI:** Yes, sir.
 4 **CHAIRMAN RABRICH:** Are there any --
 5 from the Bureau's point of view, any issues or any --
 6 anything we need to address prior to that roll
 7 letter? Is it good to go?
 8 **DR. WIERZBOWSKI:** It's good to go.
 9 **CHAIRMAN RABRICH:** All right. Thank
 10 you. I appreciate that.
 11 **DR. WIERZBOWSKI:** You're welcome.
 12 **CHAIRMAN RABRICH:** Along with that
 13 rollout, however, several of our members in the, you
 14 know, ten thousand readings of the protocol have
 15 noted a couple issues that have come up that are
 16 more, I would say typos or clarifying issues and not
 17 actual protocol changes.
 18 So, one thing that was brought up is
 19 that we changed Haldol to Olanzapine. However, we
 20 failed to do that in the hospice protocol. And I
 21 believe the intent of this committee was to replace
 22 it in all places. Is that -- so I don't know if
 23 anyone has any discussion on that item or we can just
 24 make that editorial change. Dr. Dailey?
 25 **DR. DAILEY:** No, my suggestion would

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 2 be that we just make that as an editorial.
 3 **CHAIRMAN RABRICH:** Okay.
 4 **DR. DAILEY:** Or editing change.
 5 **DR. WINSLOW:** I agree.
 6 **DR. DAILEY:** Not editorial.
 7 **DR. WINSLOW:** That was the intent of
 8 the collaborative group.
 9 **CHAIRMAN RABRICH:** That was the
 10 intent? Thank you.
 11 **DR. WINSLOW:** Yes.
 12 **CHAIRMAN RABRICH:** And I believe there
 13 was also an issue with the open fracture protocol, an
 14 and or an or, or something. I don't know if someone
 15 wanted to speak to what that -- it reads as --
 16 **DR. DAILEY:** Yeah.
 17 **CHAIRMAN RABRICH:** -- giving both or
 18 something?
 19 **DR. WINSLOW:** Yeah, the current
 20 protocol has Cefazolin, sorry, Cefazolin, and then on
 21 the second line has Moxifloxacin. My -- my request
 22 was to put the or there because it would make sense
 23 to give one or the other --
 24 **CHAIRMAN RABRICH:** Yeah.
 25 **DR. WINSLOW:** -- but not both.

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 2 **CHAIRMAN RABRICH:** I think that's a
 3 good clarifying edit because the way it reads
 4 currently, it would imply that you would give both
 5 because it doesn't say or. So, we'll --
 6 **DR. WINSLOW:** Correct.
 7 **CHAIRMAN RABRICH:** -- insert the word
 8 or there. Are there any other of those type of typo
 9 or technical issues that anyone else has noticed
 10 beyond those two that we found for the protocol? Dr.
 11 Dailey?
 12 **DR. DAILEY:** No, I think the only
 13 thing that I would comment on is that, you know, our
 14 discussion around open fractures, treatment of those
 15 with intravenous antibiotics and oral antibiotics
 16 yielded some very interesting offline conversations
 17 on the protocol committee.
 18 I would like to make data from that a
 19 standing item here for us to discuss as well as for -
 20 - for it to be a standing discussion item across from
 21 here to stack.
 22 You know, one of the things with
 23 intravenous antibiotics being administered by E.M.S.
 24 is it does satisfy the requirement for the American
 25 College of Surgeons of early treatment for open

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 2 fractures with intravenous antibiotics. The oral
 3 antibiotics do not.
 4 So, there isn't a reason to switch to
 5 an additional formulation with P.O. antibiotic for
 6 all B.L.S. squads. The Moxifloxacin system was taken
 7 directly from the special forces --
 8 **CHAIRMAN RABRICH:** Uh-huh. The
 9 treatment guidelines, yup.
 10 **DR. DAILEY:** -- treatments, the D.O. -
 11 - D.O.D. guidelines. So, I think we should continue
 12 to watch those things and see how they develop across
 13 the state and make sure this really is something
 14 that's going to be helpful for patients.
 15 **CHAIRMAN RABRICH:** Yeah. I would
 16 agree with that, and I think it's worth discussion
 17 with the collaborative group as well for the next
 18 iteration of the protocols, if -- if there should be
 19 any -- any additional changes made to that protocol.
 20 But it was a good offline discussion
 21 including the cost of those medications and -- and
 22 availability that people were discussing. So, I
 23 don't believe there's any other corrections to the
 24 protocol, just those two. So, unless anyone else has
 25 anything on the collaborative protocol for July,

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 2 we'll move on to the next item.
 3 **DR. WINSLOW:** I -- I did have one
 4 thing.
 5 **CHAIRMAN RABRICH:** Yes?
 6 **DR. WINSLOW:** It's not really a -- a -
 7 - towards meeting issue, so I thought it needed
 8 discussion.
 9 **CHAIRMAN RABRICH:** Okay.
 10 **DR. WINSLOW:** So, our regional REMAC
 11 asked a question about tranexamic acid, as we
 12 recently just approved it for use in our -- our
 13 region. The new collaborative protocol states the
 14 indications will be for traumatic and obstetric
 15 hemorrhage, and that's the change log.
 16 I had a few questions about it.
 17 First, is this applied to pediatrics as it did -- as
 18 well as adults? And second is the increase in dose
 19 to two grams appropriate based on current E.M.S.
 20 experience with any region? And could someone attest
 21 to that from a ground unit as opposed to the air
 22 units?
 23 And the third part is, should the
 24 language not state traumatic and obstetric
 25 hemorrhage, what about traumatic and non-traumatic

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 2 shock patients? Because significant blood loss can
 3 be seen in non-pregnant patients, like dysfunctional
 4 uterine bleeding. G.I. bleeding, post-surgical
 5 bleeding, and E.N.T. bleeding.
 6 **CHAIRMAN RABRICH:** Yeah.
 7 **DR. WINSLOW:** So those -- those are
 8 the three questions.
 9 **CHAIRMAN RABRICH:** Thanks. So, it's
 10 worth the discussion. I'll open it up. I -- I
 11 believe one, that the data for some of those things
 12 is not really there for G.I. bleeding and others, in
 13 the same way it is for others. I know the two grams
 14 came directly from -- again, from the -- the military
 15 T triple C guidelines, but I don't know if anyone
 16 wants to speak to those, and Dr. Dailey or others
 17 want to talk about. Oh, and the third question was
 18 whether it applies to pediatrics, so.
 19 **DR. DAILEY:** You're hitting the high
 20 points really well. There is no data for it to be
 21 useful in G.I. hemorrhage. And I think the -- the
 22 important takeaway here is that any drug that we have
 23 on our formulary can be ordered by an online
 24 physician specific to the care of any patient.
 25 So, if a paramedic thinks about that

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 2 idea and then initiates a call, discusses it with
 3 medical control, it -- that drug can then be given if
 4 it's appropriate in that setting. There will be a
 5 number of cases that -- that will present that way
 6 where a paramedic thinking about other opportunities
 7 will create a different care plan for that patient.
 8 So yes, we write it for obstetric and
 9 for traumatic shock, which is really hemorrhagic
 10 shock across the board. Could it be for other
 11 patient's spontaneous splenic hemorrhage, right, some
 12 -- some other bizarre case, absolutely. That's what
 13 medical control is for.
 14 **CHAIRMAN RABRICH:** Yeah. And then on
 15 the pediatric question, I -- I'd also be curious as
 16 to Dr. Cooper's opinion on the T.X.A. in the
 17 pediatric hemorrhaging patient.
 18 **DR. COOPER:** Thank you. The --
 19 there's no specific prohibition to the use of T.X.A.
 20 in pediatric patients. The -- the -- the truth,
 21 however, is that multiple transfusion protocols are
 22 so rarely activated in pediatric patients that, you
 23 know, the experience, you know, with it is extremely
 24 limited.
 25 However, you know, for older kids, you

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 2 know, adolescents who are involved in high-speed
 3 crashes or, you know, gunshot wounds, et cetera, you
 4 know, certainly, you know, that would be an
 5 appropriate -- an appropriate consideration.
 6 But for the -- for the younger kids,
 7 again, no prohibition, but you know, but the
 8 experience is extremely limited. Thank you.
 9 **CHAIRMAN RABRICH:** Thanks.
 10 **DR. WINSLOW:** May -- maybe just some
 11 education --
 12 **CHAIRMAN RABRICH:** Yeah.
 13 **DR. WINSLOW:** -- would be useful. For
 14 example, I -- I didn't want the -- the provider to
 15 stay in play to put an I.V. in a two-year-old if
 16 they're, you know, less than five minutes from the
 17 trauma center, for example, just to give T.X.A. And
 18 I think that would do that in education is what
 19 instances it would be indicated and in what age
 20 groups.
 21 **DR. DORSETT:** I mean, I think, that's
 22 true whether or not the patient's two years old or
 23 thirty-five years old, and I think that's part of the
 24 education around the priorities of care. These are
 25 protocols that say what is in your scope of practice.

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 2 But defining the priorities of care
 3 and how you order those things, I don't think it's
 4 going to -- it's not sort of like the role of this
 5 particular thing. And it's definitely not different
 6 in pediatrics, I don't think, than in adult.
 7 **CHAIRMAN RABRICH:** Yeah. And is that,
 8 you know, an education issue versus putting something
 9 in the protocol. To speak to it is, I think, it's
 10 education. Yeah, Dr. Cooper?
 11 **DR. COOPER:** You know, I -- I -- I
 12 honestly, I think this falls in the -- in the same,
 13 you know -- you know, general area as most of the
 14 things that we do in the prehospital arena in a rapid
 15 transport urban system, right?
 16 In a rapid transport urban system,
 17 generally speaking, you know, with very few
 18 exceptions, getting the patient to definitive care,
 19 you know, taking precedence over a lot of stay in
 20 play issues and you know, -- but again, if you're
 21 talking about, you know, long distance transports or
 22 transport delay or what have you, that's a different
 23 story. And there's again no specific
 24 contraindication to its use. I -- I certainly agree
 25 that most of these issues can be handled very

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 2 effectively in the educational environment. Thank
 3 you.
 4 **CHAIRMAN RABRICH:** Thanks.
 5 **DR. DAILEY:** If I can suggest that --
 6 we actually have Matt Harris from Northwell is here
 7 as well.
 8 **CHAIRMAN RABRICH:** Yeah.
 9 **DR. DAILEY:** And I'd love to have him
 10 come up and speak to this.
 11 **CHAIRMAN RABRICH:** Yeah, Dr. Harris is
 12 welcome to offer his opinion on this as well if he's.
 13 Not to -- not to pull him out of the audience, but.
 14 **DR. DAILEY:** Of course, he could have
 15 found a seat that was a little bit more accessible to
 16 a microphone.
 17 **CHAIRMAN RABRICH:** Yeah.
 18 **DR. HARRIS:** I didn't think I was
 19 allowed at the big kids table today, but
 20 pediatrician. Thank you. You know, I -- to Dr.
 21 Cooper's, I think eloquent point, the -- the -- the
 22 literature in the civilian world for T.X.A. is very
 23 limited.
 24 There is an ongoing pro -- prospective
 25 study through PECARN called the TikTok study, which

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 2 is expected to have, obviously exclusively civilian
 3 trauma, most of which is going to be penetrating.
 4 And the results are probably going to come in the
 5 next year.
 6 The -- the literature coming out of
 7 the military theater is quite clear that it does
 8 reduce the number of blood products that a
 9 dramatically injured child, excuse me, requires over
 10 the next twenty-four hours. And I think in most
 11 large trauma centers, to Dr. Cooper's point, we are
 12 routinely giving T.X.A. So, I -- I think that a
 13 proactive E.M.S. system, as we have in New York,
 14 should promote the use of TXA in children. There's
 15 essentially no downside.
 16 The -- the risk for thrombotic events
 17 in children is essentially zero in a limited, you
 18 know, military experience that would fully support
 19 it. Thanks.
 20 **CHAIRMAN RABRICH:** Thanks. So, I
 21 think that, you know, may -- maybe in -- in the next,
 22 in the twenty-six edition of the protocols, it's
 23 worth clarifying the pediatric shock protocol that
 24 specifically, you know, that T.X.A. may be helpful in
 25 that population.

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 2 Certainly, it can be done as Dr.
 3 Dailey was saying with other things before, what they
 4 call a medical control and a, you know, medical
 5 control physician order so. Any other comments or
 6 questions on the collaborative protocol rollout?
 7 **MR. SWEENEY:** Leah Sweeney, paramedic
 8 --
 9 **CHAIRMAN RABRICH:** Yes.
 10 **MR. SWEENEY:** -- in the Hudson Mohawk
 11 region. Would there be conservation for including a
 12 standardized dose for pediatrics in the medical
 13 control conversations for shock? Because I've seen
 14 varied literature from point -- from ten milligrams
 15 per kilogram up to, I think, thirty to forty
 16 milliliter -- milligrams per kilogram.
 17 **CHAIRMAN RABRICH:** Yes. I think that
 18 -- that's a good point and a good question for the
 19 collaborative group for some research and discussion
 20 for the next protocol iteration, but those are all
 21 great comments that we'll take back to the
 22 collaborative group as we start working on the next
 23 version, so thank you.
 24 All right, the next item on our
 25 agenda, we had some great offline discussion as well

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 2 on the B.L.S. supraglottic airway policy statement.
 3 I want to thank Gina for all her work on this and I
 4 think we had a very productive offline session with
 5 feedback and commentary. So, do you want to speak to
 6 kind of where we're at currently with the policy?
 7 **DR. WIERZBOWSKI:** Yes. We did have a
 8 very productive discussion both during the med
 9 standards subcommittee meeting and also in -- within
 10 the discussion that we posted in Boardable, so that
 11 this group could review and comment on the policy,
 12 those of that were not able to attend.
 13 So, we did have a bit of editing that
 14 happened that I think was approved by the group.
 15 But there were a couple of comments that I just want
 16 to make sure that the group addresses. With regard
 17 to the term of credentialing of providers, there was
 18 some back and forth about whether you would say
 19 credentialed or not, but credential is certainly
 20 within the purview, as you stated, Dr. Rabrich, of a
 21 med -- agency medical director make credential a
 22 provider in a certain skill or whatever is approved
 23 by protocol.
 24 So, I probably just leave it at that
 25 word there. But then Dr. Winslow did have a comment

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 2 with regard to B.L.S. providers and credentialing and
 3 the old question of regional credentialing, et
 4 cetera. And I would not -- I would want Ryan to
 5 speak to --
 6 **CHAIRMAN RABRICH:** Yes.
 7 **DR. WIERZBOWSKI:** -- that.
 8 **CHAIRMAN RABRICH:** So --
 9 **DR. WIERZBOWSKI:** Good morning,
 10 Director.
 11 **CHAIRMAN RABRICH:** Okay. Good
 12 morning, not to put you on -- yeah. So, this, this
 13 has come up, right? And there's been some questions
 14 --
 15 **DR. WIERZBOWSKI:** Yeah.
 16 **CHAIRMAN RABRICH:** -- that have
 17 circled around the concept of regional credentialing,
 18 but I think that everyone agrees that an agency
 19 medical director can approve a provider in their
 20 agency to do or not do a procedure, whether it's
 21 R.S.I. --
 22 **DR. WIERZBOWSKI:** Right.
 23 **CHAIRMAN RABRICH:** -- S.G.A.,
 24 whatever. So, certainly, there's no argument that at
 25 the agency level --

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 2 **DR. WIERZBOWSKI:** Uh-huh.
 3 **CHAIRMAN RABRICH:** -- that, that
 4 person could be approved for that. I don't -- I
 5 don't know that that is something that would be done
 6 at the regional level other than the agency providing
 7 to the region, right, potentially a list of --
 8 **DR. WIERZBOWSKI:** They could provide a
 9 list --
 10 **CHAIRMAN RABRICH:** -- grants. Right.
 11 **DR. WIERZBOWSKI:** Yes, of the --
 12 **CHAIRMAN RABRICH:** Who can do this and
 13 so forth, I don't know.
 14 **DR. WIERZBOWSKI:** -- yes, individual.
 15 **CHAIRMAN RABRICH:** Yeah.
 16 **DR. WIERZBOWSKI:** The whole -- the
 17 whole point was to state that agencies take it upon
 18 themselves with their medical directors to educate,
 19 train and --
 20 **CHAIRMAN RABRICH:** Correct.
 21 **DR. WIERZBOWSKI:** -- and -- and --
 22 **CHAIRMAN RABRICH:** The onus is on the
 23 agency to make.
 24 **DR. WIERZBOWSKI:** Exactly.
 25 **CHAIRMAN RABRICH:** Yeah.

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 2 **DR. WIERZBOWSKI:** Exactly. The last
 3 comment or -- or question that came up was with
 4 regard to, and we talked about this yesterday, Dr.
 5 Rabrich, with the question of should be -- should the
 6 waveform capnography, is it -- is it enough for it to
 7 just be viewable and present in real time, or does it
 8 need to be recorded?
 9 And that is a question for this group
 10 to consider. And we would like direction on that --
 11 **CHAIRMAN RABRICH:** Right.
 12 **DR. WIERZBOWSKI:** -- as well.
 13 **CHAIRMAN RABRICH:** So that's something
 14 -- we'll pause there. So that's something I think we
 15 should discuss, because I don't believe it reads as a
 16 requirement, is that you must record the waveform and
 17 then put it, because the thought came up, do we
 18 include that in the -- in the P.C.R., the waveform.
 19 But there are devices that aren't full
 20 monitors, like the EMMA, for example, or others that
 21 can show you a waveform, but don't necessarily record
 22 it and can't be downloaded into a record. So, I
 23 don't -- I believe the initial intent was that
 24 continuous waveform monitoring was done, but I don't
 25 believe we put in there a requirement to record and -

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 2 - and store that.
 3 But I open that point up to discussion
 4 because I think it's worth having that discussion
 5 with this group. Bearing in mind the cost that might
 6 be incurred by B.L.S. agencies that may want to do
 7 this to be able to acquire that equipment capable of
 8 that. But I don't --
 9 **DR. GREENBERG:** And that -- I think
 10 it, as you do have that discussion and the doctor
 11 around the room, feel free to talk about what your
 12 agency currently does because I think there's a
 13 number of agencies that are obviously have waveform
 14 colonography that doesn't record.
 15 **CHAIRMAN RABRICH:** Yeah.
 16 **DR. GREENBERG:** And what is the impact
 17 of any of these programs?
 18 **CHAIRMAN RABRICH:** Yes, both medically
 19 and financially.
 20 **DR. GREENBERG:** Right.
 21 **CHAIRMAN RABRICH:** Yes.
 22 **DR. GREENBERG:** Related to that.
 23 **CHAIRMAN RABRICH:** Yeah, great. I
 24 don't know who wants to start? Anyone -- anyone have
 25 commentary on this or thoughts?

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 2 **DR. WINSLOW:** I -- I had a -- a second
 3 aligned issue.
 4 **CHAIRMAN RABRICH:** Yeah.
 5 **DR. WINSLOW:** In our regional REMAC,
 6 we were wondering if the protocol should be a little
 7 bit more-clear in what is a supraglottic airway as
 8 opposed to not being an esophageal airway.
 9 **CHAIRMAN RABRICH:** Okay. So that's a
 10 good point --
 11 **DR. WINSLOW:** Uh-huh.
 12 **CHAIRMAN RABRICH:** -- which we'll get
 13 to. But I want to -- I want to address this
 14 capnography point first.
 15 **DR. WINSLOW:** Okay.
 16 **CHAIRMAN RABRICH:** So -- Don?
 17 **MR. HUDSON:** So, non-physician, first
 18 of all, that I haven't met.
 19 **CHAIRMAN RABRICH:** Well, we'll take
 20 your opinion. It's okay.
 21 **MR. HUDSON:** Well, that's very kind of
 22 you.
 23 **CHAIRMAN RABRICH:** Yeah.
 24 **MR. HUDSON:** Thank you for always
 25 listening. I'm married, so I -- I get it. That

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 2 being said, I mean, I -- I - I would suggest to the
 3 group, or -- or beg the question, I think we could
 4 all agree that waveform capnography is an absolute
 5 gold standard of care, a must have, if you will.
 6 That being said, there's technological
 7 and financial constraints, obviously, in everything
 8 that we consider. So, within Nassau, specific to our
 9 early foray into regional R.S.I. credentialing at our
 10 last airway R.S.I. committee meeting, after about a
 11 year, we revised our regional plan to require four
 12 R.S.I. continuous monitoring, recording, end
 13 uploading to the P.C.R. simply because, not just
 14 specific to R.S.I., but in virtually every airway
 15 case, good or bad or indifferent that we've reviewed,
 16 everyone wants to see the videotape, but we -- we
 17 know we had it, but we didn't save it, you know.
 18 And it's like the game day film, how
 19 are you getting better if you can't watch the film?
 20 So, I don't know that we are there yet as a mandate,
 21 but I think the time's coming. So, I -- I appreciate
 22 you having the discussion.
 23 **CHAIRMAN RABRICH:** Thanks. Oh, yeah,
 24 Dr. Winslow?
 25 **DR. WINSLOW:** Suffolk County requires

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 2 it of all use of airways, regardless of level of
 3 provider.
 4 **CHAIRMAN RABRICH:** Use of recording it
 5 or and --
 6 **DR. WINSLOW:** Yes.
 7 **CHAIRMAN RABRICH:** -- storing it?
 8 Okay.
 9 **DR. WINSLOW:** Yeah, we did it during
 10 the B.L.S. i-gel. We actually have all the data. I
 11 think we had like eighty-six uses and they did it.
 12 **CHAIRMAN RABRICH:** Okay.
 13 **MR. HUDSON:** We just, you know, as a -
 14 - a parallel, we also had the similar discussion
 15 about video laryngoscopy. Is that --
 16 **CHAIRMAN RABRICH:** Right. And do you
 17 record your intubation?
 18 **MR. HUDSON:** Now that, more commonly
 19 on the market, it's not just a single device anymore,
 20 the ability to record and store the video, it is
 21 becoming a norm or hopefully a norm. Why would we
 22 not want that saved perpetuity for anyone to review?
 23 The question is always, did the tube
 24 go in? And if it came out, when did they realize it?
 25 What did they do about it?

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 2 **CHAIRMAN RABRICH:** Right.
 3 **MR. HUDSON:** So, if we have that live
 4 recording of it, I think it allies a lot of people's
 5 fears and strengthens us as providers.
 6 **CHAIRMAN RABRICH:** Okay. Dr. Murphy,
 7 did you have a comment? I saw your --
 8 **DR. MURPHY:** Yeah, just -- just from a
 9 perspective of the original. We did not put that --
 10 we did not include that in the original pilot. We
 11 did not say that people had to record it. I think
 12 it's a good idea if it's not too onerous for people
 13 from a financial perspective versus -- but it's not
 14 in the original process.
 15 **CHAIRMAN RABRICH:** Thank you. Dr.
 16 Dorsett, I think, did you -- and then Dr. Berkowitz
 17 or whoever?
 18 **DR. DORSETT:** I was going to say that
 19 we require it with monitor upload for all R.S.I.s.
 20 When I -- I'm actually interested in is because I'm -
 21 - because of the way our system is set up, most of
 22 these are using actually like existing monitors
 23 because it's a tiered system, and they're using a
 24 monitor for those capabilities.
 25 I'm interested from somebody who works

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 2 in a B.L.S. system of what is the availability?
 3 **CHAIRMAN RABRICH:** Uh-huh.
 4 **DR. DORSETT:** I know from like a
 5 pulling data, sometimes it looks like they didn't
 6 actually record the value. And so those things are
 7 able to be reviewed, and we can see there is
 8 definitely a waveform -- and so that we're able to
 9 confirm that the airway was in, if in case there's a
 10 documentation issue of what actually, like a value
 11 made it into the chart.
 12 But how prohibitive would it be to say
 13 that you actually need a recording? I think at
 14 minimum you need an image of the waveform. Right?
 15 Because people do screenshots of the image of the
 16 waveform at those time points because that's
 17 valuable.
 18 But I'm not familiar enough with the
 19 devices that B.L.S. only agencies are using to
 20 actually understand what is the level of the barrier
 21 that we might be imposing.
 22 **CHAIRMAN RABRICH:** Good point. Dr.
 23 Berkowitz?
 24 **DR. BERKOWITZ:** Yeah. So, we've been
 25 for about a year and a half, been just back to what

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 2 Don said about recording a V.L. So, we've been doing
 3 that for about a year and a half. And the per -- and
 4 the per provider -- by provider, their improvement in
 5 -- in first pass success rate has been astronomical.
 6 Now that means every airway actually
 7 gets reviewed with a provider with a physician. And
 8 eventually we're going to move it over to our quality
 9 team and create like a structured process around it.
 10 So, you know, I don't know if that's -- it -- it's
 11 safe to make that a minimum standard. And I think
 12 that's -- that's the question is what's the minimum
 13 standard?
 14 **CHAIRMAN RABRICH:** Right.
 15 **DR. BERKOWITZ:** And then what's the --
 16 the aspirational standard? We decided to invest a
 17 lot of effort and time in going to, I think,
 18 something that might be onerous to some, but I think
 19 that the question is always what's the minimum
 20 standard? And then -- and allowing agencies that
 21 want to go further to go further.
 22 **CHAIRMAN RABRICH:** Yeah. So, I -- I
 23 think that's an excellent point. And I think that
 24 what I'm hearing so far is, yes, ideally, right?
 25 Gold standard. This would be great and we want it,

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 2 but is that the minimum standard or not?
 3 And I'd be curious to hear Dr. Dailey,
 4 but then also any B.L.S. agencies who are, who
 5 participate in the pilot and what they're using. And
 6 to Dr. Dorsett's point, like, you know, is it cost
 7 per -- what -- what equipment are you using? Is it
 8 capable of recording? So, Dr. Dailey?
 9 **DR. DAILEY:** So, as we think back
 10 historically, I remember a long time ago, Lee Burns
 11 and I having a conversation with -- with some folks
 12 at vital signs in Buffalo where we talked about the
 13 difference between the regulatory component of E.M.S.
 14 and the medical direction component of E.M.S., and
 15 how the physicians were leading a charge, and the
 16 regulators needed to remain in place to assure that
 17 these things were done safely.
 18 I think we're at a place right now
 19 particularly with this intervention where we really
 20 have a great opportunity to throw a baby out with the
 21 bath -- with the bath water. We're looking at an
 22 intervention that will be least likely to take place
 23 in a well-populated, well-funded urban area, and most
 24 likely to take place in an underfunded rural
 25 community that has less representation --

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 2 **CHAIRMAN RABRICH:** Uh-huh.
 3 **DR. DAILEY:** -- in this room,
 4 certainly squads that are not represented at this
 5 table. My concern would be that, if we impose things
 6 that will very clearly be financial restrictions on
 7 an intervention that will be extremely rare and
 8 rarely performed, we would not have this potential
 9 benefit for the personnel and the patients of that
 10 squad available.
 11 I think this is something that needs
 12 to remain a regional decision. It's the regional --
 13 reason we have regions. It's the reason that regions
 14 are given the mandate to maintain their systems of
 15 care.
 16 So, I would suggest that waveform
 17 capnography remain as it is in the language, that the
 18 documentation standard be a regional decision, and
 19 that there be no requirement to upload it from this
 20 body.
 21 **CHAIRMAN RABRICH:** Okay.
 22 **DR. GREENBERG:** So, I'll take it one
 23 step further. I -- I like the less regulation, so
 24 good. Believe it or not, yes, that's coming from me.
 25 One of the things that I would make a recommendation

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 2 from this committee is, you know, regions -- not
 3 regions, individual agencies often choose the
 4 resources that are around them to collect knowledge.
 5 Sometimes they go to their regions,
 6 sometimes they go to their peers, sometimes it
 7 happens during a site visit with, you know, one of
 8 the district chiefs.
 9 One of the things that I think if you
 10 have kind of, I think what was said, the minimum
 11 standard and the best standard, if there's something
 12 that can come out from this group of recommendation
 13 on one paper or best practices or anything that can
 14 be shared or easily accessible, I think that is the
 15 type of thing that -- that also helps us as
 16 regulators to turn and say, here we see you're using
 17 this. Oh, you're not recording? Have you seen this
 18 document? Just something for consideration. There's
 19 no requirement from our side, but at least then, and
 20 by the way, there's three subject matter experts on
 21 the bottom of it that you can reach out to and call
 22 or whatever.
 23 More things like that, and I think
 24 there's some other topics that will come up today
 25 that will be similar to it, we would love as -- as

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 2 the State E.M.S. Office to help facilitate and get
 3 that information out and things like that. And I
 4 couldn't think of a better place for that to come
 5 from -- from, you know, the SEMAC or something, and
 6 then through the regions and further out to the
 7 agencies.
 8 **CHAIRMAN RABRICH:** Yeah. So, I guess
 9 the question is, and for -- for feedback for Gina as
 10 well as do we -- do we change the wording in the
 11 policy statement to say, you know, that -- that
 12 effect that, you know, the desired, right, that --
 13 not required, but desirable is the ability to best
 14 practice is the ability to record and, you know,
 15 attach to the record, but certainly not required.
 16 **DR. WIERZBOWSKI:** Right. I think we
 17 could -- we could certainly add a -- a sentence in
 18 the policy that says exactly that, best practice
 19 would be to record, but it is not required et cetera,
 20 et cetera. I -- I think that would be a good
 21 compromise because then it's made clear to agencies
 22 that this is what you could aim for, but it's not
 23 restrictive either financially or otherwise to, in
 24 order to participate.
 25 **CHAIRMAN RABRICH:** Yeah. I -- I think

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 2 that's a -- I think that's a good place to settle
 3 where we're not discouraging more rural agencies that
 4 may not have the -- the means right now to purchase
 5 that but can still participate.
 6 And then the next question that came
 7 up is kind of, I guess, the -- the definition of a
 8 supraglottic airway, right? Like, will we consider
 9 any type of esophageal airway to be an S.G.A. or not,
 10 I think was the question.
 11 And I don't know, I don't know that we
 12 clarify that in the policy at all other than saying
 13 S.G.A., and then the question is, is it up to the
 14 agency medical director to decide if that's an
 15 acceptable S.G.A. or not? Or do we feel -- I mean, I
 16 think we all feel that, you know, esophageal airways
 17 are not appropriate at this point, but Dr. Dailey,
 18 you're nodding vehemently.
 19 **DR. DAILEY:** I -- I would go right
 20 back to regionalization. Right. Agencies should not
 21 be making independent decisions about which
 22 supraglottic airways are being used there. This is
 23 something that needs to be discussed by the receiving
 24 hospitals, the physicians who are going to be the
 25 medical directors within that - within that region

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 2 need to know what devices are approved at the
 3 regional level.
 4 This needs to be discussion there,
 5 rather than something that's comes out of left field
 6 from some miscellaneous rep that shows up --
 7 **CHAIRMAN RABRICH:** Right.
 8 **DR. DAILEY:** -- at an agency --
 9 **CHAIRMAN RABRICH:** And I don't
 10 disagree --
 11 **DR. DAILEY:** -- selling them.
 12 **CHAIRMAN RABRICH:** -- with that.
 13 Although we've had this discussion before about
 14 whether regions, right, approved devices or agency
 15 medical directors approve devices, and can the region
 16 decide what S.G.A.s are appropriate in their region
 17 or not?
 18 **DR. DAILEY:** I think a region can
 19 always decide what is appropriate. The more
 20 interesting question is whether a region can then
 21 say, this one is not appropriate, but a group of
 22 physicians at a REMAC can certainly turn to another
 23 physician and say, this is the reason we're all using
 24 this device; why would you want to go use something
 25 else? That's the -- that's the way it is. So, it's

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 2 -
 3 **CHAIRMAN RABRICH:** So, could we phrase
 4 it as regionally approved devices, regionally
 5 approved S.G.A.s and --
 6 **DR. WINSLOW:** Yes.
 7 **CHAIRMAN RABRICH:** -- I'm looking to
 8 you if you have a --
 9 **DR. GREENBERG:** So, I actually think
 10 you can approve devices. I got -- I got to go back
 11 and -- and look exactly because I will also say it's
 12 been this body's stance that we don't specifically go
 13 to specific --
 14 **CHAIRMAN RABRICH:** Not specific
 15 products.
 16 **DR. GREENBERG:** No, no, no, no.
 17 **CHAIRMAN RABRICH:** Right.
 18 **DR. GREENBERG:** I -- I understand.
 19 I'm just kind of -- but they tend to trickle down, so
 20 I don't want to.
 21 **CHAIRMAN RABRICH:** Yeah.
 22 **DR. GREENBERG:** I think the way that
 23 it was just recommended though, hey, here's fifteen
 24 doctors around the table. This is why we picked this
 25 one. This is -- why would you -- why would you go

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 2 against something like this, I think is probably a
 3 stronger situation --
 4 **CHAIRMAN RABRICH:** Uh-huh.
 5 **DR. GREENBERG:** -- in -- in compliance
 6 of something of that nature.
 7 **DR. HUDSON:** So, Dr. Hudson -- ladies
 8 first.
 9 **DR. DORSETT:** Oh -- I was going to
 10 say, I think that the policy addresses this. There's
 11 language, right, that when an agency applies to do
 12 this, they have to submit to the region what they're
 13 going to use. If they're going to change the device,
 14 they have to apply for re-approval for the region.
 15 And their medical director must attest
 16 to approval of their application. So, I think that
 17 there's safeguards in the policy that if --
 18 **CHAIRMAN RABRICH:** That exist --
 19 **DR. DORSETT:** But when --
 20 **CHAIRMAN RABRICH:** -- currently.
 21 **DR. DORSETT:** That exist currently.
 22 **CHAIRMAN RABRICH:** Yeah.
 23 **DR. DORSETT:** We don't know what
 24 devices are going to be in there.
 25 **CHAIRMAN RABRICH:** Yeah.

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 2 **DR. DORSETT:** I think we've given an
 3 adequate textbook definition of what an S.G.A. is.
 4 And there's -- I think there's regional approval. I
 5 think this makes --
 6 **CHAIRMAN RABRICH:** Okay.
 7 **DR. DORSETT:** -- enough flexibility,
 8 but enough safeguards within the way --
 9 **CHAIRMAN RABRICH:** Yeah.
 10 **DR. DORSETT:** -- it's written.
 11 **CHAIRMAN RABRICH:** Yeah. Don?
 12 **DR. HUDSON:** I was going to agree.
 13 And I think then on the regional level, is the proper
 14 place to actually have that. Only because we've had
 15 the same question come up about, well, what about
 16 esophageal? And I'm like, well, explain to me what
 17 you --
 18 **CHAIRMAN RABRICH:** Yeah.
 19 **DR. HUDSON:** -- think that means --
 20 **CHAIRMAN RABRICH:** No, more E.O.A.s or
 21 E.G.T.A.s.
 22 **DR. HUDSON:** -- because I don't think
 23 we're talking the same thing.
 24 **CHAIRMAN RABRICH:** Sorry.
 25 **DR. HUDSON:** Right. If E.O. --

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 2 E.O.A.s and E.G.T.A.s, probably that ship has --
 3 **CHAIRMAN RABRICH:** Yeah.
 4 **DR. HUDSON:** -- sailed that.
 5 **CHAIRMAN RABRICH:** Yeah.
 6 **DR. HUDSON:** Right? But maybe not?
 7 **CHAIRMAN RABRICH:** Yeah.
 8 **DR. HUDSON:** That's a regional
 9 decision.
 10 **CHAIRMAN RABRICH:** Yeah.
 11 **DR. HUDSON:** Only because when people
 12 mention other devices, even iGel, it's like --
 13 **CHAIRMAN RABRICH:** Uh-huh
 14 **DR. HUDSON:** -- well, those aren't
 15 esophageal. And I'm like, well -- but they're not
 16 tracheal, so hence they're supraglottic.
 17 **CHAIRMAN RABRICH:** Yeah.
 18 **DR. HUDSON:** And there's a
 19 disagreement on that.
 20 **CHAIRMAN RABRICH:** Yeah.
 21 **DR. HUDSON:** So, I think that regional
 22 discussion is -- is with it.
 23 **CHAIRMAN RABRICH:** No, I think it's --
 24 and I -- and I think you make an excellent point that
 25 it's kind of worded that way already, that the

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 2 agency's going to bring to the region their plan of
 3 what they want to implement. And so, I think there
 4 already exists safeguards for that.
 5 **DR. GREENBERG:** Right. And I, you
 6 know, I think the other important part is, and you
 7 can't be product specific, we don't know what's
 8 coming out a year from now.
 9 **CHAIRMAN RABRICH:** Right.
 10 **DR. GREENBERG:** You know, so though it
 11 gives that flexibility for those things, which I
 12 think is extremely important.
 13 **CHAIRMAN RABRICH:** Yeah. So, I think
 14 we're good with how that's -- that's worded.
 15 **DR. WIERZBOWSKI:** Yeah, that's what
 16 I'm gathering.
 17 **CHAIRMAN RABRICH:** Yeah. Any other --
 18 any other items on the policy that you need
 19 additional feedback on or?
 20 **DR. WIERZBOWSKI:** No, I think we're
 21 good. Those were the only things that were contained
 22 within the discussion. I will, just for awareness to
 23 the rest of the group who maybe did not know this was
 24 posted in this group's Boardable, there's a whole
 25 discussion.

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 2 Please, you know, over the next couple
 3 of weeks, go in and -- and look at it. Please put
 4 your comments in because we will be finalizing this
 5 in the next few weeks and don't want anybody to feel
 6 like they did not have an opportunity to comment or
 7 bring up a point or two about -- about the policy.
 8 **CHAIRMAN RABRICH:** Yes.
 9 **DR. WIERZBOWSKI:** But I thank you -- I
 10 thank everybody for their comments. It's a great --
 11 greatly helpful to us to have that guidance.
 12 **CHAIRMAN RABRICH:** Yeah. I think
 13 we've -- this policy has evolved into a -- into a
 14 very good place, and I think there's been great
 15 feedback from everyone on that. And again, please go
 16 in there in the next couple weeks if you can, because
 17 we do want to finalize this and get this out. Yeah,
 18 Don?
 19 **DR. DOYNOW:** So -- so one thing, Gina,
 20 I would probably run by D.L.A., that statement, best
 21 practice, because if something goes wrong, that
 22 certainly could be used against the agency.
 23 **DR. WIERZBOWSKI:** Yes. This policy
 24 will be reviewed by D.L.A. --
 25 **CHAIRMAN RABRICH:** Yeah.

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 2 **DR. WIERZBOWSKI:** -- as a general --
 3 **CHAIRMAN RABRICH:** Yeah.
 4 **DR. WIERZBOWSKI:** -- rule. So, I --
 5 **CHAIRMAN RABRICH:** Maybe it could say
 6 encouraged but not required or something to that.
 7 **DR. WIERZBOWSKI:** Right. Yes.
 8 **CHAIRMAN RABRICH:** You know, effect,
 9 but.
 10 **DR. WIERZBOWSKI:** Yup.
 11 **CHAIRMAN RABRICH:** Yeah.
 12 **DR. GREENBERG:** We'll work on --
 13 **CHAIRMAN RABRICH:** Yeah.
 14 **DR. GREENBERG:** -- wording
 15 particularly for that --
 16 **CHAIRMAN RABRICH:** Yeah.
 17 **DR. GREENBERG:** -- one. And then
 18 obviously, if acceptable by this group, we'll also
 19 run it past both of you gentlemen.
 20 **CHAIRMAN RABRICH:** Yeah. We
 21 appreciate that. Okay. So that's the S.G.A. policy,
 22 which applies currently to adult patients, but I
 23 understand there was some discussion about whether
 24 this is appropriate for Peds or not. And I -- I want
 25 to turn the conversation over to Dr. Cooper who had a

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 2 conversation at E.M.S.C. regarding this.
 3 **DR. COOPER:** Thank you. Yeah, we did
 4 have a fairly robust conversation at the E.M.S.C.
 5 meeting earlier this week. And the -- the committee
 6 voted to bring forth the following motion for
 7 consideration by medical standards and ultimately
 8 SEMAC, and I -- I'll read the motion in its entirety.
 9 That the E.M.S. for Children Advisory
 10 Committee has strongly supports the indication for
 11 basic life support supraglottic airway in the New
 12 York State Collaborative E.M.S. protocols and the --
 13 and -- and and the New York State B.L.S. statewide
 14 protocols to include pediatric patients and remove
 15 the restriction for adult patients only quote
 16 unquote.
 17 I believe it's -- can we get it
 18 posted?
 19 **CHAIRMAN RABRICH:** Yeah. It would
 20 mirror just -- yes, so the answer, just so everyone
 21 can hear that question. It would mirror the adult
 22 language, like equipped if, equipped and trained is
 23 not -- would not mandate its use. It would be --
 24 **DR. COOPER:** That's --
 25 **CHAIRMAN RABRICH:** -- the same as the

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 2 --
 3 **DR. COOPER:** That's right.
 4 **CHAIRMAN RABRICH:** -- the adult.
 5 **DR. COOPER:** Functionally, the only
 6 change is to remove the --
 7 **UNIDENTIFIED MALE:** Thank you, Peter.
 8 **DR. COOPER:** -- in a -- for adult
 9 patients only phrase within -- within that protocol.
 10 **CHAIRMAN RABRICH:** Right. That would
 11 -- the motion is to remove the -- rephrase adult
 12 patients only --
 13 **DR. COOPER:** Right.
 14 **CHAIRMAN RABRICH:** -- from the S.G.A.
 15 protocol.
 16 **DR. COOPER:** But you know, of course,
 17 because the rest of the protocol speaks about
 18 appropriate training --
 19 **CHAIRMAN RABRICH:** Uh-huh.
 20 **DR. COOPER:** -- so forth, you know.
 21 **CHAIRMAN RABRICH:** Yup, all those
 22 things would --
 23 **DR. COOPER:** Yes.
 24 **CHAIRMAN RABRICH:** -- would apply.
 25 **DR. COOPER:** That's correct. Since

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 2 this motion was brought forward by Maia Dorsett
 3 sitting to my left, I'm going to give her the
 4 opportunity to passionately --
 5 **CHAIRMAN RABRICH:** Excellent.
 6 **DR. COOPER:** -- speak about this.
 7 **CHAIRMAN RABRICH:** Appreciate that,
 8 Dr. Dorsett.
 9 **DR. COOPER:** I will also call in a few
 10 minutes on Matt Harris --
 11 **CHAIRMAN RABRICH:** Yes.
 12 **DR. COOPER:** -- who wrote a position
 13 paper for N.A.E.M.S.P. on -- that -- that included
 14 reference to this very topic.
 15 **CHAIRMAN RABRICH:** Thank you. So, Dr.
 16 Dorsett and then Dr. Harris.
 17 **DS. DORSETT:** Yeah. And honestly, I
 18 could just defer to Matt Harris, but the background
 19 on this was looking at, to me, it seemed like there
 20 was a, a care inequity. So, there was a reason that
 21 we did expansion of S.G.A.s at the B.L.S. level.
 22 And I think in particularly the use of
 23 capnography for verification, that you're
 24 appropriately ventilating a patient. When we think
 25 about what are the etiologies of cardiac arrest and

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 2 pediatric patients, I think the ability to
 3 appropriately ventilate your patient is
 4 extraordinarily important.
 5 There are ongoing randomized control
 6 trials, but those results are not going to be
 7 available for years. And there's a body of evidence,
 8 including the physician statement, that Dr. Harris
 9 can speak to, that from experts in pre-hospital care
 10 and pediatrics that endorse the use of an S.G.A. as
 11 either a primary or secondary airway in cardiac
 12 arrest for pediatric patients.
 13 So, it's really about removing the
 14 care and equity around pediatrics. Obviously, I
 15 think the important thing is, there's no mandate that
 16 you have to carry any of these things. It's just
 17 that for those agencies who want to be able to
 18 provide this service that they are not restricted
 19 from providing this for pediatric patients.
 20 And obviously as regionally as they're
 21 talking about what their education plans are going to
 22 be as they present those to the regional councils to
 23 be approved to do this, that would include if they
 24 are going to be carrying pediatric equipment, which
 25 is already specified as part of the policy.

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 2 There's nothing about the policy
 3 that's a -- only the regions can approve the
 4 education plans and make sure that they're adequately
 5 training them on pediatric patients as well.
 6 **CHAIRMAN RABRICH:** Thank you. Dr.
 7 Harris?
 8 **DR. HARRIS:** Agreed.
 9 **CHAIRMAN RABRICH:** Anything you want
 10 to add?
 11 **DR. HARRIS:** Yeah. Yeah. Yeah, I
 12 mean, listen, I think -- I think one of the really
 13 important and powerful points that Maia brought up is
 14 this is essentially a care equity problem, right?
 15 And first pass success rates in young children
 16 cardiac arrest for endotracheal intubation is below
 17 fifty percent if you're flipping a coin.
 18 And I think that's being generous. I
 19 think we're probably all well aware of that. You
 20 know, it'll be interesting to see what Henry Wang
 21 study shows, but we all know what it's going to show
 22 that the supraglottic airway device is you, you know,
 23 eighty-five to ninety percent first pass in children
 24 as it is in adults, that outcomes are better.
 25 And, you know, I think why I -- I

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 2 called this a little bit progressive earlier today
 3 because, you know, we are -- we -- we cannot wait for
 4 the thirty thousand perspective study in children,
 5 that will never come. And we know that the in-
 6 hospital data is very, very clear about this.
 7 And the mechanics of inserting an
 8 S.G.A. in a child are essentially identical to an
 9 adult. We have talked about some of the training
 10 around securing the device, right, which is something
 11 that I think is important to remind, and a good
 12 reminder for our adult patients as well. But I do
 13 think that this is a incredible step forward.
 14 And -- and the last point I'll make is
 15 that what was presented in the last two years at
 16 N.A.M.S.P. was the experience -- this past year was
 17 the experience of a -- a relatively large county in
 18 North of Seattle, where they have, as part of their
 19 cardiac arrest management for children, which I think
 20 is another topic that, you know, this body should
 21 address in the upcoming, you know, sessions is they
 22 have moved to supraglottic airway devices to
 23 minimize, you know, cardiac compression interruption
 24 and their outcomes are dramatically better.
 25 Now, my know, like that cohort was

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 2 small, like thirty or forty kids, but, you know,
 3 they're -- they like doubled or tripled their ROSC
 4 rates and survival within tech neurologic outcomes.
 5 So, I think this is a really important move forward.
 6 And for those agencies here that have
 7 predominantly B.L.S. providers is the first people on
 8 scene. This is taking a -- a really an important
 9 step forward, not just in the fact that we have low
 10 success rates for endotracheal intubation for A.L.S.
 11 providers, but, you know, begging a young child is
 12 not as easy as -- as we say it is, right?
 13 The -- the positioning of the hands in
 14 an already very nervous provider and doing that in
 15 the back of a moving ambulance, which, you know, is a
 16 separate topic on its own, is really difficult. So,
 17 I think this is a huge step forward. They fully
 18 support, and I thank Dr. Cooper and Dr. Dorsett for
 19 putting this forward.
 20 **CHAIRMAN RABRICH:** Thank you, Dr.
 21 Harris. Any other discussion? Yes, Dr. Cooper?
 22 **DR. COOPER:** Yeah, I -- I think it's
 23 appropriate to, you know, elaborate just a little bit
 24 on the discussion that took --
 25 **CHAIRMAN RABRICH:** Sure.

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 2 **DR. COOPER:** -- place at E.M.S.C. You
 3 know, while, you know, the first pass success rate
 4 for, you know, for supraglottic airways in kids, you
 5 know, is clearly much better than it is for
 6 endotracheal tube placement.
 7 It's -- it's not a hundred percent,
 8 right? And -- and I think the -- the committee's --
 9 the discussion at the committee centered around the
 10 fact that the training has to be really pretty good
 11 and really in place.
 12 You know, the question is, you know,
 13 how does -- how do we ensure -- assure that, right?
 14 And again, the -- the age-old question that was
 15 mentioned a few minutes ago, you know, where are
 16 these airways most likely to be used? If they're
 17 likely to be used then the places where the
 18 opportunities for, you know, for robust training are
 19 probably least available.
 20 So, while I think we all agree that it
 21 is a care equity issue and while we would also love
 22 to see, you know, the -- the, you know, the data from
 23 the prospective randomized trial that's currently
 24 underway before moving forward, the fact of the
 25 matter is that our alternatives are not good.

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 2 The ability to maintain bag valve mask
 3 ventilation, you know, in a -- in the back of a
 4 moving ambulance, particularly for a -- a rural team
 5 over a long distance is, you know, problematic at
 6 best, and dismal at worst.
 7 While -- and tracheal intubation, of
 8 course, even if there are, you know, advanced life
 9 support services available to do the intubation in
 10 rural areas, you know, the first pass race as -- as
 11 Dr. Harris has pointed out, is not ideal.
 12 So, the point is, we've got a device
 13 that -- that the -- the preliminary data that is in
 14 the literature does suggest substantial improvement
 15 over the -- over the currently available
 16 alternatives. And for that reason, you know, the
 17 E.M.S.C. committee was, you know, nearly unanimous in
 18 -- in supporting this direction.
 19 And the one dissenting vote was
 20 focused more -- more on the issue of -- of the
 21 logistics of implementation, rather than the desire
 22 to see this become, you know, the standard of care.
 23 And to quote a very famous E.M.S.
 24 physician who happens to be sitting to my left at the
 25 moment a, you know, that we're -- we're looking what

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 2 really is a -- not a gold standard, but in fact a
 3 real -- really a minimum standard to assure that, you
 4 know, the device is properly placed and that the --
 5 and that the child or adult is being appropriately
 6 ventilated. So, I bring this -- this issue to you to
 7 for a vote.
 8 **CHAIRMAN RABRICH:** Uh-huh.
 9 **DR. COOPER:** It -- it would require,
 10 of course, a protocol change which would, you know,
 11 be a -- a roll call vote at SEMAC. But it doesn't --
 12 I don't believe it has to be a --
 13 **CHAIRMAN RABRICH:** Correct.
 14 **DR. COOPER:** -- a roll call vote at --
 15 in this body.
 16 **CHAIRMAN RABRICH:** Yeah.
 17 **DR. COOPER:** But I -- I defer to the
 18 chair to make that critical --
 19 **CHAIRMAN RABRICH:** Yes.
 20 **DR. COOPER:** -- decision.
 21 **CHAIRMAN RABRICH:** I appreciate that
 22 input.
 23 **MR. COOPER:** Thank you.
 24 **CHAIRMAN RABRICH:** And then I guess
 25 the -- the next question beyond that, if it's a

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 2 protocol change is, is it a protocol change? Because
 3 we've already posted the July, right? Is it
 4 something that's for the next cycle, or is it of such
 5 an emergent nature that it needs to be -- tried to be
 6 included in it?
 7 So, I, you know, thoughts on that
 8 because I think we've -- we're -- we've missed the
 9 deadline for July 1.
 10 **DR. COOPER:** We understand that.
 11 **CHAIRMAN RABRICH:** Okay.
 12 **DR. COOPER:** And I -- and we all wish
 13 that this had come up sooner, but it didn't.
 14 **CHAIRMAN RABRICH:** Yeah.
 15 **DR. COOPER:** And there we are.
 16 **CHAIRMAN RABRICH:** Okay.
 17 **DR. COOPER:** But I -- I, you know, to
 18 quote Dr. Marty Eichelberger, a very famous pediatric
 19 trauma surgeon --
 20 **CHAIRMAN RABRICH:** Yeah.
 21 **DR. COOPER:** -- and E.M.S. --
 22 **CHAIRMAN RABRICH:** Yeah.
 23 **DR. COOPER:** -- physician, you know,
 24 in -- in all of our patients, it's all about the
 25 A.B.C.s. But if -- but if that's too difficult to

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 2 remember, remember A.A.A. for airway, airway, airway.
 3 **CHAIRMAN RABRICH:** Yes.
 4 **DR. COOPER:** Okay.
 5 **CHAIRMAN RABRICH:** Excellent. I would
 6 -- I would --
 7 **DR. COOPER:** So --
 8 **CHAIRMAN RABRICH:** Yes.
 9 **DR. COOPER:** I think -- I think we can
 10 justify this on an emergency basis.
 11 **CHAIRMAN RABRICH:** Okay.
 12 **DR. COOPER:** Thank you. And I -- I
 13 would ask, I guess, the bureau's input. Is this --
 14 is that even needed? Like, have we missed the
 15 notification deadlines or anything like that? If we
 16 -- if we made this deletion, adults only, are we
 17 still within a reason? Or do we need to -- is there
 18 a regulatory requirement to provide further notice
 19 beyond July 1? Would it delay anything?
 20 **DR. GREENBERG:** There's not a
 21 regulatory requirement. However, if acceptable, I
 22 would highly suggest that we stick to the same
 23 timeline and try and do the updates once a year and
 24 keep it to next year, but that is --
 25 **CHAIRMAN RABRICH:** Yeah, I think the -

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 2 - the -- well, I don't want to speak for the little
 3 committee, but I think --
 4 **DR. GREENBERG:** Yeah.
 5 **CHAIRMAN RABRICH:** -- their will is
 6 that they would like it done now, but.
 7 **DR. COOPER:** I -- I might remind --
 8 **DR. GREENBERG:** If there is a will --
 9 **DR. COOPER:** -- everyone around this.
 10 **DR. GREENBERG:** -- there is a way.
 11 **DR. COOPER:** Okay.
 12 **DR. GREENBERG:** There is a way.
 13 **DR. COOPER:** I might remind everyone
 14 around this table that --
 15 **DR. GREENBERG:** Yeah.
 16 **DR. COOPER:** -- Commissioner McDonald
 17 is the pediatrician. Thank you.
 18 **CHAIRMAN RABRICH:** That is an
 19 excellent point.
 20 **DR. GREENBERG:** If there is a will,
 21 there is a way. That -- that --
 22 **CHAIRMAN RABRICH:** okay.
 23 **DR. GREENBERG:** -- on our side, and
 24 it's not a major change in things like that, it -- it
 25 would be more up to this group of --

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 2 **CHAIRMAN RABRICH:** Okay. Yeah.
 3 **DR. GREENBERG:** -- how you said it and
 4 things of that nature.
 5 **CHAIRMAN RABRICH:** Yeah. Dr. Dailey,
 6 did you have a comment?
 7 **DR. DAILEY:** I guess this one to me
 8 comes down to keeping it simple. The change that we
 9 need to make is really editorial. The entire program
 10 is predicated on the idea of if -- if equipped and
 11 trained --
 12 **CHAIRMAN RABRICH:** Uh-huh.
 13 **MR. DAILEY:** -- because it's if
 14 equipped and trained, you can't just randomly go and
 15 implement it, you have to train. And I frankly would
 16 argue that some of the best training that I've seen
 17 out there is some of the small basic life support
 18 squads with a rural community that they are caring
 19 for.
 20 You know, this is not an area where
 21 there isn't training. This is an area where there
 22 isn't resources. So, I would say, let's get some,
 23 you know, robust training materials produced and
 24 available for the introduction of this for infants
 25 and small children. And let's remove the restriction

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 2 people are differentiating and making sure that
 3 they're training if there is a difference in the
 4 training --
 5 **CHAIRMAN RABRICH:** Right.
 6 **DR. GREENBERG:** -- in theory.
 7 **CHAIRMAN RABRICH:** Okay.
 8 **DR. GREENBERG:** Hey, this is only --
 9 our agency is only for adults.
 10 **CHAIRMAN RABRICH:** Right.
 11 **DR. GREENBERG:** Our agency is for
 12 adults --
 13 **CHAIRMAN RABRICH:** Yeah.
 14 **DR. GREENBERG:** -- and pediatrics.
 15 We've trained for both or whatever it is that --
 16 **CHAIRMAN RABRICH:** Yeah.
 17 **DR. GREENBERG:** -- that we should,
 18 that --
 19 **CHAIRMAN RABRICH:** And I think the
 20 process for that already exists at the regional level
 21 with the whole, you know, presenting your -- your
 22 plan and -- and getting approval. So, I guess what
 23 we need, oh, Dr. Murphy.
 24 **DR. GREENBERG:** It -- it -- I will.
 25 And, sorry, Dr. Murphy.

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 2 now, with the reminder that it's if equipped and
 3 trained.
 4 **CHAIRMAN RABRICH:** Yup. Ryan?
 5 **DR. GREENBERG:** I think if it's -- if
 6 -- if it's if equipped and trained, then that would
 7 eliminate the issue of what I'm concerned of.
 8 **CHAIRMAN RABRICH:** Of timing? Right.
 9 **DR. GREENBERG:** Of timing and release.
 10 **CHAIRMAN RABRICH:** Yeah.
 11 **DR. GREENBERG:** So that -- that's --
 12 that's the --
 13 **CHAIRMAN RABRICH:** Okay.
 14 **DR. GREENBERG:** -- part that --
 15 **CHAIRMAN RABRICH:** Yeah.
 16 **DR. GREENBERG:** -- we keep hearing the
 17 backlash of --
 18 **CHAIRMAN RABRICH:** It's not a
 19 mandatory protocol, let's say.
 20 **DR. GREENBERG:** Right. Exactly.
 21 **CHAIRMAN RABRICH:** Yeah.
 22 **DR. GREENBERG:** So, if it's a equipped
 23 and train, quaint, I don't think that's a thing.
 24 I'll get trained on that. I think it'd probably be -
 25 - we'd have to figure out some way to make sure that

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 2 **CHAIRMAN RABRICH:** Yeah.
 3 **DR. MURPHY:** Just a quick comment. It
 4 really is just an editorial change: remove adults
 5 only.
 6 **CHAIRMAN RABRICH:** Yeah.
 7 **DR. GREENBERG:** If you do change it
 8 now, the other thing that would work is that an
 9 agency in theory can then equip and train at any
 10 point over the course --
 11 **CHAIRMAN RABRICH:** Right.
 12 **DR. GREENBERG:** -- of the next year.
 13 **CHAIRMAN RABRICH:** Yes.
 14 **DR. GREENBERG:** So, if someone was to
 15 turn and say there is an education barrier that we
 16 won't be able to meet that timeline of July 1st --
 17 **CHAIRMAN RABRICH:** They don't need to.
 18 **DR. GREENBERG:** -- they don't need to.
 19 **CHAIRMAN RABRICH:** Right. Yeah. It's
 20 not -- okay. So, I guess what we need would be a
 21 motion that the Med Standards Committee supports.
 22 I'm -- I'm not making the motion because I'm the
 23 chair, but I'm just saying we need a motion that Med
 24 Standards supports this and wants to send it to
 25 SEMAC. Dr. Cooper, do you have a --

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 2 **DR. COOPER:** Yes. On behalf of the
 3 E.M.S.C. advisory committee, we are bringing this
 4 motion to the floor of medical standards for
 5 advancement to SEMAC. And I will allow my partner
 6 and so many things --
 7 **DR. GREENBERG:** Specific on the motion
 8 --
 9 **DR. COOPER:** -- just second.
 10 **DR. GREENBERG:** -- will be, to
 11 understand.
 12 **CHAIRMAN RABRICH:** To remove, to
 13 strike the -- to include pediatric patients and
 14 remove the restrict. Yeah, it's pretty clear there.
 15 **DR. GREENBERG:** So, you're doing same
 16 -- same --
 17 **CHAIRMAN RABRICH:** So yes, I think
 18 what we're saying is Med Standards is the same
 19 motion, adding their support to this motion to send
 20 to SEMAC.
 21 **DR. DORSETT:** I second that.
 22 **CHAIRMAN RABRICH:** Okay. Discussion -
 23 - any further discussion on this motion? All right.
 24 I --
 25 **MS. SHULTZ:** Just procedurally, Doc.

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 2 So, looking at the SEMAC agenda Med Standards goes
 3 before E.M.S.C., so that's proper.
 4 **CHAIRMAN RABRICH:** I -- I'll bring it
 5 as a seconded motion --
 6 **MS. SHULTS:** Perfect.
 7 **CHAIRMAN RABRICH:** -- during Med
 8 Standard, yeah.
 9 **MS. SHULTS:** That's fine.
 10 **DR. GREENBERG:** For the record, can
 11 you just read the motion?
 12 **CHAIRMAN RABRICH:** Yes, I will read
 13 them. So, the motion proposed by Dr. Cooper,
 14 seconded by Dr. Dorsett, says, motion for E.M.S. for
 15 Children Advisory Committee to strongly support the
 16 indication for B.L.S. supraglottic airway in the New
 17 York State Collaborative E.M.S. protocols and New
 18 York State B.L.S. statewide protocols to include
 19 pediatrics, pediatric patients, and remove the
 20 restriction for adult patients.
 21 **DR. WIERZBOWSKI:** So, should that
 22 actually say --
 23 **CHAIRMAN RABRICH:** It should say --
 24 **DR. WIERZBOWSKI:** -- Instead of
 25 E.M.S.C., it should say medical standards something?

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 2 **CHAIRMAN RABRICH:** It would say
 3 medical, yeah, motion that medical standards
 4 supports.
 5 **DR. GREENBERG:** I don't even think it
 6 would be support.
 7 **CHAIRMAN RABRICH:** Okay. So yeah,
 8 same -- same motion just from medical standards as
 9 opposed to E.M.S.C.
 10 **UNIDENTIFIED MALE:** Chair's
 11 discretion.
 12 **CHAIRMAN RABRICH:** Yeah. We're --
 13 we're saying the same thing. Basically, this
 14 committee agrees with E.M.S.C.
 15 **DR. GREENBERG:** I would say I don't
 16 think it supports. I would say the -- and feel free
 17 to discuss amongst yourselves --
 18 **CHAIRMAN RABRICH:** Uh-huh.
 19 **DR. GREENBERG:** -- this is just
 20 speaking out loud. It wouldn't be supports, I think
 21 it would be to modify that --
 22 **CHAIRMAN RABRICH:** Right.
 23 **DR. GREENBERG:** -- medical standards
 24 recommends to the modification of the --
 25 **CHAIRMAN RABRICH:** Yeah.

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 2 **DR. GREENBERG:** -- protocols. Like,
 3 I'm not sure if it would just be --
 4 **CHAIRMAN RABRICH:** Recommends --
 5 **DR. GREENBERG:** -- support thing.
 6 **CHAIRMAN RABRICH:** Right. Recommends
 7 modifying the protocols to -- yeah, I guess, it's --
 8 I don't want to wordsmith this, but it's -- yeah, you
 9 could get rid of that. And then it's basically we're
 10 saying we want the protocols changed to include the
 11 pediatric patients and not adult only.
 12 **DR. COOPER:** Mr. Chairman --
 13 **CHAIRMAN RABRICH:** Or should I read it
 14 again? Yes?
 15 **DR. COOPER:** -- if you want to make it
 16 really simple, you could say the Medical Standards
 17 Committee recommends to the SEMAC that -- that the
 18 phrase, you know, for adult --
 19 **CHAIRMAN RABRICH:** Right.
 20 **DR. COOPER:** -- patients only.
 21 **CHAIRMAN RABRICH:** Adults only be
 22 stricken from the --
 23 **DR. COOPER:** Exactly. So that would
 24 be the simplest way to handle this. And Dr. Dailey
 25 has just advised us a few moments ago to keep it

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 2 simple, so.
 3 **CHAIRMAN RABRICH:** Okay.
 4 **DR. COOPER:** We're --
 5 **CHAIRMAN RABRICH:** Well, we're good
 6 with that.
 7 **DR. COOPER:** -- the fact that we
 8 advise --
 9 **CHAIRMAN RABRICH:** So, medical
 10 standards recommend SEMAC to strike adult only from
 11 the S.G.A. protocol. We still good with that? Still
 12 good with seconding it? Okay. Okay. Any further
 13 discussion?
 14 **UNIDENTIFIED MALE:** Remove the dapper?
 15 **CHAIRMAN RABRICH:** Yeah.
 16 **UNIDENTIFIED MALE:** Just leave it on
 17 as one?
 18 **CHAIRMAN RABRICH:** You can leave it
 19 all as one.
 20 **UNIDENTIFIED MALE:** Okay.
 21 **CHAIRMAN RABRICH:** All right. So, we
 22 need a vote. And I believe you're correct. I think
 23 Med Standards can take a voice vote and then SEMAC
 24 will take a roll call vote. Here also?
 25 **UNIDENTIFIED MALE:** Got to be a roll

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 2 call vote.
 3 **CHAIRMAN RABRICH:** All right. We'll
 4 do a roll call vote. Yeah. Okay. That's what I'm
 5 being advised. It's fine.
 6 **UNIDENTIFIED MALE:** Sure.
 7 **CHAIRMAN RABRICH:** You're always safe
 8 doing a roll call vote and you can't, yeah.
 9 **DR. DAILEY:** One -- one point real --
 10 **CHAIRMAN RABRICH:** Yes.
 11 **DR. DAILEY:** -- quickly here first,
 12 sorry. It says B.L.S., right? But our intention is
 13 not for this to be C.F.R.s. Our intention is this to
 14 be in E.M.T. level intervention.
 15 **CHAIRMAN RABRICH:** Right. But it
 16 doesn't change anything that's written regarding --
 17 **DR. DAILEY:** Right.
 18 **CHAIRMAN RABRICH:** -- adult home
 19 currently.
 20 **DR. DAILEY:** Right.
 21 **CHAIRMAN RABRICH:** Right? It just
 22 strikes adult. So, it's the same.
 23 **DR. DAILEY:** Right.
 24 **CHAIRMAN RABRICH:** Nothing else
 25 changes.

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 2 **DR. GREENBERG:** I think the second
 3 part clarifies that, so.
 4 **CHAIRMAN RABRICH:** Yeah. Yeah, I
 5 think that's fine. Yeah. Okay, we're going back to
 6 the show of hands vote and we will have the roll call
 7 at SEMAC. All in favor of this motion, please
 8 indicate by raising your hand. Any opposed?
 9 Abstentions? All right, the motion is unanimously
 10 passed.
 11 **DR. GREENBERG:** And just for the
 12 record and for clarification, so this would obviously
 13 go up to commissioner and then come back, but this
 14 would be posted immediately, correct, in a
 15 modification to the current --
 16 **CHAIRMAN RABRICH:** Correct.
 17 **DR. GREENBERG:** -- regulations?
 18 **CHAIRMAN RABRICH:** Yeah.
 19 **MR. GREENBERG:** Sorry, protocols.
 20 **CHAIRMAN RABRICH:** Yeah. Because --
 21 because it is equipped -- if equipped and trained, an
 22 agency can choose the time at which they wish to --
 23 **DR. GREENBERG:** We are just making
 24 sure --
 25 **CHAIRMAN RABRICH:** Yeah.

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 2 **DR. GREENBERG:** -- everybody's on the
 3 --
 4 **CHAIRMAN RABRICH:** Yeah.
 5 **DR. GREENBERG:** -- same page.
 6 **CHAIRMAN RABRICH:** I believe that's
 7 the intent of our report. Great. All right.
 8 **DR. GREENBERG:** Thank you.
 9 **CHAIRMAN RABRICH:** Next?
 10 **DR. COOPER:** Mr. Chair?
 11 **CHAIRMAN RABRICH:** Yes?
 12 **DR. COOPER:** Mr. Chairman, the
 13 E.M.S.C. committee appreciates the indulgence of the
 14 medical standards.
 15 **CHAIRMAN RABRICH:** Yes. Well, this
 16 committee --
 17 **DR. COOPER:** And --
 18 **CHAIRMAN RABRICH:** -- appreciates the
 19 work of E.M.S.C. and --
 20 **DR. COOPER:** And --
 21 **CHAIRMAN RABRICH:** -- their
 22 recommendation.
 23 **DR. COOPER:** And the -- the agreement
 24 of the bureau to support this to the highest level.
 25 **CHAIRMAN RABRICH:** Yes.

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 2 **DR. COOPER:** Thank you, Ryan.
 3 **CHAIRMAN RABRICH:** I think it -- it --
 4 it helps advance the care of our pediatric patients
 5 in the state. So, we appreciate the -- the input.
 6 All right. Next item is an update on
 7 blood implementation. I don't know if is there an
 8 update from the bureau side on this? Ryan, anything
 9 on blood? Any update on below where blood's at or on
 10 some of your staff?
 11 **DR. GREENBERG:** Yeah, we can update on
 12 the regulations --
 13 **CHAIRMAN RABRICH:** Gina?
 14 **DR. GREENBERG:** -- and kind of how
 15 they're moving along.
 16 **CHAIRMAN RABRICH:** Yeah.
 17 **DR. WIERZBOWSKI:** Yes. So, we have
 18 one last approval before it goes into the -- into the
 19 process. But hopefully, in the next week or so it'll
 20 be all set. It'll be moving through, as we've
 21 discussed before and was discussed a little bit
 22 yesterday, this package will be going forward as an
 23 emergency pack regulatory enforcement package. And -
 24 - and enact, pardon me, it's -- I've only had one cup
 25 of coffee, so.

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 2 **CHAIRMAN RABRICH:** We understand.
 3 **DR. WIERZBOWSKI:** So, they --
 4 **CHAIRMAN RABRICH:** Ryan didn't bring
 5 coffee for everyone this morning. We know.
 6 **DR. GREENBERG:** I brought donuts for
 7 everyone --
 8 **CHAIRMAN RABRICH:** Yes, Joe.
 9 **DR. GREENBERG:** -- yesterday.
 10 **DR. GREENBERG:** Five dozen donuts.
 11 **DR. WIERZBOWSKI:** He -- he did.
 12 **CHAIRMAN RABRICH:** That was yesterday.
 13 **DR. WIERZBOWSKI:** You did. So, when a
 14 package enters -- a regulatory package enters the
 15 process as an emergency, which we feel we have
 16 justification for that, it means that at the time it
 17 goes out for public comment, it's enacted as an
 18 emergency. So, it shaves a little bit of time off.
 19 So, we're hoping that we can get this
 20 through in a timely fashion because obviously, you
 21 know, we're also working on a policy statement for
 22 the interim, for current A.T.S.s, new A.T.S.s, and
 23 also to provide guidance to agencies who want to
 24 start a prehospital blood administration --
 25 **CHAIRMAN RABRICH:** Uh-huh.

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 2 **DR. WIERZBOWSKI:** -- program prior to
 3 the regulation being enacted. Because we do have
 4 statutory authority, so we want -- we've had several
 5 inquiries in terms of agents, you know, ground
 6 agencies who want to look at starting a blood program
 7 and what do they need to do.
 8 So -- so in the interim, we're going
 9 to try to get something out for that as well, so that
 10 it's not impeding the progress and innovation of
 11 agencies to try to do that so.
 12 **CHAIRMAN RABRICH:** Thank you. I
 13 appreciate that.
 14 **DR. WIERZBOWSKI:** You're welcome.
 15 **CHAIRMAN RABRICH:** And I know there
 16 were members of this committee that were had interest
 17 and I know Dr. Dailey, Dr. Isaacson kind of helping
 18 develop best practices for implementation of a blood
 19 program and so forth. I don't know if -- if either
 20 of you have any updates on or if you're waiting for
 21 the reg or -- or have thoughts on -- on that?
 22 **DR. DAILEY:** No, I think, one more
 23 time I'll just comment to -- to the way Gina has
 24 worked with -- with the department and with the --
 25 with subject matter experts in terms of building

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 2 these regs, it's been a fantastic collaborative
 3 process. And I really look forward to seeing what
 4 comes out the other side, so.
 5 **CHAIRMAN RABRICH:** Great. Anything
 6 you want to say on blood, Doug? Are you good? Okay.
 7 All right, thank you. And then our clinical data
 8 integrity tag I think has some -- some updates and
 9 particularly around airway measures, you've
 10 discovered some interesting things?
 11 **DR. DORSETT:** Yeah, really with the
 12 airway measures, what we've been using is as a case
 13 example to work through the process. So, if I give a
 14 little bit of background, there's a national quality
 15 measure quite relevant to the discussion around
 16 S.G.A.s, that all invasive airways amongst S.G.A.s
 17 are included in this, I have confirmation with
 18 waveform capnography.
 19 Using this as an example, when
 20 regionally we pulled data from the state site, we had
 21 a very incomplete picture from our region. And we've
 22 used this as a case example working with a tremendous
 23 amount of help from Peter Brody with on the state as
 24 well as our colleagues at ImageTrend to -- and Susie
 25 of course to -- who knows all things data, to dissect

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 2 the process of where the failures occur.
 3 We've actually found failure sort of
 4 in all the different components of the system. So,
 5 it's a matter of where to start, right? So, the --
 6 the way that -- if we think about my ability at a
 7 regional level to say, what is our performance on X
 8 by pulling data and then graphing it from the state
 9 site, that data first has to be exported from the
 10 vendor. It has to be imported at the state. It has
 11 to be exported and mapped in such a way that the
 12 image trend report writer will pull those things out
 13 correctly.
 14 And by looking at our data from both
 15 sides, from what we export from the vendor as well as
 16 what we can see in the state, we found export
 17 failures. Based on schematron failures we found a
 18 lot of mapping, we found somewhere there was an
 19 import failure because on the transition to three
 20 point five agencies that had multiple codes, the
 21 vendors didn't provide multiple codes. And so, the
 22 agency wasn't actually turned on, so there was no
 23 data from that agency at the state.
 24 But then there was a -- the -- some of
 25 the report writer issues, one of the low hanging

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 2 fruit is mapping. And one of the issues that we
 3 don't have, like, defined procedure lists or defined
 4 primary impressions within New York State, which
 5 creates a problem in mapping and then report writing.
 6 So, what we've decided is like, it's a
 7 complex, there's like a lot of different things to
 8 tackle. But that's one of the first things that
 9 we're going to try and tackle. And so, we've --
 10 we're going to continue working as a -- as a group,
 11 and we've assembled some people along the way to work
 12 on defined procedural list, primary impression list,
 13 really, the list of lists that we can work throughout
 14 the state to make this mapping much more accurate.
 15 But in the meantime, we've actually
 16 found ways to sort of work around some of the mapping
 17 issues and have been able to develop some reports
 18 where for now, I actually can see every single
 19 advanced airway placement in my region, which I was
 20 not able to do the last time we met, which is, I
 21 think, a tremendous improvement.
 22 And I think that's a report that's in
 23 there that can be shared with other medical directors
 24 or other regions if people are interested.
 25 **CHAIRMAN RABRICH:** Any questions for

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 2 Dr. Dorsett or the -- the data group? Great, thanks.
 3 Appreciate the work. We will move on to new business
 4 now.
 5 First item here is finger
 6 thoracostomies for LifeNet Air Medical. I don't know
 7 if this is informational, or if someone wants to
 8 speak to this or?
 9 **DR. DAILEY:** Yeah, this -- this is
 10 informational. The patient care guidelines from
 11 LifeNet of New York come to the Hudson Valley --
 12 Hudson Mohawk Regional REMAC just for review. They
 13 are going to be adding this based on a number of
 14 patients they've cared for that have gotten needle
 15 thoracotomies without great success.
 16 And the expectation that this would
 17 then allow the opportunity hopefully, for more live
 18 patients to be put in helicopters and brought to
 19 trauma centers. This will also be a notification at
 20 STAC. And certainly, the local medical directors or
 21 regional medical directors for LifeNet of New Yorkers
 22 sharing that as well.
 23 **CHAIRMAN RABRICH:** Okay. Ryan?
 24 **DR. GREENBERG:** I assume you're
 25 talking about for emergency calls? Scene calls?

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 2 **CHAIRMAN RABRICH:** Scene calls.
 3 **DR. GREENBERG:** Although I guess it
 4 could be in facility too, if they develop a tension -
 5 -
 6 **DR. DAILEY:** For a --
 7 **DR. GREENBERG:** -- layer on vent.
 8 **DR. DAILEY:** -- patient who undergoes
 9 an emergency or has an emergency.
 10 **DR. GREENBERG:** So, I'm -- and
 11 guessing my question is, so it's an emergency
 12 protocol for procedure?
 13 **DR. DAILEY:** Guideline. They -- they
 14 don't operate on protocols. They operate on
 15 guidelines.
 16 **CHAIRMAN RABRICH:** Okay.
 17 **DR. GREENBERG:** I think, we'll discuss
 18 this one further.
 19 **CHAIRMAN RABRICH:** Yeah. Maybe worth
 20 taking offline and --
 21 **DR. GREENBERG:** Sure.
 22 **CHAIRMAN RABRICH:** -- seeing, you
 23 know. All right, well, thank you for that
 24 informational item. Next, there was a couple
 25 comments in -- in the discussion about R.S.I.

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 2 training and credentialing process. I believe, you
 3 know, the current -- I think the way most regions
 4 operate is that, right, that the agency medical
 5 director basically signs off on their providers who
 6 can do R.S.I., that they've met the training and
 7 credentialing and then notify the region.
 8 But I know I -- I think, was it you
 9 Dr. Winslow? Yeah. So, if you wanted to kind of
 10 frame the -- the question?
 11 **DR. WINSLOW:** Thank you. Yeah, this
 12 is a request from the Suffolk County REMAC. I'm just
 13 going to read it. So, line one of the New York State
 14 Collaborative States regional policy slash procedure
 15 determines credentialing of paramedics authorized to
 16 utilize this protocol. And under the oxygen and
 17 airway management protocol, it states rapid sequence
 18 intubation if regionally credentialed.
 19 Suffolk County has been credentialing
 20 paramedics to perform the R.S.I. procedure since
 21 2011, and to date have credentialed over five hundred
 22 paramedics currently active one hundred and seventy-
 23 nine, who have collectively performed over one
 24 thousand procedures in the 911 system.
 25 The R.S.I. program in Suffolk County

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 2 has a very thorough quality improvement program,
 3 which involves the agency medical director, agency
 4 paramedic supervisors, and REMAC leadership. All
 5 R.S.I. cases are reviewed at the agency level and
 6 again, at the REMAC level.
 7 One hundred percent of the cases have
 8 been reviewed for over fourteen years now. The
 9 regional REMAC policy is that all R.S.I. paramedics
 10 must be credentialed by the R.S.I. subcommittee to
 11 meeting the minimum standards set by the REMAC.
 12 This is to have a minimum of three
 13 years full-time paramedic experience and ten
 14 successful non R.S.I. field intubations in their
 15 career in addition to taking a difficult airway
 16 course and then taking an original R.S.I. training
 17 course offered in Suffolk County.
 18 After meeting at the regional REMAC
 19 requirements and credentials, the paramedic is then
 20 secondarily credentialed at their agency as the
 21 agency medical director having oversight over the
 22 agency.
 23 You may recall in 2022 when I
 24 presented the Suffolk County's R.S.I. program to the
 25 SEMAC, which kind of became the foundation of the

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 2 current R.S.I. protocol. Other regions in New York
 3 State have adopted our regional policy on R.S.I. and
 4 our continuous quality improvement process, I believe
 5 is a best practice.
 6 Recently, several physicians in
 7 Suffolk County have questioned whether a regional
 8 REMAC rate credential a paramedic to perform R.S.I.
 9 or even to set the minimum standards. This is a
 10 regional policy. Currently, there is a regional
 11 policy on R.S.I. paramedic credentialing that we have
 12 had in Suffolk County over the last ten years. It is
 13 updated periodically with the involvement of the
 14 entire R.S.I. subcommittee and the REMAC.
 15 In Suffolk County, there is a regional
 16 approach to R.S.I. as there are many instances where
 17 R.S.I. is requested as a mutual aid from one agency
 18 that doesn't have a provider that can perform the
 19 skill. We also have both ground paramedics from
 20 twenty-six different E.M.S. agencies and the Air
 21 Medical Program paramedics performing the R.S.I.
 22 procedure in the same fashion and under the same
 23 quality improvement system, and this works well in
 24 our region, and also allows for a paramedic to be
 25 credentialed to provide the procedure at several

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 2 agencies, as many agency -- as many providers work in
 3 multiple agencies.
 4 At the last meeting of the Suffolk
 5 County REMAC, a motion was made by the R.S.I.
 6 subcommittee chair that all paramedics in Suffolk
 7 County are required to be credentialed by the R.S.I.
 8 subcommittee. The motion passed seventeen to zero
 9 with three abstentions. I asked for clarification
 10 from the SEMAC on whether or not the Suffolk County
 11 REMEC may credential R.S.I. paramedics in our region.
 12 **CHAIRMAN RABRICH:** Thank you. I have
 13 an opinion, but you know -- and I know other regions
 14 do different things, but does anyone want to speak to
 15 that? I guess, your question is, is it -- can -- is
 16 -- is it the regional subcommittee that can
 17 credential them, or does it reside at the agency
 18 medical director level? Is that --
 19 **DR. WINSLOW:** The question was may
 20 Suffolk County REMAC credential R.S.I. paramedics in
 21 our region. That was the way the motion was read.
 22 **CHAIRMAN RABRICH:** Okay. Anyone want
 23 to offer an opinion or discuss, or, I know Ryan's
 24 being very quiet at the moment, but. Dr. Dailey?
 25 **DR. DAILEY:** I think quite frankly,

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 2 that if all of the medical directors in that region
 3 have come together collaboratively --
 4 **CHAIRMAN RABRICH:** Uh-huh.
 5 **DR. DAILEY:** -- and develop a
 6 standard, that group can then credential.
 7 **CHAIRMAN RABRICH:** Yeah.
 8 **DR. DAILEY:** I think that, to me, is
 9 very reasonable and is the establishment of a system.
 10 It's not the REMAC unilaterally saying we are going
 11 to credential, it's the collaborative group of R.S.I.
 12 credentialing medical directors saying we will accept
 13 each other's credential. We will create one standard
 14 that that credential will be born from. And
 15 therefore, it actually is each individual agency
 16 working as a team.
 17 **CHAIRMAN RABRICH:** Yeah. Other
 18 thoughts? Oh, Dr. Berkowitz, and then we'll -- we'll
 19 go to -- yeah.
 20 **DR. BERKOWITZ:** I'm happy now.
 21 **CHAIRMAN RABRICH:** Yup.
 22 **DR. BERKOWITZ:** Yeah, so I think it --
 23 it -- it sounds like what you're saying is the
 24 program agency may credential and the agencies
 25 themselves.

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 2 **DR. GREENBERG:** The REMAC.
 3 **DR. BERKOWITZ:** REMAC, sorry.
 4 **CHAIRMAN RABRICH:** REMAC. REMAC.
 5 **DR. BERKOWITZ:** Okay.
 6 **CHAIRMAN RABRICH:** Yeah.
 7 **DR. BERKOWITZ:** The program agency
 8 definitely doesn't --
 9 **CHAIRMAN RABRICH:** Right.
 10 **DR. BERKOWITZ:** -- credential. The
 11 REMAC may credential --
 12 **UNIDENTIFIED MALE:** Maybe facilitates.
 13 **CHAIRMAN RABRICH:** Yeah.
 14 **DR. BERKOWITZ:** Maybe facilitates the
 15 credentialing fund. The -- the -- and the agency
 16 itself may credential so doesn't -- doesn't preclude
 17 the agency.
 18 **CHAIRMAN RABRICH:** Right.
 19 **DR. BERKOWITZ:** So, the question is --
 20 **CHAIRMAN RABRICH:** And they may be
 21 aligned, those two.
 22 **DR. BERKOWITZ:** And they may be --
 23 **CHAIRMAN RABRICH:** Yeah.
 24 **DR. BERKOWITZ:** And hopefully --
 25 **CHAIRMAN RABRICH:** Yes.

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 2 **DR. BERKOWITZ:** -- as Mike said, they
 3 should be --
 4 **CHAIRMAN RABRICH:** They are aligned.
 5 Right
 6 **DR. BERKOWITZ:** They should be -- they
 7 should be -- they should be aligned. It should be
 8 the same standard.
 9 **CHAIRMAN RABRICH:** Yeah.
 10 **DR. BERKOWITZ:** But it's -- it's about
 11 the standard and not about who's doing.
 12 **CHAIRMAN RABRICH:** Right. And I think
 13 a region can certainly create a standard for their
 14 region of how care should be administered. Right.
 15 Maia then Don.
 16 **DR. DORSETT:** I just want to add a
 17 clarifying question. If the region has not
 18 credentialed somebody to do this, and you have a
 19 regional policy around credentialing that everybody
 20 has agreed to at the REMAC, and you get a new medical
 21 director who thinks, you know, Jane Schmo paramedic
 22 is like phenomenal R.S.I. and wants the credential
 23 independent of the process, agreed upon a region,
 24 what is the power of the region to prevent that
 25 provider from being credentialed at that level?

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 2 Because I think this is a significant
 3 patient safety issue where the standards, I think we
 4 learned, like, I mean, we had a very similar process.
 5 We thought that our process was great. We started
 6 looking at our airway measures and our performance on
 7 peri-intubation, hypoxia and hypotension. And we
 8 realized that we were not as great as we thought we
 9 were with even the degree of attention and the amount
 10 of work that we do -- did to improve that. And where
 11 we have significantly improved that over the last
 12 five months as part of participation in the airway
 13 collaborative designing that process at an individual
 14 agency level, I think is frankly dangerous.
 15 **CHAIRMAN RABRICH:** Thank you.
 16 **DR. WINSLOW:** If I may?
 17 **CHAIRMAN RABRICH:** I think yes, I
 18 think Don wanted --
 19 **DR. HUDSON:** No.
 20 **CHAIRMAN RABRICH:** No, go ahead.
 21 **DR. WINSLOW:** Thank you. That was
 22 exactly our point is we have collective data now of a
 23 thousand intubations. If you look at one agency, one
 24 agency may do one a year or two a year. It doesn't
 25 allow you to look at it.

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 2 So, it really can't be just an agency
 3 looking at this for patient safety and that was our
 4 concern. We set the minimum standard as a regional
 5 REMAC policy and allow for agencies to abide by the
 6 policy. It -- we -- we were challenged by some
 7 agency medical directors who wanted to go below this
 8 minimum and we -- we disagreed.
 9 **CHAIRMAN RABRICH:** I -- I think it's
 10 pretty clear that regions can set a minimum standard.
 11 **UNIDENTIFIED MALE:** That's going to be
 12 --
 13 **CHAIRMAN RABRICH:** That's -- yeah.
 14 **DR. GREENBERG:** So, I -- I think
 15 there's a significant, there's -- there's several
 16 things that are going on in the conversation. Can a
 17 region say standard? I will tell you, I believe,
 18 that they can say standard, I think, and a lot of
 19 what we're hearing more in that collaboration of, you
 20 know, fifteen medical directors coming together,
 21 setting a standard is there, can an agency credential
 22 their providers? Yes, an agency could credential
 23 their providers. An agency may be asked by the
 24 region to credential their providers based on a
 25 standard set by a region. I think that would be

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 2 appropriate.
 3 Or an agency may ask the region to
 4 perform the credentialing on their behalf, which I
 5 know we've seen, I know in -- in certain regions like
 6 the southern tier that -- that -- that happens, there
 7 is credentialing that happens by the region for the
 8 agencies because maybe that agency only does or only
 9 has four paramedics, and they feel more comfortable
 10 with it.
 11 But we have agencies that have, I
 12 don't know, Doug, you have a thousand paramedics?
 13 Probably fifteen hundred? Higher?
 14 **DR. ISAACS:** Fourteen hundred.
 15 **DR. GREENBERG:** Fourteen -- fourteen
 16 hundred. Oh, down up, no. Training a hundred and
 17 fifty each year. So, I -- I think there's -- there's
 18 a variable there of setting a standard and then the -
 19 - the word of credentialing, we won't get too deep
 20 into that one.
 21 But the question becomes who can do
 22 credentialing? And so, I think that becomes more of
 23 the question that's out there now of if the standard
 24 is set by a region, then who can do the
 25 credentialing? And are there options? And I'd

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 2 probably say, yes, there are options. Some may
 3 choose to use them. Some may choose not to.
 4 **CHAIRMAN RABRICH:** Yeah. And I think
 5 the question comes down to, rights, that a group of
 6 physicians have gotten together and decided that this
 7 is -- this is the minimum standard. This is how we
 8 want this performed in our region.
 9 And then, you know, having an agency -
 10 - does the agency have an ability to say, well, I
 11 don't, you know, I know you're all full of it. I'm
 12 going to do my own thing and make my own standard. I
 13 think that's where we've run into a problem, right?
 14 Because I think we all agree from a
 15 medical point of view that if a group of physicians
 16 have gotten together and discussed this and decided
 17 this is the best practice and how we want this
 18 performed in our region, then the agency should have
 19 to at least meet that. I'm not saying they can't
 20 credential on their own, but they should meet that
 21 standard. I think Mark wants to say something.
 22 **DR. COOPER:** Yeah. At the risk of
 23 opening a can of worms, which has already been
 24 opened, by the way.
 25 **CHAIRMAN RABRICH:** Yes. It's too late

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 2 for that, yeah.
 3 **DR. COOPER:** You know, there is a
 4 distinction between credentialing and privileging.
 5 **CHAIRMAN RABRICH:** Uh-huh.
 6 **DR. COOPER:** And every hospital gets
 7 into this issue that a -- that an individual can be,
 8 you know, generally credentialed on the basis of
 9 education, training, experience, et cetera, et
 10 cetera, et cetera. But what specific skills they are
 11 -- they are authorized to perform within -- within
 12 that, you know, or under the umbrella of the general
 13 credentialing, you know, is something that's
 14 important.
 15 And -- and -- and -- and it -- it --
 16 it -- you know, one could argue that you know, given
 17 the relatively limited number of skills that -- that
 18 are available to our prehospital colleagues that, you
 19 know, that credentialing and privileging are
 20 essentially the same.
 21 But, you know, when you get down to an
 22 issue, for example, in a -- in an area where there
 23 are relatively few, you know, advanced life support
 24 providers, as an example. You know, and there's an
 25 issue with a particular privilege or performing a

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 2 particular privilege, you know -- you know, it's --
 3 it at the present time.
 4 We kind of have an all or none
 5 situation that, you know, you're de credentialed or
 6 you or -- or not, where -- whereas maybe, you know,
 7 you -- you -- what you really want to do is say,
 8 listen, we need a restriction on this particular
 9 privilege until such time as there some kind of
 10 retraining, what have you, what have you, you know.
 11 So, I think that whatever we do with
 12 this, I think that distinction needs to be squarely
 13 addressed. And I don't know that we've actually
 14 really gotten into the -- the -- the subtle
 15 differences between credentialing and privileging,
 16 you know, in this -- in this, you know, body at the -
 17 - in the past.
 18 But it's something, I think as we
 19 become ever more sophisticated, you know, with the --
 20 with the, you know, the -- the broadening scope of
 21 practice with which, you know, we're all familiar, I
 22 think that's an issue that really does need to be
 23 addressed at some -- in some way. Thank you.
 24 **CHAIRMAN RABRICH:** And I think you're
 25 right. We've -- we've kind of circled around this

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 2 issue for a couple years now with credentialing and
 3 what is credential, but you're right, right. Like a
 4 -- if you want to look at this at like the physician
 5 level, there's a D.O.P., right?
 6 There's a delineation of privileges
 7 and a hospital can set, you know, these are
 8 requirements for you to be privileged for this
 9 particular procedure or technique, right? So, yes,
 10 that's a good point.
 11 And I think that we could look at
 12 R.S.I. as this is a privilege, right? That you --
 13 you can practice as a paramedic, but this privilege
 14 has to meet the standard set by the region. And
 15 then, you know, I -- we're not going to solve it
 16 today, but, you know, maybe there needs to be a
 17 discussion about, you know, Ryan, if we -- if there
 18 is some regulatory change we need to advocate for,
 19 because I think we all believe that there should be a
 20 standard, right? That's set by a group across the
 21 region.
 22 But if there's something limiting us
 23 from doing that, and we need to go in a different
 24 direction, whether it's regulatory or -- or
 25 legislative or something, then I think that's

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 2 something we need to know and -- and move forward
 3 with.
 4 **DR. GREENBERG:** And I -- I got to --
 5 I'll say, I think this is, you know, the right time
 6 and there's a number of things that keep coming up,
 7 but also related to more advanced skills, more things
 8 that are moving forward, the -- the timing of the
 9 different things -- look at that, the alarm's gone
 10 off for the time.
 11 **CHAIRMAN RABRICH:** Yeah.
 12 **DR. GREENBERG:** That it's the right
 13 time and place for it. So, if you'd like, we can
 14 also at the bureau side, we can look at that between
 15 now and next meeting and then --
 16 **CHAIRMAN RABRICH:** Yeah.
 17 **DR. GREENBERG:** -- maybe get back to
 18 you.
 19 **CHAIRMAN RABRICH:** I think that would
 20 be good. And if we need to set up a small working
 21 group or something to report back, I think we can do
 22 that as well so.
 23 **DR. GREENBERG:** That'd be great.
 24 Thanks.
 25 **CHAIRMAN RABRICH:** Dr. Berkowitz?

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 2 **DR. GREENBERG:** Dr. Berkowitz?
 3 **CHAIRMAN RABRICH:** Yeah
 4 **DR. BERKOWITZ:** Just -- I just think
 5 that the -- every time we talk about this, I always
 6 think the national scope of practice model is the --
 7 the -- a foundational document to help guide us. And
 8 I would recommend that, you know, any -- anyone, you
 9 know, wanting to explore this -- the, you know, look
 10 at that because that is, I think that's -- that sets
 11 out a lot of clarity. I think it's helpful.
 12 **CHAIRMAN RABRICH:** I think it is. And
 13 I think it'd be helpful to have a member of training
 14 at ED on that group as well. Mr. Hudson, you were
 15 going to say?
 16 **DR. BERKOWITZ:** It's amazing how
 17 training is --
 18 **DR. HUDSON:** Yeah. I mean,
 19 admittedly, right, we've all been dancing around this
 20 for way too long so.
 21 **CHAIRMAN RABRICH:** Uh-huh.
 22 **DR. HUDSON:** Nassau specifically is
 23 waiting on a D.L.A. opinion for very much like this.
 24 And again, it's to read between the lines and be a
 25 little bit, probably terse, the question is not one

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 2 of the duties of REMAC, but the authority of REMAC.
 3 And not when everyone will cooperate, but what
 4 happens when somebody goes rogue.
 5 So, we need an answer to that. And I
 6 know everything's been held up understandably by
 7 budget and everything else, but now's the time.
 8 **DR. GREENBERG:** I would agree. Just
 9 to fully understand or have clarity from this group
 10 as a body, the understanding or the part that we're
 11 trying to achieve is for a REMAC to set a standard,
 12 fill in the blank, whatever that might be for, and
 13 for the opportunity for credentialing or
 14 applications, fill the blank, whatever you want to
 15 use that word to be, to be done either by a region if
 16 they're doing it collectively, or an agency medical
 17 director who is agreeing to follow the standard set
 18 by the region.
 19 **DR. HUDSON:** I -- I -- I would suggest
 20 to the group, and again, remove the medicine from it.
 21 Just -- I think somewhere is, right, there's --
 22 there's the authority for a region to make an emblem
 23 or a patch.
 24 **UNIDENTIFIED MALE:** No more patches.
 25 **DR. HUDSON:** But -- well, only because

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 2 it's such a material thing that we can all just say,
 3 okay, so here's the regional patch. That's not the
 4 problem. It's what -- what happens then when
 5 somebody won't wear the patch?
 6 What is the authority of that region
 7 to enforce that? And then that would touch not only
 8 uniform operations medicine oversight. I mean, it's
 9 the same answer, regardless. What do we do when
 10 somebody won't?
 11 **DR. GREENBERG:** And -- and I think
 12 that's the -- the second part of it that comes with
 13 it. I just want make sure what we're looking in to
 14 follow that we're on the same page.
 15 **CHAIRMAN RABRICH:** I -- I think what
 16 you stated is correct.
 17 **DR. DORSETT:** I think it's a little
 18 bit modification and I'm just going to open the can
 19 of worms bigger. I think if we're going to reopen
 20 this, I think we need to look. I know there's
 21 lawsuits and stuff about their ability of the region
 22 to credential, because like, for example, there is
 23 multiple levels of credentialing.
 24 So, as an agency medical director, I
 25 can credential people to do things at the agency.

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 2 But I think having regional oversight about the
 3 safety of people to practice, because right now the
 4 reality of what happens is somebody gets put -- does
 5 dangerous things, they get put on a performance
 6 improvement plan, even if it's referred to regional
 7 patient safety and they identify things, they can
 8 make recommendations, but they don't have the power
 9 to do credential. They have to go and it has to go
 10 through a state thing.
 11 And so, people who are doing dangerous
 12 things, demonstrating poor clinical judgment, who are
 13 not complying with plans that are about patient
 14 safety, just rotate amongst different agencies
 15 because everybody wants somebody with a pulse who's
 16 going to respond to a call.
 17 And I think we are so afraid of like
 18 things because of things that have happened that we
 19 haven't given REMACs, like at least regional
 20 oversight who actually like, know these people have
 21 data, have -- right, these patient safety issues to
 22 say, you are not safe to practice and you cannot
 23 practice until you comply and have a good cooperation
 24 from that regional level to the state. Which, I mean
 25 --

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 2 **CHAIRMAN RABRICH:** Right.
 3 **DR. DORSETT:** -- like the state, I've
 4 had cases, right, where the state has been effective
 5 in restricting somebody's privileges. But it took a
 6 long time and that person circulated in our system
 7 doing things that were not safe for patients --
 8 **CHAIRMAN RABRICH:** Right.
 9 **DR. DORSETT:** -- for a long time. And
 10 I was not the medical director of those agencies.
 11 And there's also a limitation and liability as a
 12 medical director of me calling another medical
 13 director and saying, don't hire that person, right?
 14 There's a deprivation of liberty, potential risk and
 15 so on.
 16 **CHAIRMAN RABRICH:** Yeah.
 17 **DR. DORSETT:** I -- I think we have to
 18 be -- we have to give, say, we're here to ensure safe
 19 and effective and quality patient care and what are
 20 the safeguards that we have to be able to do that.
 21 **CHAIRMAN RABRICH:** Yeah. I -- I think
 22 that's a key point. And I think, you know, to your
 23 other point, there is a process, right? The state
 24 has a process to -- but it takes time, right?
 25 Because there's a whole due process and

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 2 investigation, right? And it takes them time.
 3 So, I think what we're saying is how
 4 does a region safeguard their patients in the
 5 interim, right? While that -- the state will be
 6 going through that process. But the regional concern
 7 is we -- patient safety while that's going on, where
 8 one agency medical director may know this is a real
 9 problem and I've restricted him here, but I can't
 10 stop it anywhere else.
 11 And I know the state's doing what the
 12 state does, but it's going to take time. Ryan?
 13 **DR. GREENBERG:** Did anyone else have a
 14 comment first? No? So, there is a process in the
 15 state. It does take time depending on what it is
 16 because it is due process.
 17 There is a faster process for
 18 significant things that happens several times a year
 19 when things are more egregious than what it is. And
 20 I -- I've had this -- and I understand the
 21 frustration that comes with this, right?
 22 I'm not -- I'm not going to argue the
 23 frustration. I'm not going to argue the frustration
 24 of sometimes how long something can take. But what
 25 often comes up is, you know, the way that -- that we

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 2 look in -- in several different things.
 3 You know, if -- if any of you are a
 4 physician in one hospital and something happens in
 5 that hospital and you moonlight at a second hospital,
 6 what happens when you do something wrong at one
 7 hospital?
 8 And I'm asking the question, do you
 9 immediately get restricted at all of them, even
 10 though you might be a bad provider? And I don't mean
 11 you might, just in general, if -- if -- if there's --
 12 if there's a doctor who's a bad provider and they get
 13 restricted at one hospital, my question for this
 14 group, and I -- I would like you enlighten me, what
 15 happens to the job that you moonlight at?
 16 **DR. DORSETT:** It's only when you apply
 17 for a new one. But I don't think -- I think that
 18 there's things that are dangerous in physician
 19 credentialing, and there's people who shouldn't be
 20 doctors who still get to be doctors, but I have no
 21 control over that.
 22 But I do have, right, around the
 23 region, we know people who are doing, and I think
 24 it's -- there has to be due process at the region.
 25 It's not like the region just decides. I think for

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 2 the -- the REMAC to take the responsibility on this,
 3 right?
 4 Like, it goes through a regional
 5 patient safety. There is a due process review, there
 6 is a concern. It's brought to the regional medical
 7 director. It's discussed. And it's -- it's by no
 8 means super-fast, but I think you need to be able to
 9 have a temporary restriction of privileges to
 10 safeguard patient safety.
 11 And I don't think that regions take
 12 this lightly --
 13 **CHAIRMAN RABRICH:** So, the
 14 commissioner has that power, right? And that's
 15 usually where that happens if it's egregious, right?
 16 Whether it's a physician, a paramedic. The
 17 commissioner can immediately suspend someone's
 18 ability to -- to practice. But --
 19 **DR. GREENBERG:** Very quickly.
 20 **CHAIRMAN RABRICH:** Well, right.
 21 **DR. GREENBERG:** Within --
 22 **CHAIRMAN RABRICH:** Well, not -- not in
 23 a normal process.
 24 **DR. GREENBERG:** Not months,
 25 absolutely.

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 2 **CHAIRMAN RABRICH:** Very fast. Yes.
 3 **DR. GREENBERG:** And -- and by the way,
 4 and happens a couple times a year.
 5 **CHAIRMAN RABRICH:** Right. But you
 6 know, that's -- that something has to rise to a
 7 certain level for that to happen. I think there's
 8 concerns about these people that, you know, we know
 9 there's issues and it's dangerous, but --
 10 **DR. DORSETT:** Yeah, I'm talking about
 11 the people who beat people up on video.
 12 **CHAIRMAN RABRICH:** Yeah.
 13 **DR. DORSETT:** I'm talking about people
 14 who have consistent issues with their clinical
 15 judgment or procedural skills or something that is a
 16 clear pattern who say, we need to work on this
 17 because we have to take better care of patients.
 18 And when you say, we need to work on
 19 this, they're like, see you, I'm going someplace
 20 else, and they continue and there's no way to say
 21 like, no, you actually need to work on this, it's a
 22 consistent problem.
 23 **CHAIRMAN RABRICH:** Yeah.
 24 **DR. BLACK:** Specifically, the
 25 physicians though. If a physician has their

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 2 privileges suspended at a hospital greater than
 3 thirty days, it's reported to the National
 4 Practitioner Data Bank. And that is pushed to all
 5 hospitals who subscribe to that physician.
 6 So typically, when a physician is
 7 credentialed, their medical staff office is
 8 subscribing to that physician and they get notified.
 9 Any lawsuit action that is finalized also goes to
 10 that. So, a hospital will be notified if an action
 11 is taken at different hospital, greater than thirty
 12 days.
 13 **COURT REPORTER:** Can you say your
 14 name, please?
 15 **DR. BLACK:** Dr. Black. Kirby Black.
 16 **COURT REPORTER:** Thank you.
 17 **DR. BLACK:** SEMAC member.
 18 **DR. GREENBERG:** And if an action is
 19 taken against a paramedic as well, just in case you
 20 know, we report that same database as well.
 21 **DR. DOYNOW:** So, just one quick
 22 comment here. Mike and I have been around for a long
 23 time, and for years -- no, I hate to say how long.
 24 **CHAIRMAN RABRICH:** You're saying
 25 they're old.

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 2 **DR. DOYNOW:** Yes. Unfortunately. For
 3 years, REMAC basically had the power to credential
 4 paramedics, credentialed medical directors. And then
 5 for regions aren't quite clear, a few years ago that
 6 power was more or less removed, and the way the law
 7 was interpreted that the medical director had the
 8 ultimate authority.
 9 I think we really need to think about
 10 moving back to the REMACs having that authority
 11 because it's a group of knowledgeable physicians, not
 12 just one person. And probably would give the
 13 paramedic better due process anyway because it'd be
 14 more than one opinion.
 15 So, I don't know, Ryan, if there's a
 16 way to -- to go back to that model.
 17 **CHAIRMAN RABRICH:** Yeah. I think
 18 that's part of what we have to kind of look into
 19 before the next meeting, right? And that -- that
 20 plan of discussion --
 21 **DR. GREENBERG:** I think that would all
 22 be inclusive in that and looking at that and things
 23 like that. I just -- again, I -- I bring it up is,
 24 you know, whether it's a nurse, a physician or
 25 something else, there -- there's very few other

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 2 medical professions that, you know, can get
 3 restricted on a dime, you know, immediately in
 4 multiple places.
 5 And -- and we really need to look at
 6 it at the more global level. And -- and I would even
 7 say at the state level, because look, reality is --
 8 is that -- that -- that -- let's say you had the
 9 authority. Let's say tomorrow, we say, you have the
 10 authority, somebody does something wrong, whatever
 11 that might be, you can restrict them.
 12 It doesn't stop them from going to
 13 next county over. But yet, if they lose their state
 14 certification or restrict their state certification
 15 or something of that nature, it does from a state
 16 level, so.
 17 **CHAIRMAN RABRICH:** I want to -- yeah,
 18 I want -- I know Dr. Winslow has had his hand up for
 19 a while, so Dr. Winslow and then we'll get back over
 20 here.
 21 **DR. COOPER:** Yeah. I've been in --
 22 I've been on Suffolk and the REMAC for twenty-four
 23 years. And the way the process used to work was, if
 24 there was a serious patient harm concern, such that
 25 the agency medical director notified the bureau and

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 2 began an investigation, that case was brought to the
 3 REMAC Q.I. subcommittee for a closed-door discussion
 4 and every agency medical director is a member of that
 5 group.
 6 They're allowed to make an independent
 7 assessment of that case, even if it was in a
 8 different agency for the next patient that that
 9 person should take care of. That has been put on
 10 pause after the policy statement was rescinded with,
 11 quite frankly, no information attached to it.
 12 Ryan, if there's been a legal case for
 13 which we can then learn something, it needs to be
 14 shared with the group, so that we can adjust our
 15 regional policies.
 16 **DR. GREENBERG:** I think that all falls
 17 in line with --
 18 **CHAIRMAN RABRICH:** Yup.
 19 **DR. GREENBERG:** -- kind of the
 20 discussion and happy to come back with it.
 21 **CHAIRMAN RABRICH:** Dr. Berkowitz, Dr.
 22 Dailey.
 23 **DR. BERKOWITZ:** So, just real quick.
 24 So, I have the pleasure of being involved in -- in
 25 multiple regions and being in involved in, you know,

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 2 quality concerns in -- in all -- in all of them,
 3 frankly. And one of -- one of the things I can say
 4 from my experience is that, there is a tremendous
 5 amount of heterogeneity between the different regions
 6 and how they approach concerns regarding patient
 7 safety and quality.
 8 And this -- this -- we -- there should
 9 not be heterogeneity, you know, although I -- you
 10 know, that the -- the -- there should be a common
 11 approach that is similar and everyone does it
 12 differently. And I don't know how that's in the
 13 interests of our patients, nor in the interests of
 14 our providers if every region approaches it with
 15 their own way.
 16 **CHAIRMAN RABRICH:** Dr. Cooper. Well,
 17 sorry. Go ahead.
 18 **DR. GREENBERG:** And I will also
 19 stress, and I know it's come up a couple times. If
 20 ever there's a patient harm issue, it should
 21 immediately be reported to the state. So, just want
 22 to make sure that's out there.
 23 **DR. COOPER:** Thank you. The statement
 24 was just made a few moments ago that -- that if there
 25 is a physician, you know, harm issue, that it gets

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 2 reported immediately to the National Practitioner
 3 Data Bank. That is true.
 4 However, unless one is up for, you
 5 know, re-credentialing, as Dr. Dorsett pointed out,
 6 even the hospital across the street may not -- may --
 7 may not have a clue that something has changed in the
 8 National Practitioner Data Bank, right?
 9 So, they would have to become aware
 10 that -- that that had been reported. And it -- it's,
 11 you know, that's sort of similar to what we do, you
 12 know, at the beginning of every REMAC and REMSCO
 13 meeting where we report on the, you know, the -- the
 14 disciplinary actions that have been taken, you know,
 15 by the state.
 16 That's the requirement to do that at
 17 every, you know, REMAC, REMSCO meeting now, as we all
 18 know. But again, how many of the, you know, agency
 19 medical directors necessarily, you know, are aware of
 20 what took place at a REMAC, REMSCO meeting or read
 21 the minutes.
 22 So, it may not be the case that --
 23 that -- that folks in the region necessarily
 24 understand that there has been, you know, some sort
 25 of restriction placed. I -- I just point that out

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 2 because it's not as though there's no mechanism, but
 3 it's also not as though it's a mechanism that
 4 necessarily moves as quickly as it needs to move in
 5 certain circumstances.
 6 So, I -- I -- I'm just adding my voice
 7 to all of those who say, we need a resolution to
 8 this, and we need it as soon as we can get it. Thank
 9 you.
 10 **CHAIRMAN RABRICH:** Yeah. Yup. I
 11 think -- I think we've gotten some good feedback
 12 about kind of the focus on this, and between now and
 13 the fall, we will do some work offline to see what
 14 recommendations we can come back with to accomplish
 15 what everyone's saying, so.
 16 All right. Next item is, there was an
 17 offline discussion over the last couple months about
 18 Cyanokit shortages, and they're really not being an
 19 effective alternative. So, I don't know how much of
 20 a discussion we want to have. I think it's more just
 21 for awareness. I mean, people want to share as -- or
 22 if it's particularly bad in certain regions or what
 23 people are doing right now, or -- or you know, how
 24 the current supply is. I don't know. If anyone
 25 wants to comment on the Cyanokit. Yeah, Doug?

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 2 **DR. ISAACS:** My understanding from
 3 speaking with the manufacturer directly several times
 4 over the past month or two, they're up to -- up to
 5 speed in the manufacturing. So, that really -- that
 6 shortage should really -- should not be so much
 7 anymore. Are there regions still having trouble
 8 acquiring the medication or?
 9 **CHAIRMAN RABRICH:** I think there are,
 10 but I'm seeing a lot of nodding around the room.
 11 **DR. GREENBERG:** I think there are, but
 12 I think if that change has happened recently where
 13 they're back up to, I think --
 14 **DR. ISAACS:** It started at the end of
 15 January, but I just spoke to them yesterday. And
 16 they -- they said that really -- there really
 17 shouldn't be any more shortages.
 18 **DR. GREENBERG:** So, I think -- I think
 19 the -- the word back would be to, if any region is
 20 having a problem to maybe follow-up with them and
 21 maybe they can move up in the priority list. I know
 22 we've gotten some ask related to it, and we said
 23 without, you know, an F.D.A. approval to use an
 24 expired medication or something of that nature, then
 25 you have to go based on what is on the -- the

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 2 documents., but I know that there was also supply
 3 chain issues.
 4 **DR. ISAACS:** Yeah. One of the things
 5 manufacturers sends them to the distributor, so
 6 really, that might be kind of like the -- the middle
 7 middleman issue potentially.
 8 **DR. GREENBERG:** So, maybe a follow up
 9 in --
 10 **CHAIRMAN RABRICH:** Yeah.
 11 **DR. GREENBERG:** -- in the fall?
 12 **CHAIRMAN RABRICH:** In the fall and see
 13 where we're -- how people are doing. Yeah.
 14 **DR. GREENBERG:** Yeah. I -- I think
 15 your information could be critical though. I'm just
 16 -- now is the time to follow up with your distributor
 17 or whomever, because they might have the stuff back
 18 in stock.
 19 **CHAIRMAN RABRICH:** Yup. Thanks, Doug.
 20 All right. Next, before we get to the training and
 21 that input thing, there was a -- there was a also
 22 offline discussion regarding the glucagon pilot. And
 23 then the kind of the discussion that was had at the
 24 last meeting of this group before this meeting was,
 25 you know, is this a pilot?

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 2 Do we continue with it as a pilot? Or
 3 because I.M. injection as a B.L.S. skill already is
 4 this something that could just be added as a
 5 protocol? So, I don't know. Did you want to add --
 6 maybe if you give a little background about kind of
 7 how this came up and what the need really is?
 8 **DR. COOPER:** We've -- we didn't -- so,
 9 this came from Suffolk County, and we would have to
 10 apply to the bureau for permission to be a pilot
 11 program.
 12 But instead of going through an
 13 approval process for something as simple as moving
 14 the scope of practice from the A.E.M.T., which gives
 15 I.M. glucagon to the E.M.T. if equipped and trained,
 16 maybe it's easiest to move it in protocol as opposed
 17 to going through the process of what happened with
 18 the Hudson Valley and the i-gel project, which was a
 19 lot more involved, but I didn't want to delay the
 20 ability to give I.M. glucagon to our B.L.S. providers
 21 who already have the ability to check a blood sugar,
 22 give I.M. injection and do this in seven other
 23 states.
 24 So, it was a discussion I'm gathering
 25 from the way the previous discussion about the

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 2 collaborative rollout is it is too late in this
 3 cycle. So, I'm going to recommend that the
 4 collaborative protocol group add this to the next
 5 generation to make it in protocol. And we will do
 6 the pilot program for one year and report back to the
 7 group. But that was -- should chunk it to the
 8 discussion.
 9 **CHAIRMAN RABRICH:** Okay. Any
 10 comments? Feedback? I did, you know, because in my
 11 own experience, right, I haven't given -- it hasn't
 12 been that often that I've needed to give glucagon.
 13 So I was, you know, I had a question
 14 like, what's the need? Like, how often is this
 15 happening around the state? So, I -- I did actually
 16 ask Peter to -- to take a look at some 2024 date if
 17 he could.
 18 And I just think those num -- what he
 19 was able to find is a little interesting that I
 20 thought maybe we would just share that with the group
 21 just for perspective, and then we certainly can --
 22 can move that forward.
 23 So, I will wait for Peter to come to a
 24 microphone and then basically just give us some --
 25 again, it's -- it's not perfect data, but it's just

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 2 an idea of utilization that we've had.
 3 **DR. BROODY:** It was a fun exercise for
 4 a Tuesday night though.
 5 **CHAIRMAN RABRICH:** We appreciate your
 6 efforts.
 7 **DR. BROODY:** And for the record, I'm
 8 Peter Brody, the Branch Chief of Data and Informatics
 9 in the Bureau. We looked at this from two different
 10 perspectives.
 11 The first was, how much glucagon was
 12 administered in 2024 as documented. Currently there
 13 are one thousand five hundred and sixty encounters
 14 that we identified across the state as receiving
 15 glucagon. We looked to see what the triggers were.
 16 For that, we followed the protocol backwards to be
 17 able to identify that.
 18 When looking at how many B.L.S.
 19 transporting agencies, we kept it to transporting
 20 because there might be some reimbursement to cover
 21 the cost of glucagon. From June until December, we
 22 found approximately eight hundred and ninety
 23 encounters where a patient had a blood sugar of sixty
 24 or less and had a G.C.S. of twelve or less for about
 25 eight hundred and ninety.

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 2 If you project that back a little
 3 closer to January, you might run upwards of slightly
 4 over a thousand statewide.
 5 **CHAIRMAN RABRICH:** Thank you. So
 6 again, numbers that I think are a little higher than
 7 I initially thought we'd see, but just -- just
 8 informational for the group and something to think
 9 about. Yeah, we'll go to the collaborative for
 10 discussion, and I believe Suffolk is going to proceed
 11 with the -- the one year -- no, will it only be
 12 Suffolk County or similar to i-gel? Could other
 13 regions participate if they chose to?
 14 **DR. WINSLOW:** When we -- when we put
 15 the application into the bureau, we'll open it up to
 16 other regions. I'm just going to put a one-year
 17 timestamp on it --
 18 **CHAIRMAN RABRICH:** Uh-huh.
 19 **DR. WINSLOW:** -- so I don't run into
 20 multiple years. I will tell you, in our region we
 21 looked at this; there were twenty-six patients who
 22 would have benefited. It is small numbers, but it's
 23 in scope of practice, and I don't think this is a
 24 huge lift. What's the downside?
 25 **CHAIRMAN RABRICH:** Yeah, I think it's

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 2 -- I think it's training on the medication, right,
 3 and the cost because glucagon's not cheap, but again,
 4 it's if -- if equipped and trained, right?
 5 So, any other comments on the
 6 glucagon? Or if not, we'll move on to the next item.
 7 It came up in discussion about having
 8 training ED input specifically to that issue,
 9 speaking to scope of practice and any specific
 10 training needs with protocol rollouts to have a -- a
 11 more formalized process for T&E kind of review and
 12 input into the protocol updates.
 13 And while we -- the collaborative
 14 group does have some members of training an ED who
 15 also participate in the collaborative group, we
 16 thought that timing would be, you know, maybe after
 17 the December SEMAC SEMSCO meeting of each year when
 18 the protocols are generally first introduced and
 19 discussed, and prior to the February meeting where
 20 they get voted on, that we'd have a -- a formal
 21 review of the draft protocols by training an ED to
 22 offer any feedback on knowledge gaps, training
 23 requirements, scope of practice issues, et cetera. I
 24 don't know.
 25 Don, did you want to add anything to

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 2 that?
 3 **DR. HUDSON:** Yeah, so I mean, that's
 4 the recommendation. It's just -- it's just a
 5 checkbox in the process. So, I think it's an easy
 6 addition and an easy lift. And just to illustrate
 7 how that works is, so the question of B.L.S.
 8 intramuscular glucagon, right? We're over the hump
 9 with, we know E.M.T.s can safely use syringes and
 10 reconstitute and utilize vials, drawing off
 11 medications. Thank you, COVID.
 12 If anything good came of that, we had
 13 that come out of that for immunizations at the E.M.T.
 14 level. Then following that through the E.M.S.
 15 education standards and, you know, the publishers and
 16 what's commonly out there, the only nuance of the
 17 missing piece would be glucagon's not really
 18 mentioned per se in the indications
 19 contraindications, right, all -- all the rights and
 20 wrongs.
 21 So, that's where, if trained and
 22 equipped, would regionalize that process, which is
 23 what I think we all want and assure that there's some
 24 education where those voids can be filled. So, I --
 25 I think we're in a good place.

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 2 **DR. GREENBERG:** Dr. Chair?
 3 **CHAIRMAN RABRICH:** Yes, sir.
 4 **DR. GREENBERG:** On that same front, I
 5 would say that the division would greatly appreciate
 6 it, a more streamlined process. I know that as these
 7 protocols come out, we get asked on a regular basis.
 8 Is Dr. Dailey or Jeremy coming out with anything
 9 anytime soon?
 10 And, you know, we wait for what the
 11 region decided to do for that rollout. I will also
 12 say that we are happy to help support in any of those
 13 initiatives providing Vital Science Academy as a
 14 platform for everyone, which all providers can access
 15 and things of that nature and move forward from that
 16 front.
 17 **CHAIRMAN RABRICH:** Thank you.
 18 **DR. HUDSON:** Well, and -- and to that,
 19 I mean, it's this validation through training an ED
 20 and national scope of practice and E.M.S. education
 21 standards that we can weigh, you know, so this has
 22 got to be a statewide rollout per se, or is this not
 23 a huge substantive change?
 24 It's just a, you know, procedural one,
 25 and that can be regionalized or agency based if they

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 2 so, you know, are compelled.
 3 **CHAIRMAN RABRICH:** Yeah, no, I think
 4 that'll be helpful to streamline the process. Thank
 5 you. We do have a little time left and we happen to
 6 have a group of paramedic students here. So, we
 7 thought I'll let Ryan introduce them, but we thought
 8 it would be good to give them the opportunity to pose
 9 some questions to this group and to the physicians of
 10 this group regarding E.M.S. practice, so.
 11 **DR. GREENBERG:** So, we have had a lot
 12 of input in yesterday, but one of the things is, so
 13 B.M.C.C., Bureau of Manhattan Community College,
 14 Megan's program is here, the paramedic students,
 15 that's this whole wing of uniform personnel over
 16 here.
 17 Our half of her paramedic class who
 18 have come up to state council, the other half is
 19 actually sitting in the classroom watching us live
 20 from The OWL.
 21 And you know, yesterday there were a
 22 lot of really good questions. I had the opportunity
 23 to speak to them outside what their thoughts were,
 24 you know, what's some input. And at the end of the
 25 day yesterday, we asked them to say, can you pick one

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 2 or two people to come up and ask one or two questions
 3 that you may have after watching this to our medical
 4 standards group? This is the future of our
 5 paramedics.
 6 This is, you know, we're excited to
 7 have them here to see the regulatory process and the
 8 things of how things change and how, you know,
 9 approval processes happen and everything else. And
 10 so, we thought the opportunity to speak to the -- the
 11 medical standards group at a state level, they've
 12 been to, I think, their REMAC and their REMSCO as
 13 well.
 14 And so, this is their exposure to the
 15 state standard. And so, if you don't mind, we'd like
 16 to invite, I'm not sure who they decided to come --
 17 **CHAIRMAN RABRICH:** Yup.
 18 **DR. GREENBERG:** -- speak. Tucker --
 19 Tucker spoke yesterday, so he wasn't allowed to speak
 20 today.
 21 **CHAIRMAN RABRICH:** Yeah.
 22 **DR. GREENBERG:** So, I just wanted to
 23 come up --
 24 **CHAIRMAN RABRICH:** Yes, we -- we
 25 welcome you and we are, you know, it's great to have

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 2 you here participating, and this is your opportunity
 3 to speak to the E.M.S. physicians of the state and
 4 ask your questions. So, we look forward to -- to
 5 hearing what you guys have.
 6 **DR. GREENBERG:** Just please make sure
 7 when you first speak, to state your first name and
 8 last name.
 9 **CHAIRMAN RABRICH:** Yeah.
 10 **DR. HUDSON:** I like it already that
 11 you have a pen and pencil rather than a tablet, so I
 12 like it.
 13 **MR. WONG:** Well, the -- the paper was
 14 free, so why not?
 15 **DR. HUDSON:** I'm on board. Go with
 16 it.
 17 **MR. WONG:** My name is Jeremy Wong. As
 18 stated before, I'm part of the B.M.C.C. paramedic
 19 program. Just give me one second. Sorry. It's a --
 20 it's a little -- it's a little scary talking in front
 21 of so many people.
 22 **DR. GREENBERG:** The paper has to
 23 reboot, so.
 24 **MR. WONG:** Yeah. It's --
 25 **DR. GREENBERG:** He's going to turn the

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 2 page.
 3 **MR. WONG:** It ran out of battery. So,
 4 I -- I guess I'll start with my takeaways from
 5 yesterday and this morning. Coming from my
 6 experience as -- as an E.M.S. provider, which is not
 7 extensive by any means, it's nice to see the process
 8 of change and, you know, that change does, in fact,
 9 happen.
 10 A lot of the times we're in the field,
 11 you know, we ask questions like, why can't we do
 12 this? Why can't we do that? You know, and a -- a
 13 lot of the frustration ends up being, it's not that
 14 hard to make change, right?
 15 So, it's -- it's good to see the
 16 process and understand why sometimes it takes a
 17 longer time for -- for these protocol updates to come
 18 out and everything like that. Yeah. And it's a --
 19 it's a good experience. I feel like a lot of
 20 paramedic programs should be doing, you know, be part
 21 of the meetings to some degree, whether or not in
 22 person or back at home. You know, it's -- it's a
 23 good experience for medics to have just to see what -
 24 - what, you know, they are doing and how it works.
 25 My question to the group is, in my --

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 2 my experience and my colleague's experience, A.L.S.
 3 providers are required to attend in-person C.M.E.s to
 4 -- with a physician to recertify their cards. And
 5 that kind of brought up the idea of, on the flip
 6 side, should there be a requirement for medical
 7 directors to be involved in the field -- actually in
 8 the field work with the providers that they are
 9 overseeing?
 10 **CHAIRMAN RABRICH:** It's a good
 11 question. Yeah. Yeah.
 12 **MR. WONG:** I know it's not the easiest
 13 thing to implement. And I -- I trust that you guys
 14 have a hard enough job as it is, but a lot of our
 15 thought was, if we can see our medical directors in
 16 person, if we can work with them in the field, then
 17 we kind of get a better sense of what should we be
 18 doing --
 19 **CHAIRMAN RABRICH:** Uh-huh.
 20 **MR. WONG:** -- in these very difficult
 21 calls. Like, sometimes I'll get calls with my
 22 preceptors and they're like, that's a great question
 23 you asked. I don't know the answer.
 24 **CHAIRMAN RABRICH:** Uh-huh.
 25 **MR. WONG:** And then we'll just mull

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 2 over it for a little bit, and then I'll forget about
 3 it the next week.
 4 **CHAIRMAN RABRICH:** Yup.
 5 **MR. WONG:** So, I just want -- want to
 6 get your input on it.
 7 **CHAIRMAN RABRICH:** Yeah, yeah. So,
 8 that's a great question. I think there are several
 9 medical directors on this table that tell you they do
 10 that and want to do that, but you know, I'll open it
 11 up for discussion.
 12 But I -- I personally would agree that
 13 that is the best way to interact with providers and
 14 to understand what they're dealing with in the field
 15 and you know, it's like live C.M.E., right? Like,
 16 you do a call together and discuss it. And it --
 17 it's interesting that, you know, you bring that up,
 18 which is a great question.
 19 I think sometimes we -- we tend to
 20 just our presence can be intimidating to some
 21 providers, or they're -- maybe not all -- all field
 22 providers agree with what you just said, but I do
 23 think it is a best practice and I'll -- I'll open --
 24 I -- I knew Maia was going to have a comment on this,
 25 but I'll open it up for discussion.

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 2 **DR. DORSETT:** I -- I have, sir, two
 3 comments. I think requirement is a hard thing to get
 4 to, but I think it's something to aspire to. I can
 5 say for part of the process of board certification,
 6 E.M.S., which is not a requirement because a lot of
 7 agencies wouldn't have a medical director right now
 8 because of the -- the number of E.M.S. physicians.
 9 Part of that is actually you have to
 10 do time in the field. And that just like you have to
 11 log procedures that you have to do in the field.
 12 People who go through an E.M.S. fellowship actually
 13 have to log things that they have actually done in
 14 the out of hospital environment.
 15 And as somebody, I'm a little bit of a
 16 -- aware, lots of times when you become an E.M.S.
 17 medical director, you were a paramedic or an E.M.T.,
 18 and that's what drew you to that. I was never that.
 19 And so, there was no more valuable
 20 experience that I had during my training than being
 21 in the field with the people who are actually doing
 22 the work because there's -- and so, I totally agree
 23 with you.
 24 To the intimidation comment, I think
 25 that there's some degree of that, but I think

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 2 actually one of the things, the value of having a
 3 medical director in the field is that if we can
 4 behave ourselves, we can actually teach and -- and we
 5 also make mistakes all the time.
 6 I think it's actually one of the ways
 7 to break down the barrier that we're actually just
 8 humans. We make mistakes too, that there's things
 9 that we don't know. And that really our primary job
 10 is to support you in taking the best possible care of
 11 patients.
 12 So, a requirement today, I -- I think
 13 that would be a tough one, but something to aspire
 14 to, for sure.
 15 **CHAIRMAN RABRICH:** Yeah, I think
 16 that's a great comment. Others have comments on this
 17 or -- or feedback? It's a great question.
 18 **DR. HALLINAN:** I love the question. I
 19 have to say I'm a volunteer interior firefighter and
 20 the experience that I get to see. And I was an
 21 E.M.T. way back in college, so -- but to be on a
 22 scene with where the car has just rolled over, and
 23 the patient is still entrapped or you're on a fire
 24 scene and they're pulling the person out.
 25 And you know, I am very cognizant of

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 2 the fact that there are paramedics and E.M.T.s doing
 3 their job, and my chief was like, you know, on a
 4 scene, you're -- you're a firefighter, you're not a
 5 physician. I was like, well, kind of. So, it's a
 6 very interesting role to juggle.
 7 And I like to just, you know, watch
 8 everything. And if I'm needed for anything, then I'm
 9 there. But the -- I agree fully with you that the
 10 experience and getting to see the chaos pre-hospital
 11 is crucial because in -- in a controlled setting in
 12 an E.D. or whatever, that's way different than when,
 13 like the -- you know, what's hitting the fan and, you
 14 know, you're -- you're trying to pull somebody out of
 15 a really bad place.
 16 So, I agree with you. I think it's
 17 invaluable.
 18 **CHAIRMAN RABRICH:** Thanks. And --
 19 sorry, go ahead.
 20 **DR. BERKOWITZ:** So, just, you know, I
 21 think is from the perspective, we built up a program
 22 over the past few years for our -- our medical
 23 directors to participate. And it took a lot of -- a
 24 lot of effort. It's a lot harder than -- than --
 25 than we expected and we didn't expect it to be easy.

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 2 I do think that one thing that -- that
 3 we can do to support this -- this -- this request is
 4 probably provide maybe, as a group, some standards or
 5 guidance to agencies that want to -- to do this so
 6 that they can get it off, you know, get it off the
 7 ground in the -- in the -- in the -- in the way
 8 that's most provider centric to helping the crews in
 9 the field and making it supporting -- supporting
 10 them.
 11 So, that's something that maybe we
 12 could talk offline about, is there some guidance we
 13 can -- we can provide to agencies that want to
 14 develop a program to do the right way.
 15 **CHAIRMAN RABRICH:** Thanks. Dr.
 16 Cooper.
 17 **DR. COOPER:** Thank you. As a quick
 18 aside, the two most recent speakers, so both use the
 19 word support. There were a number of years ago,
 20 you'll all remember in the -- I think, the first
 21 edition of the N.A.E.M.S.P. Medical Directors, you
 22 know, a handbook, Dr. Alexander Quill who many of us
 23 from New York City remember fondly, really got into
 24 helping to define, you know, the concept of medical
 25 oversight and to include both direct and indirect

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 2 medical control.
 3 But I -- I -- I've always felt that
 4 that -- that that paradigm was lacking the crucial
 5 element of medical support, because as Dr. -- Dr.
 6 Dorsett and -- and others have pointed out, that's
 7 our primary function.
 8 Yes, we sit -- we sit here, whether
 9 we're here at the SEMAC or whether at -- whether we
 10 are at our individual REMACs, you know -- you know,
 11 defining, you know, the -- the practice that takes
 12 place within our region or state, the fact of the
 13 matter is that the most important thing that we do is
 14 to support our pre-hospital colleagues in -- in -- in
 15 every way that we can.
 16 We're -- so, I -- I -- I laude my
 17 colleague from, you know, from the -- the Borough of
 18 Manhattan Community College Program and hope that all
 19 of us can embrace the -- the -- the wishes that he
 20 has put forward for us. Thank you.
 21 **CHAIRMAN RABRICH:** Yup. Thanks. Did
 22 you have --
 23 **DR. HUDSON:** So --
 24 **CHAIRMAN RABRICH:** Go ahead.
 25 **DR. HUDSON:** Just one. So, there was

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 2 a time where the medics and doctors knew each other's
 3 first names and were handpicked by our medical
 4 directors to be paramedics that wasn't just an old
 5 T.V. show. And I agree, we need to get back to that.
 6 **CHAIRMAN RABRICH:** Thanks, Don. Okay.
 7 We have -- yup. Second question.
 8 **MR. ALAN:** Well, my question isn't as
 9 difficult as his, but.
 10 **CHAIRMAN RABRICH:** Just say you're --
 11 just for the -- say your name for the --
 12 **MR. ALAN:** My name is Alan. First and
 13 foremost, thank you very much for this opportunity.
 14 And my question is, given the increase in pediatric
 15 behavioral health emergencies, does the current L --
 16 New York State B.L.S. and A.L.S. protocol provide
 17 enough guidance in managing, assessing, and safely
 18 transporting with them?
 19 **CHAIRMAN RABRICH:** Good. All right.
 20 I will turn it over to our pediatric expert.
 21 **DR. COOPER:** We are so glad that you
 22 asked.
 23 **CHAIRMAN RABRICH:** Yes. Where did
 24 Harris go?
 25 **DR. COOPER:** The short answer -- the

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 2 short answer is yes, there's been a -- a major focus
 3 on this, that the E.M.S.C. committee and -- and
 4 elsewhere, nationally, of course, in the last -- a
 5 few years.
 6 I would encourage everyone, you know,
 7 not just our paramedic student colleagues, but also
 8 all of us to visit the E.I.I.C. website, the -- the
 9 E.M.S.C. innovation and implementation center based
 10 in -- out of Texas, that has extraordinary resources
 11 available in terms of dealing with behavioral
 12 emergencies and children.
 13 And I'll just further add -- and I --
 14 I don't know whether Dr. Rabrich wants me to comment
 15 -- comment on the other issues that took place at
 16 E.M.S.C. at this meeting or wait for SEMAC.
 17 But -- but the -- there is a major
 18 project ongoing, which we hope to get wrapped up by
 19 the fall that deals with the agitated pediatric
 20 patient and educational materials that are being
 21 developed by some of your peers right around the
 22 table.
 23 And I, of course, thank Chief Pataki
 24 of -- of the fire department of the City of New York,
 25 as well as Matt Harris at Northwell and Maia Dorsett

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 2 in Rochester, together with other colleagues from
 3 around the state who are putting together some really
 4 crackerjack educational videos based upon scripts
 5 that have already been prepared and are available.
 6 So, stay tuned, you know, and we
 7 should have some happy surprises for you within the
 8 next several months. Thanks for bringing it up.
 9 Thanks.
 10 **CHAIRMAN RABRICH:** Yeah -- these --
 11 these are great questions. You must have like a
 12 really good instructor or something, but great
 13 questions. And Dr. Harris, did you want to add
 14 anything? I know this is a major issue that we're
 15 all dealing with, but.
 16 **CHAIRMAN RABRICH:** No, I -- I think
 17 that these videos are really going to be
 18 instrumental. I think that these are really
 19 challenging cases and the incidence has gone up, as
 20 you mentioned, right? These are challenging cases
 21 for B.L.S. providers, A.L.S. providers, physicians.
 22 I mean, these are really generally
 23 challenging cases, and they're high consequence cases
 24 to the patient as well. So, I do think that these
 25 videos that are being produced, you know, under

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 2 leadership of Dr. Cooper and E.M.S.C. are really
 3 going to be, I think, a fundamental part of your
 4 education moving forward.
 5 **DR. COOPER:** I might add that Amy
 6 Eisenhower who has, you know, assumed a huge role in
 7 supporting the E.M.S.C. for children program over the
 8 years, reminded me of a resource that's available on
 9 the state website right now.
 10 Amy, would you like to make a comment
 11 about that, so that everyone hears it from, you know,
 12 you rather than me?
 13 **DR. EISENHAVER:** Thank you, Dr.
 14 Cooper. So, New York State is one of the states that
 15 participates in the E.M.S. for Children program,
 16 which Dr. Cooper mentioned, the E.I.I.C., and a
 17 larger umbrella of resources for pediatric patients.
 18 And in line with the updated
 19 protocols, I think three years ago, two or three
 20 years ago, we created a pediatric de-escalation
 21 document, and that's available on the New York State
 22 E.M.S.C. site. You can order it, it's laminated, so
 23 it's safe for ambulances. And so, I know a lot of
 24 students have been ordering them, so you guys are
 25 welcome to order as well.

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 2 **DR. COOPER:** We've also been working
 3 closely with the team from the Department of Health
 4 that's -- that's supporting the crisis stabilization
 5 centers to ensure that they are appropriately
 6 prepared for -- for pediatric patients under
 7 appropriate circumstances. So, more to come on that
 8 in the next few months as well.
 9 **CHAIRMAN RABRICH:** Thank you. And
 10 thank you for your -- thank you for your questions.
 11 Very insightful. We're very pleased that you made
 12 the trip here and that, you know, you have the
 13 opportunity to kind of see the process and -- and
 14 interact with us, and we really appreciate it.
 15 And best of luck in your -- in your
 16 course and your career. So, thank you.
 17 **DR. COOPER:** Thank you.
 18 **CHAIRMAN RABRICH:** All right. Is
 19 there -- I -- is there any -- yes. So, any other
 20 items of new business? Go ahead.
 21 **DR. WINSLOW:** Thanks. Yeah, Dr.
 22 Doynow at the last meeting, a SEMAC asked me to look
 23 at the agency medical director credentialing issue.
 24 We had a boardable discussion group. And I will say
 25 that I think this is best a regional REMAC issue.

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 2 So, I'd just like to make the
 3 following motion. In order to serve as a New York
 4 State E.M.S. agency medical director, the physician
 5 must be credentialed as an online medical control
 6 physician by their regional REMAC. Can I have a
 7 second?
 8 **CHAIRMAN RABRICH:** Say a second. Dr.
 9 Dailey seconded. Discussion on the motion.
 10 **DR. WINSLOW:** So, we thought that was
 11 like the cleanest language because then it ties it to
 12 Article 30. Right now, regional REMACs are
 13 credentialing all over the state, but it's been
 14 questioned by some physicians. You know, what right
 15 do you have? So, this seems to me a clean fix and I
 16 -- I hope there's some support for it.
 17 **CHAIRMAN RABRICH:** Okay. Other --
 18 **DR. WINSLOW:** I should say E.M.S.
 19 **CHAIRMAN RABRICH:** E.M.S. Yeah.
 20 **DR. WINSLOW:** Sorry.
 21 **CHAIRMAN RABRICH:** So, the motion
 22 reads an order for a physician to serve as an E.M.S.
 23 agency service medical director in New York State.
 24 The physician shall be approved by the regional REMAC
 25 as an online medical control physician.

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 2 **DR. WINSLOW:** Right. I, on purpose,
 3 forgive me, Winslow. I, on purpose steered away from
 4 the word credential --
 5 **CHAIRMAN RABRICH:** Uh-huh.
 6 **DR. WINSLOW:** -- because I think that's
 7 a contentious one. The approved language is also
 8 what Article 30 states.
 9 **CHAIRMAN RABRICH:** Yup. Other
 10 discussion on this motion? No? All in favor.
 11 **DR. HUDSON:** Just -- I'm sorry.
 12 **CHAIRMAN RABRICH:** Yeah, sorry. Go
 13 ahead.
 14 **DR. HUDSON:** A question, do you want
 15 to keep it online or is that too restrictive? Should
 16 it just be --
 17 **DR. WINSLOW:** The -- the intent is
 18 that they meet the qualifications --
 19 **CHAIRMAN RABRICH:** Right.
 20 **DR. WINSLOW:** -- to be online.
 21 **CHAIRMAN RABRICH:** To provide online
 22 medical.
 23 **DR. WINSLOW:** Correct. Each agency
 24 REMAC decides who can be an online medical control
 25 position --

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 2 **CHAIRMAN RABRICH:** Uh-huh.
 3 **DR. WINSLOW:** -- by Article 30. So,
 4 now an agency medical director would be held to the
 5 REMAC.
 6 **CHAIRMAN RABRICH:** Yeah. And I think
 7 there are regions that kind of do this already. So,
 8 yeah.
 9 **DR. HUDSON:** I -- I'm just thinking,
 10 to me, online means on the phone. What if they're on
 11 scene? Do you want to just --
 12 **DR. GREENBERG:** So, I think there's
 13 Article 30 wording that relates to this because the -
 14 - it is the -- it is specifically say in there that
 15 for medical control, and I believe they used the word
 16 online. I'd have to go back and check.
 17 **CHAIRMAN RABRICH:** Yeah. The intent
 18 here was to mirror that language.
 19 **DR. GREENBERG:** Right.
 20 **CHAIRMAN RABRICH:** But if it's --
 21 yeah, if it needs to be changed, we can change it.
 22 The motion.
 23 **DR. GREENBERG:** We can go back. I
 24 don't have it specifically right now, but we can go
 25 back and look at those.

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 2 **CHAIRMAN RABRICH:** All right. Other
 3 discussion, Dr. Dailey?
 4 **DR. COOPER:** The only thing I would
 5 add to this is, I think this is again, something
 6 that's very different in our more populous areas of
 7 the state. Quite frankly, I think that this is
 8 equally important in our less populous areas of the
 9 state, but this now gets even more complicated,
 10 right?
 11 Because I would very much like to make
 12 sure that all of our small basic life support
 13 agencies have online medical control physicians as
 14 their medical directors. I'm not sure that we have
 15 the statutory authority to require that. I think we
 16 do at the A.L.S. level.
 17 And the other thing in terms of that
 18 then becomes REMAC participation, which then gets
 19 back to the ability for us to have, sort of, blended
 20 meetings which allow participation for people who are
 21 remote.
 22 So, I think this one very quickly ends
 23 up with many additional components to it, unless we
 24 add the term A.L.S. agency medical director.
 25 **DR. WINSLOW:** I accept that change.

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 2 **DR. COOPER:** Okay.
 3 **DR. WINSLOW:** Because I got to tell
 4 you, I think the way our -- the law was intended was
 5 that A.L.S. was at the purview of the REMAC, but it's
 6 a less clear situation when it comes to B.L.S.
 7 **CHAIRMAN RABRICH:** So, you're saying,
 8 so before E.M.S., if we say to serve as an A.L.S.,
 9 E.M.S. agency service medical director?
 10 **DR. WINSLOW:** Correct. You can just
 11 make it clean language. Just say advanced life
 12 support, I guess.
 13 **CHAIRMAN RABRICH:** Yup. Dr. Cooper?
 14 **DR. COOPER:** Would that apply to any
 15 associate or assistant medical directors as well?
 16 **DR. WINSLOW:** Yes.
 17 **DR. COOPER:** Thank you.
 18 **CHAIRMAN RABRICH:** Any other
 19 discussion? All right. All in favor of this motion,
 20 raise your hand. Anyone opposed? Abstentions? All
 21 right, the motion is approved unanimously. Anything
 22 else, Dr. Winslow? Okay. Anyone else have any other
 23 --
 24 **DR. GREENBERG:** It wasn't unanimous.
 25 No.

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 2 **CHAIRMAN RABRICH:** Oh, just -- I
 3 didn't see anyone opposed. Of the people who voted.
 4 Everyone voted for it.
 5 **DR. GREENBERG:** Did everybody vote?
 6 You might want to try that one again.
 7 **CHAIRMAN RABRICH:** All right. All in
 8 favor, raise your hand. Okay. Anyone opposed? Any
 9 abstentions?
 10 **UNIDENTIFIED MALE:** I'm not --.
 11 **CHAIRMAN RABRICH:** Then we're right.
 12 So, of the people who were able to vote, they all
 13 voted affirmatively. There are members of the
 14 committee who are not voting, right? So, yes. The
 15 motion carries. Any other business?
 16 **MS. SWEENEY:** I just wanted to circle
 17 back to something that Don was saying earlier that I
 18 felt was over shadowed, which was enforcement by the
 19 REMSCOs and --
 20 **DR. GREENBERG:** Do me a favor, state
 21 your name first and bring the mic a little bit closer
 22 down so the sonographer can hear you.
 23 **MS. SWEENEY:** Leah Sweeney, paramedic
 24 in the Hudson Mohawk region. I just wanted to circle
 25 back to something that Don was saying earlier about

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 2 more generally enforcement in REMSCOs. I know that
 3 this is really not the purview of this subcommittee,
 4 but I just wanted to make sure that this was touched
 5 on and something that could be discussed later when
 6 there are more appropriate subcommittee.
 7 And sort of making sure that, because
 8 I think that's something that in general is something
 9 that I've been seeing as a theme in the last day or
 10 two, is kind of, if we want to have like, data
 11 integrity standards or REMAC credentialing standards,
 12 that the enforcement is something that seems to be a
 13 little bit not as clear as Don was mentioning
 14 earlier.
 15 **CHAIRMAN RABRICH:** Yup. Okay. We
 16 appreciate the feedback. Anything else? All right.
 17 Seeing nothing else, I'll entertain a motion to
 18 adjourn.
 19 **DR. WINSLOW:** Motion.
 20 **CHAIRMAN RABRICH:** Motion. All right.
 21 All in favor of adjourning. There we go. We are --
 22 we are adjourned.
 23 **DR. COOPER:** Thank you, Dan.
 24 (The meeting adjourned at 10:06 a.m.)
 25

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 2 STATE OF NEW YORK
 3 I, DANIELLE CHRISTIAN, do hereby certify that the
 4 foregoing was reported by me, in the cause, at the time
 5 and place, as stated in the caption hereto, at Page 1
 6 hereof; that the foregoing typewritten transcription,
 7 consisting of pages number 1 to 135, inclusive, is a true
 8 record prepared by Associated Reporters Int'l., Inc. from
 9 materials provided by me.
 10 IN WITNESS WHEREOF, I have hereunto
 11 subscribed my name, this the 30th day of May, 2025.
 12
 13 DANIELLE CHRISTIAN, Reporter
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