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

5/7/2025 - Medical Standards - Saratoga Springs, NY

APPEARANCES:

ALBERT SHIH
AMANDA SHULTS
AMY EISENHAUER
ARTHUR COOPER
DANIEL OLSSON
DAVID VIOLANTE
DONALD DOYNOW
DONALD HUDSON
DOUGLAS ISAACS
GINA WIERZBOWSKI
JASON WINSLOW
JERMEY WONG
JONATHAN BERKOWITZ
KATHLEEN HALLINAN
KIRBY BLACK
LEAH SWEENEY
LYNN FARRUGGIA
MAIA DORSETT
MATTHEW HARRIS
MICHAEL DAILEY
MICKEY FORNESS
PAMELA MURPHY
PETER BRODY
RYAN GREENBERG
TERESA HAMILTON

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(The meeting commenced at 8:05 a.m.)

CHAIRMAN RABRICH: Seats, please. I'm going to call the meeting of the May 7th Medical Standards Meeting Committee to order. I'm Dr. Jeff Rabrich. I'm the Chair of the committee. There -- attendance will be going around. Please sign in to the meeting, and then we will start with some old business.

So, an update on the collaborative protocol July rollout. I know that the protocols are posted on the Bureau website. I don't believe there's any issues with the July 1 implementation, but I don't know if there's Gina or someone else from the Bureau can speak to. Are we on track or?

DR. WIERZBOWSKI: I'm sorry, Dr. Rabrich.

CHAIRMAN RABRICH: That's okay.

DR. WIERZBOWSKI: It's -- it's -- good morning to you.

CHAIRMAN RABRICH: Good morning.

DR. WIERZBOWSKI: What did -- what did you need to know?

CHAIRMAN RABRICH: The July 1 protocol rollout. I know the protocols are posted on the

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website.

DR. WIERZBOWSKI: Yes, sir.

CHAIRMAN RABRICH: Are there any -- from the Bureau's point of view, any issues or any -- anything we need to address prior to that roll letter? Is it good to go?

DR. WIERZBOWSKI: It's good to go.

CHAIRMAN RABRICH: All right. Thank you. I appreciate that.

DR. WIERZBOWSKI: You're welcome.

CHAIRMAN RABRICH: Along with that rollout, however, several of our members in the, you know, ten thousand readings of the protocol have noted a couple issues that have come up that are more, I would say typos or clarifying issues and not actual protocol changes.

So, one thing that was brought up is that we changed Haldol to Olanzapine. However, we failed to do that in the hospice protocol. And I believe the intent of this committee was to replace it in all places. Is that -- so I don't know if anyone has any discussion on that item or we can just make that editorial change. Dr. Dailey?

DR. DAILEY: No, my suggestion would

be that we just make that as an editorial.

CHAIRMAN RABRICH: Okay.

DR. DAILEY: Or editing change.

DR. WINSLOW: I agree.

DR. DAILEY: Not editorial.

DR. WINSLOW: That was the intent of the collaborative group.

CHAIRMAN RABRICH: That was the intent? Thank you.

DR. WINSLOW: Yes.

CHAIRMAN RABRICH: And I believe there was also an issue with the open fracture protocol, an and or an or, or something. I don't know if someone wanted to speak to what that -- it reads as --

DR. DAILEY: Yeah.

CHAIRMAN RABRICH: -- giving both or something?

DR. WINSLOW: Yeah, the current protocol has Cefazolin, sorry, Cefazolin, and then on the second line has Moxifloxacin. My -- my request was to put the or there because it would make sense to give one or the other --

CHAIRMAN RABRICH: Yeah.

DR. WINSLOW: -- but not both.

CHAIRMAN RABRICH: I think that's a good clarifying edit because the way it reads currently, it would imply that you would give both because it doesn't say or. So, we'll --

DR. WINSLOW: Correct.

CHAIRMAN RABRICH: -- insert the word or there. Are there any other of those type of typo or technical issues that anyone else has noticed beyond those two that we found for the protocol? Dr. Dailey?

DR. DAILEY: No, I think the only thing that I would comment on is that, you know, our discussion around open fractures, treatment of those with intravenous antibiotics and oral antibiotics yielded some very interesting offline conversations on the protocol committee.

I would like to make data from that a standing item here for us to discuss as well as for -- for it to be a standing discussion item across from here to stack.

You know, one of the things with intravenous antibiotics being administered by E.M.S. is it does satisfy the requirement for the American College of Surgeons of early treatment for open

fractures with intravenous antibiotics. The oral antibiotics do not.

So, there isn't a reason to switch to an additional formulation with P.O. antibiotic for all B.L.S. squads. The Moxifloxacin system was taken directly from the special forces --

CHAIRMAN RABRICH: Uh-huh. The treatment guidelines, yup.

DR. DAILEY: -- treatments, the D.O. -- D.O.D. guidelines. So, I think we should continue to watch those things and see how they develop across the state and make sure this really is something that's going to be helpful for patients.

CHAIRMAN RABRICH: Yeah. I would agree with that, and I think it's worth discussion with the collaborative group as well for the next iteration of the protocols, if -- if there should be any -- any additional changes made to that protocol.

But it was a good offline discussion including the cost of those medications and -- and availability that people were discussing. So, I don't believe there's any other corrections to the protocol, just those two. So, unless anyone else has anything on the collaborative protocol for July,

we'll move on to the next item.

DR. WINSLOW: I -- I did have one thing.

CHAIRMAN RABRICH: Yes?

DR. WINSLOW: It's not really a -- a -- towards meeting issue, so I thought it needed discussion.

CHAIRMAN RABRICH: Okay.

DR. WINSLOW: So, our regional REMAC asked a question about tranexamic acid, as we recently just approved it for use in our -- our region. The new collaborative protocol states the indications will be for traumatic and obstetric hemorrhage, and that's the change log.

I had a few questions about it. First, is this applied to pediatrics as it did -- as well as adults? And second is the increase in dose to two grams appropriate based on current E.M.S. experience with any region? And could someone attest to that from a ground unit as opposed to the air units?

And the third part is, should the language not state traumatic and obstetric hemorrhage, what about traumatic and non-traumatic

shock patients? Because significant blood loss can be seen in non-pregnant patients, like dysfunctional uterine bleeding. G.I. bleeding, post-surgical bleeding, and E.N.T. bleeding.

CHAIRMAN RABRICH: Yeah.

DR. WINSLOW: So those -- those are the three questions.

CHAIRMAN RABRICH: Thanks. So, it's worth the discussion. I'll open it up. I -- I believe one, that the data for some of those things is not really there for G.I. bleeding and others, in the same way it is for others. I know the two grams came directly from -- again, from the -- the military T triple C guidelines, but I don't know if anyone wants to speak to those, and Dr. Dailey or others want to talk about. Oh, and the third question was whether it applies to pediatrics, so.

DR. DAILEY: You're hitting the high points really well. There is no data for it to be useful in G.I. hemorrhage. And I think the -- the important takeaway here is that any drug that we have on our formulary can be ordered by an online physician specific to the care of any patient.

So, if a paramedic thinks about that

idea and then initiates a call, discusses it with medical control, it -- that drug can then be given if it's appropriate in that setting. There will be a number of cases that -- that will present that way where a paramedic thinking about other opportunities will create a different care plan for that patient.

So yes, we write it for obstetric and for traumatic shock, which is really hemorrhagic shock across the board. Could it be for other patient's spontaneous splenic hemorrhage, right, some -- some other bizarre case, absolutely. That's what medical control is for.

CHAIRMAN RABRICH: Yeah. And then on the pediatric question, I -- I'd also be curious as to Dr. Cooper's opinion on the T.X.A. in the pediatric hemorrhaging patient.

DR. COOPER: Thank you. The -- there's no specific prohibition to the use of T.X.A. in pediatric patients. The -- the -- the truth, however, is that multiple transfusion protocols are so rarely activated in pediatric patients that, you know, the experience, you know, with it is extremely limited.

However, you know, for older kids, you

know, adolescents who are involved in high-speed crashes or, you know, gunshot wounds, et cetera, you know, certainly, you know, that would be an appropriate -- an appropriate consideration.

But for the -- for the younger kids, again, no prohibition, but you know, but the experience is extremely limited. Thank you.

CHAIRMAN RABRICH: Thanks.

DR. WINSLOW: May -- maybe just some education --

CHAIRMAN RABRICH: Yeah.

DR. WINSLOW: -- would be useful. For example, I -- I didn't want the -- the provider to stay in play to put an I.V. in a two-year-old if they're, you know, less than five minutes from the trauma center, for example, just to give T.X.A. And I think that would do that in education is what instances it would be indicated and in what age groups.

DR. DORSETT: I mean, I think, that's true whether or not the patient's two years old or thirty-five years old, and I think that's part of the education around the priorities of care. These are protocols that say what is in your scope of practice.

But defining the priorities of care and how you order those things, I don't think it's going to -- it's not sort of like the role of this particular thing. And it's definitely not different in pediatrics, I don't think, than in adult.

CHAIRMAN RABRICH: Yeah. And is that, you know, an education issue versus putting something in the protocol. To speak to it is, I think, it's education. Yeah, Dr. Cooper?

DR. COOPER: You know, I -- I -- I honestly, I think this falls in the -- in the same, you know -- you know, general area as most of the things that we do in the prehospital arena in a rapid transport urban system, right?

In a rapid transport urban system, generally speaking, you know, with very few exceptions, getting the patient to definitive care, you know, taking precedence over a lot of stay in play issues and you know, -- but again, if you're talking about, you know, long distance transports or transport delay or what have you, that's a different story. And there's again no specific contraindication to its use. I -- I certainly agree that most of these issues can be handled very

effectively in the educational environment. Thank you.

CHAIRMAN RABRICH: Thanks.

DR. DAILEY: If I can suggest that -- we actually have Matt Harris from Northwell is here as well.

CHAIRMAN RABRICH: Yeah.

DR. DAILEY: And I'd love to have him come up and speak to this.

CHAIRMAN RABRICH: Yeah, Dr. Harris is welcome to offer his opinion on this as well if he's. Not to -- not to pull him out of the audience, but.

DR. DAILEY: Of course, he could have found a seat that was a little bit more accessible to a microphone.

CHAIRMAN RABRICH: Yeah.

DR. HARRIS: I didn't think I was allowed at the big kids table today, but pediatrician. Thank you. You know, I -- to Dr. Cooper's, I think eloquent point, the -- the -- the literature in the civilian world for T.X.A. is very limited.

There is an ongoing pro -- prospective study through PECARN called the TikTok study, which

is expected to have, obviously exclusively civilian trauma, most of which is going to be penetrating. And the results are probably going to come in the next year.

The -- the literature coming out of the military theater is quite clear that it does reduce the number of blood products that a dramatically injured child, excuse me, requires over the next twenty-four hours. And I think in most large trauma centers, to Dr. Cooper's point, we are routinely giving T.X.A. So, I -- I think that a proactive E.M.S. system, as we have in New York, should promote the use of TXA in children. There's essentially no downside.

The -- the risk for thrombotic events in children is essentially zero in a limited, you know, military experience that would fully support it. Thanks.

CHAIRMAN RABRICH: Thanks. So, I think that, you know, may -- maybe in -- in the next, in the twenty-six edition of the protocols, it's worth clarifying the pediatric shock protocol that specifically, you know, that T.X.A. may be helpful in that population.

Certainly, it can be done as Dr. Dailey was saying with other things before, what they call a medical control and a, you know, medical control physician order so. Any other comments or questions on the collaborative protocol rollout?

MR. SWEENEY: Leah Sweeney, paramedic --

CHAIRMAN RABRICH: Yes.

MR. SWEENEY: -- in the Hudson Mohawk region. Would there be conservation for including a standardized dose for pediatrics in the medical control conservations for shock? Because I've seen varied literature from point -- from ten milligrams per kilogram up to, I think, thirty to forty milliliter -- milligrams per kilogram.

CHAIRMAN RABRICH: Yes. I think that -- that's a good point and a good question for the collaborative group for some research and discussion for the next protocol iteration, but those are all great comments that we'll take back to the collaborative group as we start working on the next version, so thank you.

All right, the next item on our agenda, we had some great offline discussion as well

on the B.L.S. supraglottic airway policy statement. I want to thank Gina for all her work on this and I think we had a very productive offline session with feedback and commentary. So, do you want to speak to kind of where we're at currently with the policy?

DR. WIERZBOWSKI: Yes. We did have a very productive discussion both during the med standards subcommittee meeting and also in -- within the discussion that we posted in Boardable, so that this group could review and comment on the policy, those of that were not able to attend.

So, we did have a bit of editing that happened that I think was a approved by the group. But there were a couple of comments that I just want to make sure that the group addresses. With regard to the term of credentialing of providers, there was some back and forth about whether you would say credentialed or not, but credential is certainly within the purview, as you stated, Dr. Rabrich, of a med -- agency medical director make credential a provider in a certain skill or whatever is approved by protocol.

So, I probably just leave it at that word there. But then Dr. Winslow did have a comment

with regard to B.L.S. providers and credentialing and the old question of regional credentialing, et cetera. And I would not -- I would want Ryan to speak to --

CHAIRMAN RABRICH: Yes.

DR. WIERZBOWSKI: -- that.

CHAIRMAN RABRICH: So --

DR. WIERZBOWSKI: Good morning, Director.

CHAIRMAN RABRICH: Okay. Good morning, not to put you on -- yeah. So, this, this has come up, right? And there's been some questions --

DR. WIERZBOWSKI: Yeah.

CHAIRMAN RABRICH: -- that have circled around the concept of regional credentialing, but I think that everyone agrees that an agency medical director can approve a provider in their agency to do or not do a procedure, whether it's R.S.I. --

DR. WIERZBOWSKI: Right.

CHAIRMAN RABRICH: -- S.G.A., whatever. So, certainly, there's no argument that at the agency level --

DR. WIERZBOWSKI: Uh-huh.

CHAIRMAN RABRICH: -- that, that person could be approved for that. I don't -- I don't know that that is something that would be done at the regional level other than the agency providing to the region, right, potentially a list of --

DR. WIERZBOWSKI: They could provide a list --

CHAIRMAN RABRICH: -- grants. Right.

DR. WIERZBOWSKI: Yes, of the --

CHAIRMAN RABRICH: Who can do this and so forth, I don't know.

DR. WIERZBOWSKI: -- yes, individual.

CHAIRMAN RABRICH: Yeah.

DR. WIERZBOWSKI: The whole -- the whole point was to state that agencies take it upon themselves with their medical directors to educate, train and --

CHAIRMAN RABRICH: Correct.

DR. WIERZBOWSKI: -- and -- and --

CHAIRMAN RABRICH: The onus is on the agency to make.

DR. WIERZBOWSKI: Exactly.

CHAIRMAN RABRICH: Yeah.

DR. WIERZBOWSKI: Exactly. The last comment or -- or question that came up was with regard to, and we talked about this yesterday, Dr. Rabrich, with the question of should be -- should the waveform capnography, is it -- is it enough for it to just be viewable and present in real time, or does it need to be recorded?

And that is a question for this group to consider. And we would like direction on that --

CHAIRMAN RABRICH: Right.

DR. WIERZBOWSKI: -- as well.

CHAIRMAN RABRICH: So that's something -- we'll pause there. So that's something I think we should discuss, because I don't believe it reads as a requirement, is that you must record the waveform and then put it, because the thought came up, do we include that in the -- in the P.C.R., the waveform.

But there are devices that aren't full monitors, like the EMMA, for example, or others that can show you a waveform, but don't necessarily record it and can't be downloaded into a record. So, I don't -- I believe the initial intent was that continuous waveform monitoring was done, but I don't believe we put in there a requirement to record and -

- and store that.

But I open that point up to discussion because I think it's worth having that discussion with this group. Bearing in mind the cost that might be incurred by B.L.S. agencies that may want to do this to be able to acquire that equipment capable of that. But I don't --

DR. GREENBERG: And that -- I think it, as you do have that discussion and the doctor around the room, feel free to talk about what your agency currently does because I think there's a number of agencies that are obviously have waveform colonography that doesn't record.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: And what is the impact of any of these programs?

CHAIRMAN RABRICH: Yes, both medically and financially.

DR. GREENBERG: Right.

CHAIRMAN RABRICH: Yes.

DR. GREENBERG: Related to that.

CHAIRMAN RABRICH: Yeah, great. I don't know who wants to start? Anyone -- anyone have commentary on this or thoughts?

DR. WINSLOW: I -- I had a -- a second aligned issue.

CHAIRMAN RABRICH: Yeah.

DR. WINSLOW: In our regional REMAC, we were wondering if the protocol should be a little bit more-clear in what is a supraglottic airway as opposed to not being an esophageal airway.

CHAIRMAN RABRICH: Okay. So that's a good point --

DR. WINSLOW: Uh-huh.

CHAIRMAN RABRICH: -- which we'll get to. But I want to -- I want to address this capnography point first.

DR. WINSLOW: Okay.

CHAIRMAN RABRICH: So -- Don?

MR. HUDSON: So, non-physician, first of all, that I haven't met.

CHAIRMAN RABRICH: Well, we'll take your opinion. It's okay.

MR. HUDSON: Well, that's very kind of you.

CHAIRMAN RABRICH: Yeah.

MR. HUDSON: Thank you for always listening. I'm married, so I -- I get it. That

being said, I mean, I -- I - I would suggest to the group, or -- or beg the question, I think we could all agree that waveform capnography is an absolute gold standard of care, a must have, if you will.

That being said, there's technological and financial constraints, obviously, in everything that we consider. So, within Nassau, specific to our early foray into regional R.S.I. credentialing at our last airway R.S.I. committee meeting, after about a year, we revised our regional plan to require four R.S.I. continuous monitoring, recording, end uploading to the P.C.R. simply because, not just specific to R.S.I., but in virtually every airway case, good or bad or indifferent that we've reviewed, everyone wants to see the videotape, but we -- we know we had it, but we didn't save it, you know.

And it's like the game day film, how are you getting better if you can't watch the film? So, I don't know that we are there yet as a mandate, but I think the time's coming. So, I -- I appreciate you having the discussion.

CHAIRMAN RABRICH: Thanks. Oh, yeah, Dr. Winslow?

DR. WINSLOW: Suffolk County requires

it of all use of airways, regardless of level of provider.

CHAIRMAN RABRICH: Use of recording it or and --

DR. WINSLOW: Yes.

CHAIRMAN RABRICH: -- storing it? Okay.

DR. WINSLOW: Yeah, we did it during the B.L.S. i-gel. We actually have all the data. I think we had like eighty-six uses and they did it.

CHAIRMAN RABRICH: Okay.

MR. HUDSON: We just, you know, as a -- - a parallel, we also had the similar discussion about video laryngoscopy. Is that --

CHAIRMAN RABRICH: Right. And do you record your intubation?

MR. HUDSON: Now that, more commonly on the market, it's not just a single device anymore, the ability to record and store the video, it is becoming a norm or hopefully a norm. Why would we not want that saved perpetuity for anyone to review?

The question is always, did the tube go in? And if it came out, when did they realize it? What did they do about it?

CHAIRMAN RABRICH: Right.

MR. HUDSON: So, if we have that live recording of it, I think it allies a lot of people's fears and strengthens us as providers.

CHAIRMAN RABRICH: Okay. Dr. Murphy, did you have a comment? I saw your --

DR. MURPHY: Yeah, just -- just from a perspective of the original. We did not put that -- we did not include that in the original pilot. We did not say that people had to record it. I think it's a good idea if it's not too onerous for people from a financial perspective versus -- but it's not in the original process.

CHAIRMAN RABRICH: Thank you. Dr. Dorsett, I think, did you -- and then Dr. Berkowitz or whoever?

DR. DORSETT: I was going to say that we require it with monitor upload for all R.S.I.s. When I -- I'm actually interested in is because I'm -- - because of the way our system is set up, most of these are using actually like existing monitors because it's a tiered system, and they're using a monitor for those capabilities.

I'm interested from somebody who works

in a B.L.S. system of what is the availability?

CHAIRMAN RABRICH: Uh-huh.

DR. DORSETT: I know from like a pulling data, sometimes it looks like they didn't actually record the value. And so those things are able to be reviewed, and we can see there is definitely a waveform -- and so that we're able to confirm that the airway was in, if in case there's a documentation issue of what actually, like a value made it into the chart.

But how prohibitive would it be to say that you actually need a recording? I think at minimum you need an image of the waveform. Right? Because people do screenshots of the image of the waveform at those time points because that's valuable.

But I'm not familiar enough with the devices that B.L.S. only agencies are using to actually understand what is the level of the barrier that we might be imposing.

CHAIRMAN RABRICH: Good point. Dr. Berkowitz?

DR. BERKOWITZ: Yeah. So, we've been for about a year and a half, been just back to what

Don said about recording a V.L. So, we've been doing that for about a year and a half. And the per -- and the per provider -- by provider, their improvement in -- in first pass success rate has been astronomical.

Now that means every airway actually gets reviewed with a provider with a physician. And eventually we're going to move it over to our quality team and create like a structured process around it. So, you know, I don't know if that's -- it -- it's safe to make that a minimum standard. And I think that's -- that's the question is what's the minimum standard?

CHAIRMAN RABRICH: Right.

DR. BERKOWITZ: And then what's the -- the aspirational standard? We decided to invest a lot of effort and time in going to, I think, something that might be onerous to some, but I think that the question is always what's the minimum standard? And then -- and allowing agencies that want to go further to go further.

CHAIRMAN RABRICH: Yeah. So, I -- I think that's an excellent point. And I think that what I'm hearing so far is, yes, ideally, right? Gold standard. This would be great and we want it,

but is that the minimum standard or not?

And I'd be curious to hear Dr. Dailey, but then also any B.L.S. agencies who are, who participate in the pilot and what they're using. And to Dr. Dorsett's point, like, you know, is it cost per -- what -- what equipment are you using? Is it capable of recording? So, Dr. Dailey?

DR. DAILEY: So, as we think back historically, I remember a long time ago, Lee Burns and I having a conversation with -- with some folks at vital signs in Buffalo where we talked about the difference between the regulatory component of E.M.S. and the medical direction component of E.M.S., and how the physicians were leading a charge, and the regulators needed to remain in place to assure that these things were done safely.

I think we're at a place right now particularly with this intervention where we really have a great opportunity to throw a baby out with the bath -- with the bath water. We're looking at an intervention that will be least likely to take place in a well-populated, well-funded urban area, and most likely to take place in an underfunded rural community that has less representation --

CHAIRMAN RABRICH: Uh-huh.

DR. DAILEY: -- in this room, certainly squads that are not represented at this table. My concern would be that, if we impose things that will very clearly be financial restrictions on an intervention that will be extremely rare and rarely performed, we would not have this potential benefit for the personnel and the patients of that squad available.

I think this is something that needs to remain a regional decision. It's the regional -- reason we have regions. It's the reason that regions are given the mandate to maintain their systems of care.

So, I would suggest that waveform capnography remain as it is in the language, that the documentation standard be a regional decision, and that there be no requirement to upload it from this body.

CHAIRMAN RABRICH: Okay.

DR. GREENBERG: So, I'll take it one step further. I -- I like the less regulation, so good. Believe it or not, yes, that's coming from me. One of the things that I would make a recommendation

from this committee is, you know, regions -- not regions, individual agencies often choose the resources that are around them to collect knowledge.

Sometimes they go to their regions, sometimes they go to their peers, sometimes it happens during a site visit with, you know, one of the district chiefs.

One of the things that I think if you have kind of, I think what was said, the minimum standard and the best standard, if there's something that can come out from this group of recommendation on one paper or best practices or anything that can be shared or easily accessible, I think that is the type of thing that -- that also helps us as regulators to turn and say, here we see you're using this. Oh, you're not recording? Have you seen this document? Just something for consideration. There's no requirement from our side, but at least then, and by the way, there's three subject matter experts on the bottom of it that you can reach out to and call or whatever.

More things like that, and I think there's some other topics that will come up today that will be similar to it, we would love as -- as

the State E.M.S. Office to help facilitate and get that information out and things like that. And I couldn't think of a better place for that to come from -- from, you know, the SEMAC or something, and then through the regions and further out to the agencies.

CHAIRMAN RABRICH: Yeah. So, I guess the question is, and for -- for feedback for Gina as well as do we -- do we change the wording in the policy statement to say, you know, that -- that effect that, you know, the desired, right, that -- not required, but desirable is the ability to best practice is the ability to record and, you know, attach to the record, but certainly not required.

DR. WIERZBOWSKI: Right. I think we could -- we could certainly add a -- a sentence in the policy that says exactly that, best practice would be to record, but it is not required et cetera, et cetera. I -- I think that would be a good compromise because then it's made clear to agencies that this is what you could aim for, but it's not restrictive either financially or otherwise to, in order to participate.

CHAIRMAN RABRICH: Yeah. I -- I think

that's a -- I think that's a good place to settle where we're not discouraging more rural agencies that may not have the -- the means right now to purchase that but can still participate.

And then the next question that came up is kind of, I guess, the -- the definition of a supraglottic airway, right? Like, will we consider any type of esophageal airway to be an S.G.A. or not, I think was the question.

And I don't know, I don't know that we clarify that in the policy at all other than saying S.G.A., and then the question is, is it up to the agency medical director to decide if that's an acceptable S.G.A. or not? Or do we feel -- I mean, I think we all feel that, you know, esophageal airways are not appropriate at this point, but Dr. Dailey, you're nodding vehemently.

DR. DAILEY: I -- I would go right back to regionalization. Right. Agencies should not be making independent decisions about which supraglottic airways are being used there. This is something that needs to be discussed by the receiving hospitals, the physicians who are going to be the medical directors within that - within that region

need to know what devices are approved at the regional level.

This needs to be discussion there, rather than something that's comes out of left field from some miscellaneous rep that shows up --

CHAIRMAN RABRICH: Right.

DR. DAILEY: -- at an agency --

CHAIRMAN RABRICH: And I don't disagree --

DR. DAILEY: -- selling them.

CHAIRMAN RABRICH: -- with that. Although we've had this discussion before about whether regions, right, approved devices or agency medical directors approve devices, and can the region decide what S.G.A.s are appropriate in their region or not?

DR. DAILEY: I think a region can always decide what is appropriate. The more interesting question is whether a region can then say, this one is not appropriate, but a group of physicians at a REMAC can certainly turn to another physician and say, this is the reason we're all using this device; why would you want to go use something else? That's the -- that's the way it is. So, it's

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CHAIRMAN RABRICH: So, could we phrase it as regionally approved devices, regionally approved S.G.A.s and --

DR. WINSLOW: Yes.

CHAIRMAN RABRICH: -- I'm looking to you if you have a --

DR. GREENBERG: So, I actually think you can approve devices. I got -- I got to go back and -- and look exactly because I will also say it's been this body's stance that we don't specifically go to specific --

CHAIRMAN RABRICH: Not specific products.

DR. GREENBERG: No, no, no, no.

CHAIRMAN RABRICH: Right.

DR. GREENBERG: I -- I understand. I'm just kind of -- but they tend to trickle down, so I don't want to.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: I think the way that it was just recommended though, hey, here's fifteen doctors around the table. This is why we picked this one. This is -- why would you -- why would you go

against something like this, I think is probably a stronger situation --

CHAIRMAN RABRICH: Uh-huh.

DR. GREENBERG: -- in -- in compliance of something of that nature.

DR. HUDSON: So, Dr. Hudson -- ladies first.

DR. DORSETT: Oh -- I was going to say, I think that the policy addresses this. There's language, right, that when an agency applies to do this, they have to submit to the region what they're going to use. If they're going to change the device, they have to apply for re-approval for the region. And their medical director must attest to approval of their application. So, I think that there's safeguards in the policy that if --

CHAIRMAN RABRICH: That exist --

DR. DORSETT: But when --

CHAIRMAN RABRICH: -- currently.

DR. DORSETT: That exist currently.

CHAIRMAN RABRICH: Yeah.

DR. DORSETT: We don't know what devices are going to be in there.

CHAIRMAN RABRICH: Yeah.

DR. DORSETT: I think we've given an adequate textbook definition of what an S.G.A. is. And there's -- I think there's regional approval. I think this makes --

CHAIRMAN RABRICH: Okay.

DR. DORSETT: -- enough flexibility, but enough safeguards within the way --

CHAIRMAN RABRICH: Yeah.

DR. DORSETT: -- it's written.

CHAIRMAN RABRICH: Yeah. Don?

DR. HUDSON: I was going to agree. And I think then on the regional level, is the proper place to actually have that. Only because we've had the same question come up about, well, what about esophageal? And I'm like, well, explain to me what you --

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: -- think that means --

CHAIRMAN RABRICH: No, more E.O.A.s or E.G.T.A.s.

DR. HUDSON: -- because I don't think we're talking the same thing.

CHAIRMAN RABRICH: Sorry.

DR. HUDSON: Right. If E.O. --

E.O.A.s and E.G.T.A.s, probably that ship has --

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: -- sailed that.

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: Right? But maybe not?

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: That's a regional decision.

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: Only because when people mention other devices, even iGel, it's like --

CHAIRMAN RABRICH: Uh-huh

DR. HUDSON: -- well, those aren't esophageal. And I'm like, well -- but they're not tracheal, so hence they're supraglottic.

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: And there's a disagreement on that.

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: So, I think that regional discussion is -- is with it.

CHAIRMAN RABRICH: No, I think it's -- and I -- and I think you make an excellent point that it's kind of worded that way already, that the

agency's going to bring to the region their plan of what they want to implement. And so, I think there already exists safeguards for that.

DR. GREENBERG: Right. And I, you know, I think the other important part is, and you can't be product specific, we don't know what's coming out a year from now.

CHAIRMAN RABRICH: Right.

DR. GREENBERG: You know, so though it gives that flexibility for those things, which I think is extremely important.

CHAIRMAN RABRICH: Yeah. So, I think we're good with how that's -- that's worded.

DR. WIERZBOWSKI: Yeah, that's what I'm gathering.

CHAIRMAN RABRICH: Yeah. Any other -- any other items on the policy that you need additional feedback on or?

DR. WIERZBOWSKI: No, I think we're good. Those were the only things that were contained within the discussion. I will, just for awareness to the rest of the group who maybe did not know this was posted in this group's Boardable, there's a whole discussion.

Please, you know, over the next couple of weeks, go in and -- and look at it. Please put your comments in because we will be finalizing this in the next few weeks and don't want anybody to feel like they did not have an opportunity to comment or bring up a point or two about -- about the policy.

CHAIRMAN RABRICH: Yes.

DR. WIERZBOWSKI: But I thank you -- I thank everybody for their comments. It's a great -- greatly helpful to us to have that guidance.

CHAIRMAN RABRICH: Yeah. I think we've -- this policy has evolved into a -- into a very good place, and I think there's been great feedback from everyone on that. And again, please go in there in the next couple weeks if you can, because we do want to finalize this and get this out. Yeah, Don?

DR. DOYNOW: So -- so one thing, Gina, I would probably run by D.L.A., that statement, best practice, because if something goes wrong, that certainly could be used against the agency.

DR. WIERZBOWSKI: Yes. This policy will be reviewed by D.L.A. --

CHAIRMAN RABRICH: Yeah.

DR. WIERZBOWSKI: -- as a general --

CHAIRMAN RABRICH: Yeah.

DR. WIERZBOWSKI: -- rule. So, I --

CHAIRMAN RABRICH: Maybe it could say encouraged but not required or something to that.

DR. WIERZBOWSKI: Right. Yes.

CHAIRMAN RABRICH: You know, effect, but.

DR. WIERZBOWSKI: Yup.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: We'll work on --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- wording particularly for that --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- one. And then obviously, if acceptable by this group, we'll also run it past both of you gentlemen.

CHAIRMAN RABRICH: Yeah. We appreciate that. Okay. So that's the S.G.A. policy, which applies currently to adult patients, but I understand there was some discussion about whether this is appropriate for Peds or not. And I -- I want to turn the conversation over to Dr. Cooper who had a

conversation at E.M.S.C. regarding this.

DR. COOPER: Thank you. Yeah, we did have a fairly robust conversation at the E.M.S.C. meeting earlier this week. And the -- the committee voted to bring forth the following motion for consideration by medical standards and ultimately SEMAC, and I -- I'll read the motion in its entirety.

That the E.M.S. for Children Advisory Committee has strongly supports the indication for basic life support supraglottic airway in the New York State Collaborative E.M.S. protocols and the -- and -- and and the New York State B.L.S. statewide protocols to include pediatric patients and remove the restriction for adult patients only quote unquote.

I believe it's -- can we get it posted?

CHAIRMAN RABRICH: Yeah. It would mirror just -- yes, so the answer, just so everyone can hear that question. It would mirror the adult language, like equipped if, equipped and trained is not -- would not mandate its use. It would be --

DR. COOPER: That's --

CHAIRMAN RABRICH: -- the same as the

--

DR. COOPER: That's right.

CHAIRMAN RABRICH: -- the adult.

DR. COOPER: Functionally, the only change is to remove the --

UNIDENTIFIED MALE: Thank you, Peter.

DR. COOPER: -- in a -- for adult patients only phrase within -- within that protocol.

CHAIRMAN RABRICH: Right. That would -- the motion is to remove the -- rephrase adult patients only --

DR. COOPER: Right.

CHAIRMAN RABRICH: -- from the S.G.A. protocol.

DR. COOPER: But you know, of course, because the rest of the protocol speaks about appropriate training --

CHAIRMAN RABRICH: Uh-huh.

DR. COOPER: -- so forth, you know.

CHAIRMAN RABRICH: Yup, all those things would --

DR. COOPER: Yes.

CHAIRMAN RABRICH: -- would apply.

DR. COOPER: That's correct. Since

this motion was brought forward by Maia Dorsett sitting to my left, I'm going to give her the opportunity to passionately --

CHAIRMAN RABRICH: Excellent.

DR. COOPER: -- speak about this.

CHAIRMAN RABRICH: Appreciate that, Dr. Dorsett.

DR. COOPER: I will also call in a few minutes on Matt Harris --

CHAIRMAN RABRICH: Yes.

DR. COOPER: -- who wrote a position paper for N.A.E.M.S.P. on -- that -- that included reference to this very topic.

CHAIRMAN RABRICH: Thank you. So, Dr. Dorsett and then Dr. Harris.

DS. DORSETT: Yeah. And honestly, I could just defer to Matt Harris, but the background on this was looking at, to me, it seemed like there was a, a care inequity. So, there was a reason that we did expansion of S.G.A.s at the B.L.S. level.

And I think in particularly the use of capnography for verification, that you're appropriately ventilating a patient. When we think about what are the etiologies of cardiac arrest and

pediatric patients, I think the ability to appropriately ventilate your patient is extraordinarily important.

There are ongoing randomized control trials, but those results are not going to be available for years. And there's a body of evidence, including the physician statement, that Dr. Harris can speak to, that from experts in pre-hospital care and pediatrics that endorse the use of an S.G.A. as either a primary or secondary airway in cardiac arrest for pediatric patients.

So, it's really about removing the care and equity around pediatrics. Obviously, I think the important thing is, there's no mandate that you have to carry any of these things. It's just that for those agencies who want to be able to provide this service that they are not restricted from providing this for pediatric patients.

And obviously as regionally as they're talking about what their education plans are going to be as they present those to the regional councils to be approved to do this, that would include if they are going to be carrying pediatric equipment, which is already specified as part of the policy.

There's nothing about the policy that's a -- only the regions can approve the education plans and make sure that they're adequately training them on pediatric patients as well.

CHAIRMAN RABRICH: Thank you. Dr. Harris?

DR. HARRIS: Agreed.

CHAIRMAN RABRICH: Anything you want to add?

DR. HARRIS: Yeah. Yeah. Yeah, I mean, listen, I think -- I think one of the really important and powerful points that Maia brought up is this is essentially a care equity problem, right? And first pass success rates in young children cardiac arrest for endotracheal intubation is below fifty percent if you're flipping a coin.

And I think that's being generous. I think we're probably all well aware of that. You know, it'll be interesting to see what Henry Wang study shows, but we all know what it's going to show that the supraglottic airway device is you, you know, eighty-five to ninety percent first pass in children as it is in adults, that outcomes are better.

And, you know, I think why I -- I

called this a little bit progressive earlier today because, you know, we are -- we -- we cannot wait for the thirty thousand perspective study in children, that will never come. And we know that the in-hospital data is very, very clear about this.

And the mechanics of inserting an S.G.A. in a child are essentially identical to an adult. We have talked about some of the training around securing the device, right, which is something that I think is important to remind, and a good reminder for our adult patients as well. But I do think that this is a incredible step forward.

And -- and the last point I'll make is that what was presented in the last two years at N.A.M.S.P. was the experience -- this past year was the experience of a -- a relatively large county in North of Seattle, where they have, as part of their cardiac arrest management for children, which I think is another topic that, you know, this body should address in the upcoming, you know, sessions is they have moved to supraglottic airway devices to minimize, you know, cardiac compression interruption and their outcomes are dramatically better.

Now, my know, like that cohort was

small, like thirty or forty kids, but, you know, they're -- they like doubled or tripled their ROSC rates and survival within tech neurologic outcomes. So, I think this is a really important move forward.

And for those agencies here that have predominantly B.L.S. providers is the first people on scene. This is taking a -- a really an important step forward, not just in the fact that we have low success rates for endotracheal intubation for A.L.S. providers, but, you know, begging a young child is not as easy as -- as we say it is, right?

The -- the positioning of the hands in an already very nervous provider and doing that in the back of a moving ambulance, which, you know, is a separate topic on its own, is really difficult. So, I think this is a huge step forward. They fully support, and I thank Dr. Cooper and Dr. Dorsett for putting this forward.

CHAIRMAN RABRICH: Thank you, Dr. Harris. Any other discussion? Yes, Dr. Cooper?

DR. COOPER: Yeah, I -- I think it's appropriate to, you know, elaborate just a little bit on the discussion that took --

CHAIRMAN RABRICH: Sure.

DR. COOPER: -- place at E.M.S.C. You know, while, you know, the first pass success rate for, you know, for supraglottic airways in kids, you know, is clearly much better than it is for endotracheal tube placement.

It's -- it's not a hundred percent, right? And -- and I think the -- the committee's -- the discussion at the committee centered around the fact that the training has to be really pretty good and really in place.

You know, the question is, you know, how does -- how do we ensure -- assure that, right? And again, the -- the age-old question that was mentioned a few minutes ago, you know, where are these airways most likely to be used? If they're likely to be used then the places where the opportunities for, you know, for robust training are probably least available.

So, while I think we all agree that it is a care equity issue and while we would also love to see, you know, the -- the, you know, the data from the prospective randomized trial that's currently underway before moving forward, the fact of the matter is that our alternatives are not good.

The ability to maintain bag valve mask ventilation, you know, in a -- in the back of a moving ambulance, particularly for a -- a rural team over a long distance is, you know, problematic at best, and dismal at worst.

While -- and tracheal intubation, of course, even if there are, you know, advanced life support services available to do the intubation in rural areas, you know, the first pass race as -- as Dr. Harris has pointed out, is not ideal.

So, the point is, we've got a device that -- that the -- the preliminary data that is in the literature does suggest substantial improvement over the -- over the currently available alternatives. And for that reason, you know, the E.M.S.C. committee was, you know, nearly unanimous in -- in supporting this direction.

And the one dissenting vote was focused more -- more on the issue of -- of the logistics of implementation, rather than the desire to see this become, you know, the standard of care.

And to quote a very famous E.M.S. physician who happens to be sitting to my left at the moment a, you know, that we're -- we're looking what

really is a -- not a gold standard, but in fact a real -- really a minimum standard to assure that, you know, the device is properly placed and that the -- and that the child or adult is being appropriately ventilated. So, I bring this -- this issue to you to for a vote.

CHAIRMAN RABRICH: Uh-huh.

DR. COOPER: It -- it would require, of course, a protocol change which would, you know, be a -- a roll call vote at SEMAC. But it doesn't -- I don't believe it has to be a --

CHAIRMAN RABRICH: Correct.

DR. COOPER: -- a roll call vote at -- in this body.

CHAIRMAN RABRICH: Yeah.

DR. COOPER: But I -- I defer to the chair to make that critical --

CHAIRMAN RABRICH: Yes.

DR. COOPER: -- decision.

CHAIRMAN RABRICH: I appreciate that input.

MR. COOPER: Thank you.

CHAIRMAN RABRICH: And then I guess the -- the next question beyond that, if it's a

protocol change is, is it a protocol change? Because we've already posted the July, right? Is it something that's for the next cycle, or is it of such an emergent nature that it needs to be -- tried to be included in it?

So, I, you know, thoughts on that because I think we've -- we're -- we've missed the deadline for July 1.

DR. COOPER: We understand that.

CHAIRMAN RABRICH: Okay.

DR. COOPER: And I -- and we all wish that this had come up sooner, but it didn't.

CHAIRMAN RABRICH: Yeah.

DR. COOPER: And there we are.

CHAIRMAN RABRICH: Okay.

DR. COOPER: But I -- I, you know, to quote Dr. Marty Eichelberger, a very famous pediatric trauma surgeon --

CHAIRMAN RABRICH: Yeah.

DR. COOPER: -- and E.M.S. --

CHAIRMAN RABRICH: Yeah.

DR. COOPER: -- physician, you know, in -- in all of our patients, it's all about the A.B.C.s. But if -- but if that's too difficult to

remember, remember A.A.A. for airway, airway, airway.

CHAIRMAN RABRICH: Yes.

DR. COOPER: Okay.

CHAIRMAN RABRICH: Excellent. I would -- I would --

DR. COOPER: So --

CHAIRMAN RABRICH: Yes.

DR. COOPER: I think -- I think we can justify this on an emergency basis.

CHAIRMAN RABRICH: Okay.

DR. COOPER: Thank you. And I -- I would ask, I guess, the bureau's input. Is this -- is that even needed? Like, have we missed the notification deadlines or anything like that? If we -- if we made this deletion, adults only, are we still within a reason? Or do we need to -- is there a regulatory requirement to provide further notice beyond July 1? Would it delay anything?

DR. GREENBERG: There's not a regulatory requirement. However, if acceptable, I would highly suggest that we stick to the same timeline and try and do the updates once a year and keep it to next year, but that is --

CHAIRMAN RABRICH: Yeah, I think the -

- the -- well, I don't want to speak for the little committee, but I think --

DR. GREENBERG: Yeah.

CHAIRMAN RABRICH: -- their will is that they would like it done now, but.

DR. COOPER: I -- I might remind --

DR. GREENBERG: If there is a will --

DR. COOPER: -- everyone around this.

DR. GREENBERG: -- there is a way.

DR. COOPER: Okay.

DR. GREENBERG: There is a way.

DR. COOPER: I might remind everyone around this table that --

DR. GREENBERG: Yeah.

DR. COOPER: -- Commissioner McDonald is the pediatrician. Thank you.

CHAIRMAN RABRICH: That is an excellent point.

DR. GREENBERG: If there is a will, there is a way. That -- that --

CHAIRMAN RABRICH: okay.

DR. GREENBERG: -- on our side, and it's not a major change in things like that, it -- it would be more up to this group of --

CHAIRMAN RABRICH: Okay. Yeah.

DR. GREENBERG: -- how you said it and things of that nature.

CHAIRMAN RABRICH: Yeah. Dr. Dailey, did you have a comment?

DR. DAILEY: I guess this one to me comes down to keeping it simple. The change that we need to make is really editorial. The entire program is predicated on the idea of if -- if equipped and trained --

CHAIRMAN RABRICH: Uh-huh.

MR. DAILEY: -- because it's if equipped and trained, you can't just randomly go and implement it, you have to train. And I frankly would argue that some of the best training that I've seen out there is some of the small basic life support squads with a rural community that they are caring for.

You know, this is not an area where there isn't training. This is an area where there isn't resources. So, I would say, let's get some, you know, robust training materials produced and available for the introduction of this for infants and small children. And let's remove the restriction

now, with the reminder that it's if equipped and trained.

CHAIRMAN RABRICH: Yup. Ryan?

DR. GREENBERG: I think if it's -- if -- if it's if equipped and trained, then that would eliminate the issue of what I'm concerned of.

CHAIRMAN RABRICH: Of timing? Right.

DR. GREENBERG: Of timing and release.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: So that -- that's -- that's the --

CHAIRMAN RABRICH: Okay.

DR. GREENBERG: -- part that --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- we keep hearing the backlash of --

CHAIRMAN RABRICH: It's not a mandatory protocol, let's say.

DR. GREENBERG: Right. Exactly.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: So, if it's a equipped and train, quaint, I don't think that's a thing. I'll get trained on that. I think it'd probably be -- we'd have to figure out some way to make sure that

people are differentiating and making sure that they're training if there is a difference in the training --

CHAIRMAN RABRICH: Right.

DR. GREENBERG: -- in theory.

CHAIRMAN RABRICH: Okay.

DR. GREENBERG: Hey, this is only -- our agency is only for adults.

CHAIRMAN RABRICH: Right.

DR. GREENBERG: Our agency is for adults --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- and pediatrics. We've trained for both or whatever it is that --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- that we should, that --

CHAIRMAN RABRICH: And I think the process for that already exists at the regional level with the whole, you know, presenting your -- your plan and -- and getting approval. So, I guess what we need, oh, Dr. Murphy.

DR. GREENBERG: It -- it -- I will. And, sorry, Dr. Murphy.

CHAIRMAN RABRICH: Yeah.

DR. MURPHY: Just a quick comment. It really is just an editorial change: remove adults only.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: If you do change it now, the other thing that would work is that an agency in theory can then equip and train at any point over the course --

CHAIRMAN RABRICH: Right.

DR. GREENBERG: -- of the next year.

CHAIRMAN RABRICH: Yes.

DR. GREENBERG: So, if someone was to turn and say there is an education barrier that we won't be able to meet that timeline of July 1st --

CHAIRMAN RABRICH: They don't need to.

DR. GREENBERG: -- they don't need to.

CHAIRMAN RABRICH: Right. Yeah. It's not -- okay. So, I guess what we need would be a motion that the Med Standards Committee supports. I'm -- I'm not making the motion because I'm the chair, but I'm just saying we need a motion that Med Standards supports this and wants to send it to SEMAC. Dr. Cooper, do you have a --

DR. COOPER: Yes. On behalf of the E.M.S.C. advisory committee, we are bringing this motion to the floor of medical standards for advancement to SEMAC. And I will allow my partner and so many things --

DR. GREENBERG: Specific on the motion --

DR. COOPER: -- just second.

DR. GREENBERG: -- will be, to understand.

CHAIRMAN RABRICH: To remove, to strike the -- to include pediatric patients and remove the restrict. Yeah, it's pretty clear there.

DR. GREENBERG: So, you're doing same -- same --

CHAIRMAN RABRICH: So yes, I think what we're saying is Med Standards is the same motion, adding their support to this motion to send to SEMAC.

DR. DORSETT: I second that.

CHAIRMAN RABRICH: Okay. Discussion -- any further discussion on this motion? All right. I --

MS. SHULTZ: Just procedurally, Doc.

So, looking at the SEMAC agenda Med Standards goes before E.M.S.C., so that's proper.

CHAIRMAN RABRICH: I -- I'll bring it as a seconded motion --

MS. SHULTS: Perfect.

CHAIRMAN RABRICH: -- during Med Standard, yeah.

MS. SHULTS: That's fine.

DR. GREENBERG: For the record, can you just read the motion?

CHAIRMAN RABRICH: Yes, I will read them. So, the motion proposed by Dr. Cooper, seconded by Dr. Dorsett, says, motion for E.M.S. for Children Advisory Committee to strongly support the indication for B.L.S. supraglottic airway in the New York State Collaborative E.M.S. protocols and New York State B.L.S. statewide protocols to include pediatrics, pediatric patients, and remove the restriction for adult patients.

DR. WIERZBOWSKI: So, should that actually say --

CHAIRMAN RABRICH: It should say --

DR. WIERZBOWSKI: -- Instead of E.M.S.C., it should say medical standards something?

CHAIRMAN RABRICH: It would say medical, yeah, motion that medical standards supports.

DR. GREENBERG: I don't even think it would be support.

CHAIRMAN RABRICH: Okay. So yeah, same -- same motion just from medical standards as opposed to E.M.S.C.

UNIDENTIFIED MALE: Chair's discretion.

CHAIRMAN RABRICH: Yeah. We're -- we're saying the same thing. Basically, this committee agrees with E.M.S.C.

DR. GREENBERG: I would say I don't think it supports. I would say the -- and feel free to discuss amongst yourselves --

CHAIRMAN RABRICH: Uh-huh.

DR. GREENBERG: -- this is just speaking out loud. It wouldn't be supports, I think it would be to modify that --

CHAIRMAN RABRICH: Right.

DR. GREENBERG: -- medical standards recommends to the modification of the --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- protocols. Like, I'm not sure if it would just be --

CHAIRMAN RABRICH: Recommends --

DR. GREENBERG: -- support thing.

CHAIRMAN RABRICH: Right. Recommends modifying the protocols to -- yeah, I guess, it's -- I don't want to wordsmith this, but it's -- yeah, you could get rid of that. And then it's basically we're saying we want the protocols changed to include the pediatric patients and not adult only.

DR. COOPER: Mr. Chairman --

CHAIRMAN RABRICH: Or should I read it again? Yes?

DR. COOPER: -- if you want to make it really simple, you could say the Medical Standards Committee recommends to the SEMAC that -- that the phrase, you know, for adult --

CHAIRMAN RABRICH: Right.

DR. COOPER: -- patients only.

CHAIRMAN RABRICH: Adults only be stricken from the --

DR. COOPER: Exactly. So that would be the simplest way to handle this. And Dr. Dailey has just advised us a few moments ago to keep it

simple, so.

CHAIRMAN RABRICH: Okay.

DR. COOPER: We're --

CHAIRMAN RABRICH: Well, we're good with that.

DR. COOPER: -- the fact that we advise --

CHAIRMAN RABRICH: So, medical standards recommend SEMAC to strike adult only from the S.G.A. protocol. We still good with that? Still good with seconding it? Okay. Okay. Any further discussion?

UNIDENTIFIED MALE: Remove the dapper?

CHAIRMAN RABRICH: Yeah.

UNIDENTIFIED MALE: Just leave it on as one?

CHAIRMAN RABRICH: You can leave it all as one.

UNIDENTIFIED MALE: Okay.

CHAIRMAN RABRICH: All right. So, we need a vote. And I believe you're correct. I think Med Standards can take a voice vote and then SEMAC will take a roll call vote. Here also?

UNIDENTIFIED MALE: Got to be a roll

call vote.

CHAIRMAN RABRICH: All right. We'll do a roll call vote. Yeah. Okay. That's what I'm being advised. It's fine.

UNIDENTIFIED MALE: Sure.

CHAIRMAN RABRICH: You're always safe doing a roll call vote and you can't, yeah.

DR. DAILEY: One -- one point real --

CHAIRMAN RABRICH: Yes.

DR. DAILEY: -- quickly here first, sorry. It says B.L.S., right? But our intention is not for this to be C.F.R.s. Our intention is this to be in E.M.T. level intervention.

CHAIRMAN RABRICH: Right. But it doesn't change anything that's written regarding --

DR. DAILEY: Right.

CHAIRMAN RABRICH: -- adult home currently.

DR. DAILEY: Right.

CHAIRMAN RABRICH: Right? It just strikes adult. So, it's the same.

DR. DAILEY: Right.

CHAIRMAN RABRICH: Nothing else changes.

DR. GREENBERG: I think the second part clarifies that, so.

CHAIRMAN RABRICH: Yeah. Yeah, I think that's fine. Yeah. Okay, we're going back to the show of hands vote and we will have the roll call at SEMAC. All in favor of this motion, please indicate by raising your hand. Any opposed? Abstentions? All right, the motion is unanimously passed.

DR. GREENBERG: And just for the record and for clarification, so this would obviously go up to commissioner and then come back, but this would be posted immediately, correct, in a modification to the current --

CHAIRMAN RABRICH: Correct.

DR. GREENBERG: -- regulations?

CHAIRMAN RABRICH: Yeah.

MR. GREENBERG: Sorry, protocols.

CHAIRMAN RABRICH: Yeah. Because -- because it is equipped -- if equipped and trained, an agency can choose the time at which they wish to --

DR. GREENBERG: We are just making sure --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- everybody's on the --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- same page.

CHAIRMAN RABRICH: I believe that's the intent of our report. Great. All right.

DR. GREENBERG: Thank you.

CHAIRMAN RABRICH: Next?

DR. COOPER: Mr. Chair?

CHAIRMAN RABRICH: Yes?

DR. COOPER: Mr. Chairman, the E.M.S.C. committee appreciates the indulgence of the medical standards.

CHAIRMAN RABRICH: Yes. Well, this committee --

DR. COOPER: And --

CHAIRMAN RABRICH: -- appreciates the work of E.M.S.C. and --

DR. COOPER: And --

CHAIRMAN RABRICH: -- their recommendation.

DR. COOPER: And the -- the agreement of the bureau to support this to the highest level.

CHAIRMAN RABRICH: Yes.

DR. COOPER: Thank you, Ryan.

CHAIRMAN RABRICH: I think it -- it -- it helps advance the care of our pediatric patients in the state. So, we appreciate the -- the input.

All right. Next item is an update on blood implementation. I don't know if is there an update from the bureau side on this? Ryan, anything on blood? Any update on below where blood's at or on some of your staff?

DR. GREENBERG: Yeah, we can update on the regulations --

CHAIRMAN RABRICH: Gina?

DR. GREENBERG: -- and kind of how they're moving along.

CHAIRMAN RABRICH: Yeah.

DR. WIERZBOWSKI: Yes. So, we have one last approval before it goes into the -- into the process. But hopefully, in the next week or so it'll be all set. It'll be moving through, as we've discussed before and was discussed a little bit yesterday, this package will be going forward as an emergency pack regulatory enforcement package. And -- and enact, pardon me, it's -- I've only had one cup of coffee, so.

CHAIRMAN RABRICH: We understand.

DR. WIERZBOWSKI: So, they --

CHAIRMAN RABRICH: Ryan didn't bring coffee for everyone this morning. We know.

DR. GREENBERG: I brought donuts for everyone --

CHAIRMAN RABRICH: Yes, Joe.

DR. GREENBERG: -- yesterday.

DR. GREENBERG: Five dozen donuts.

DR. WIERZBOWSKI: He -- he did.

CHAIRMAN RABRICH: That was yesterday.

DR. WIERZBOWSKI: You did. So, when a package enters -- a regulatory package enters the process as an emergency, which we feel we have justification for that, it means that at the time it goes out for public comment, it's enacted as an emergency. So, it shaves a little bit of time off.

So, we're hoping that we can get this through in a timely fashion because obviously, you know, we're also working on a policy statement for the interim, for current A.T.S.s, new A.T.S.s, and also to provide guidance to agencies who want to start a prehospital blood administration --

CHAIRMAN RABRICH: Uh-huh.

DR. WIERZBOWSKI: -- program prior to the regulation being enacted. Because we do have statutory authority, so we want -- we've had several inquiries in terms of agents, you know, ground agencies who want to look at starting a blood program and what do they need to do.

So -- so in the interim, we're going to try to get something out for that as well, so that it's not impeding the progress and innovation of agencies to try to do that so.

CHAIRMAN RABRICH: Thank you. I appreciate that.

DR. WIERZBOWSKI: You're welcome.

CHAIRMAN RABRICH: And I know there were members of this committee that were had interest and I know Dr. Dailey, Dr. Isaacson kind of helping develop best practices for implementation of a blood program and so forth. I don't know if -- if either of you have any updates on or if you're waiting for the reg or -- or have thoughts on -- on that?

DR. DAILEY: No, I think, one more time I'll just comment to -- to the way Gina has worked with -- with the department and with the -- with subject matter experts in terms of building

these regs, it's been a fantastic collaborative process. And I really look forward to seeing what comes out the other side, so.

CHAIRMAN RABRICH: Great. Anything you want to say on blood, Doug? Are you good? Okay. All right, thank you. And then our clinical data integrity tag I think has some -- some updates and particularly around airway measures, you've discovered some interesting things?

DR. DORSETT: Yeah, really with the airway measures, what we've been using is as a case example to work through the process. So, if I give a little bit of background, there's a national quality measure quite relevant to the discussion around S.G.A.s, that all invasive airways amongst S.G.A.s are included in this, I have confirmation with waveform capnography.

Using this as an example, when regionally we pulled data from the state site, we had a very incomplete picture from our region. And we've used this as a case example working with a tremendous amount of help from Peter Brody with on the state as well as our colleagues at ImageTrend to -- and Susie of course to -- who knows all things data, to dissect

the process of where the failures occur.

We've actually found failure sort of in all the different components of the system. So, it's a matter of where to start, right? So, the -- the way that -- if we think about my ability at a regional level to say, what is our performance on X by pulling data and then graphing it from the state site, that data first has to be exported from the vendor. It has to be imported at the state. It has to be exported and mapped in such a way that the image trend report writer will pull those things out correctly.

And by looking at our data from both sides, from what we export from the vendor as well as what we can see in the state, we found export failures. Based on schematron failures we found a lot of mapping, we found somewhere there was an import failure because on the transition to three point five agencies that had multiple codes, the vendors didn't provide multiple codes. And so, the agency wasn't actually turned on, so there was no data from that agency at the state.

But then there was a -- the -- some of the report writer issues, one of the low hanging

fruit is mapping. And one of the issues that we don't have, like, defined procedure lists or defined primary impressions within New York State, which creates a problem in mapping and then report writing.

So, what we've decided is like, it's a complex, there's like a lot of different things to tackle. But that's one of the first things that we're going to try and tackle. And so, we've -- we're going to continue working as a -- as a group, and we've assembled some people along the way to work on defined procedural list, primary impression list, really, the list of lists that we can work throughout the state to make this mapping much more accurate.

But in the meantime, we've actually found ways to sort of work around some of the mapping issues and have been able to develop some reports where for now, I actually can see every single advanced airway placement in my region, which I was not able to do the last time we met, which is, I think, a tremendous improvement.

And I think that's a report that's in there that can be shared with other medical directors or other regions if people are interested.

CHAIRMAN RABRICH: Any questions for

Dr. Dorsett or the -- the data group? Great, thanks. Appreciate the work. We will move on to new business now.

First item here is finger thoracostomies for LifeNet Air Medical. I don't know if this is informational, or if someone wants to speak to this or?

DR. DAILEY: Yeah, this -- this is informational. The patient care guidelines from LifeNet of New York come to the Hudson Valley -- Hudson Mohawk Regional REMAC just for review. They are going to be adding this based on a number of patients they've cared for that have gotten needle thoracotomies without great success.

And the expectation that this would then allow the opportunity hopefully, for more live patients to be put in helicopters and brought to trauma centers. This will also be a notification at STAC. And certainly, the local medical directors or regional medical directors for LifeNet of New Yorkers sharing that as well.

CHAIRMAN RABRICH: Okay. Ryan?

DR. GREENBERG: I assume you're talking about for emergency calls? Scene calls?

CHAIRMAN RABRICH: Scene calls.

DR. GREENBERG: Although I guess it could be in facility too, if they develop a tension -- -

DR. DAILEY: For a --

DR. GREENBERG: -- layer on vent.

DR. DAILEY: -- patient who undergoes an emergency or has an emergency.

DR. GREENBERG: So, I'm -- and guessing my question is, so it's an emergency protocol for procedure?

DR. DAILEY: Guideline. They -- they don't operate on protocols. They operate on guidelines.

CHAIRMAN RABRICH: Okay.

DR. GREENBERG: I think, we'll discuss this one further.

CHAIRMAN RABRICH: Yeah. Maybe worth taking offline and --

DR. GREENBERG: Sure.

CHAIRMAN RABRICH: -- seeing, you know. All right, well, thank you for that informational item. Next, there was a couple comments in -- in the discussion about R.S.I.

training and credentialing process. I believe, you know, the current -- I think the way most regions operate is that, right, that the agency medical director basically signs off on their providers who can do R.S.I., that they've met the training and credentialing and then notify the region.

But I know I -- I think, was it you Dr. Winslow? Yeah. So, if you wanted to kind of frame the -- the question?

DR. WINSLOW: Thank you. Yeah, this is a request from the Suffolk County REMAC. I'm just going to read it. So, line one of the New York State Collaborative States regional policy slash procedure determines credentialing of paramedics authorized to utilize this protocol. And under the oxygen and airway management protocol, it states rapid sequence intubation if regionally credentialed.

Suffolk County has been credentialing paramedics to perform the R.S.I. procedure since 2011, and to date have credentialed over five hundred paramedics currently active one hundred and seventy-nine, who have collectively performed over one thousand procedures in the 911 system.

The R.S.I. program in Suffolk County

has a very thorough quality improvement program, which involves the agency medical director, agency paramedic supervisors, and REMAC leadership. All R.S.I. cases are reviewed at the agency level and again, at the REMAC level.

One hundred percent of the cases have been reviewed for over fourteen years now. The regional REMAC policy is that all R.S.I. paramedics must be credentialed by the R.S.I. subcommittee to meeting the minimum standards set by the REMAC.

This is to have a minimum of three years full-time paramedic experience and ten successful non R.S.I. field intubations in their career in addition to taking a difficult airway course and then taking an original R.S.I. training course offered in Suffolk County.

After meeting at the regional REMAC requirements and credentials, the paramedic is then secondarily credentialed at their agency as the agency medical director having oversight over the agency.

You may recall in 2022 when I presented the Suffolk County's R.S.I. program to the SEMAC, which kind of became the foundation of the

current R.S.I. protocol. Other regions in New York State have adopted our regional policy on R.S.I. and our continuous quality improvement process, I believe is a best practice.

Recently, several physicians in Suffolk County have questioned whether a regional REMAC rate credential a paramedic to perform R.S.I. or even to set the minimum standards. This is a regional policy. Currently, there is a regional policy on R.S.I. paramedic credentialing that we have had in Suffolk County over the last ten years. It is updated periodically with the involvement of the entire R.S.I. subcommittee and the REMAC.

In Suffolk County, there is a regional approach to R.S.I. as there are many instances where R.S.I. is requested as a mutual aid from one agency that doesn't have a provider that can perform the skill. We also have both ground paramedics from twenty-six different E.M.S. agencies and the Air Medical Program paramedics performing the R.S.I. procedure in the same fashion and under the same quality improvement system, and this works well in our region, and also allows for a paramedic to be credentialed to provide the procedure at several

agencies, as many agency -- as many providers work in multiple agencies.

At the last meeting of the Suffolk County REMAC, a motion was made by the R.S.I. subcommittee chair that all paramedics in Suffolk County are required to be credentialed by the R.S.I. subcommittee. The motion passed seventeen to zero with three abstentions. I asked for clarification from the SEMAC on whether or not the Suffolk County REMEC may credential R.S.I. paramedics in our region.

CHAIRMAN RABRICH: Thank you. I have an opinion, but you know -- and I know other regions do different things, but does anyone want to speak to that? I guess, your question is, is it -- can -- is -- is it the regional subcommittee that can credential them, or does it reside at the agency medical director level? Is that --

DR. WINSLOW: The question was may Suffolk County REMAC credential R.S.I. paramedics in our region. That was the way the motion was read.

CHAIRMAN RABRICH: Okay. Anyone want to offer an opinion or discuss, or, I know Ryan's being very quiet at the moment, but. Dr. Dailey?

DR. DAILEY: I think quite frankly,

that if all of the medical directors in that region have come together collaboratively --

CHAIRMAN RABRICH: Uh-huh.

DR. DAILEY: -- and develop a standard, that group can then credential.

CHAIRMAN RABRICH: Yeah.

DR. DAILEY: I think that, to me, is very reasonable and is the establishment of a system. It's not the REMAC unilaterally saying we are going to credential, it's the collaborative group of R.S.I. credentialing medical directors saying we will accept each other's credential. We will create one standard that that credential will be born from. And therefore, it actually is each individual agency working as a team.

CHAIRMAN RABRICH: Yeah. Other thoughts? Oh, Dr. Berkowitz, and then we'll -- we'll go to -- yeah.

DR. BERKOWITZ: I'm happy now.

CHAIRMAN RABRICH: Yup.

DR. BERKOWITZ: Yeah, so I think it -- it -- it sounds like what you're saying is the program agency may credential and the agencies themselves.

DR. GREENBERG: The REMAC.

DR. BERKOWITZ: REMAC, sorry.

CHAIRMAN RABRICH: REMAC. REMAC.

DR. BERKOWITZ: Okay.

CHAIRMAN RABRICH: Yeah.

DR. BERKOWITZ: The program agency definitely doesn't --

CHAIRMAN RABRICH: Right.

DR. BERKOWITZ: -- credential. The REMAC may credential --

UNIDENTIFIED MALE: Maybe facilitates.

CHAIRMAN RABRICH: Yeah.

DR. BERKOWITZ: Maybe facilitates the credentialing fund. The -- the -- and the agency itself may credential so doesn't -- doesn't preclude the agency.

CHAIRMAN RABRICH: Right.

DR. BERKOWITZ: So, the question is --

CHAIRMAN RABRICH: And they may be aligned, those two.

DR. BERKOWITZ: And they may be --

CHAIRMAN RABRICH: Yeah.

DR. BERKOWITZ: And hopefully --

CHAIRMAN RABRICH: Yes.

DR. BERKOWITZ: -- as Mike said, they should be --

CHAIRMAN RABRICH: They are aligned. Right

DR. BERKOWITZ: They should be -- they should be -- they should be aligned. It should be the same standard.

CHAIRMAN RABRICH: Yeah.

DR. BERKOWITZ: But it's -- it's about the standard and not about who's doing.

CHAIRMAN RABRICH: Right. And I think a region can certainly create a standard for their region of how care should be administered. Right. Maia then Don.

DR. DORSETT: I just want to add a clarifying question. If the region has not credentialed somebody to do this, and you have a regional policy around credentialing that everybody has agreed to at the REMAC, and you get a new medical director who thinks, you know, Jane Schmo paramedic is like phenomenal R.S.I. and wants the credential independent of the process, agreed upon a region, what is the power of the region to prevent that provider from being credentialed at that level?

Because I think this is a significant patient safety issue where the standards, I think we learned, like, I mean, we had a very similar process. We thought that our process was great. We started looking at our airway measures and our performance on peri-intubation, hypoxia and hypotension. And we realized that we were not as great as we thought we were with even the degree of attention and the amount of work that we do -- did to improve that. And where we have significantly improved that over the last five months as part of participation in the airway collaborative designing that process at an individual agency level, I think is frankly dangerous.

CHAIRMAN RABRICH: Thank you.

DR. WINSLOW: If I may?

CHAIRMAN RABRICH: I think yes, I think Don wanted --

DR. HUDSON: No.

CHAIRMAN RABRICH: No, go ahead.

DR. WINSLOW: Thank you. That was exactly our point is we have collective data now of a thousand intubations. If you look at one agency, one agency may do one a year or two a year. It doesn't allow you to look at it.

So, it really can't be just an agency looking at this for patient safety and that was our concern. We set the minimum standard as a regional REMAC policy and allow for agencies to abide by the policy. It -- we -- we were challenged by some agency medical directors who wanted to go below this minimum and we -- we disagreed.

CHAIRMAN RABRICH: I -- I think it's pretty clear that regions can set a minimum standard.

UNIDENTIFIED MALE: That's going to be --

CHAIRMAN RABRICH: That's -- yeah.

DR. GREENBERG: So, I -- I think there's a significant, there's -- there's several things that are going on in the conversation. Can a region say standard? I will tell you, I believe, that they can say standard, I think, and a lot of what we're hearing more in that collaboration of, you know, fifteen medical directors coming together, setting a standard is there, can an agency credential their providers? Yes, an agency could credential their providers. An agency may be asked by the region to credential their providers based on a standard set by a region. I think that would be

appropriate.

Or an agency may ask the region to perform the credentialing on their behalf, which I know we've seen, I know in -- in certain regions like the southern tier that -- that -- that happens, there is credentialing that happens by the region for the agencies because maybe that agency only does or only has four paramedics, and they feel more comfortable with it.

But we have agencies that have, I don't know, Doug, you have a thousand paramedics? Probably fifteen hundred? Higher?

DR. ISAACS: Fourteen hundred.

DR. GREENBERG: Fourteen -- fourteen hundred. Oh, down up, no. Training a hundred and fifty each year. So, I -- I think there's -- there's a variable there of setting a standard and then the -- the word of credentialing, we won't get too deep into that one.

But the question becomes who can do credentialing? And so, I think that becomes more of the question that's out there now of if the standard is set by a region, then who can do the credentialing? And are there options? And I'd

probably say, yes, there are options. Some may choose to use them. Some may choose not to.

CHAIRMAN RABRICH: Yeah. And I think the question comes down to, rights, that a group of physicians have gotten together and decided that this is -- this is the minimum standard. This is how we want this performed in our region.

And then, you know, having an agency -- - does the agency have an ability to say, well, I don't, you know, I know you're all full of it. I'm going to do my own thing and make my own standard. I think that's where we've run into a problem, right?

Because I think we all agree from a medical point of view that if a group of physicians have gotten together and discussed this and decided this is the best practice and how we want this performed in our region, then the agency should have to at least meet that. I'm not saying they can't credential on their own, but they should meet that standard. I think Mark wants to say something.

DR. COOPER: Yeah. At the risk of opening a can of worms, which has already been opened, by the way.

CHAIRMAN RABRICH: Yes. It's too late

for that, yeah.

DR. COOPER: You know, there is a distinction between credentialing and privileging.

CHAIRMAN RABRICH: Uh-huh.

DR. COOPER: And every hospital gets into this issue that a -- that an individual can be, you know, generally credentialed on the basis of education, training, experience, et cetera, et cetera, et cetera. But what specific skills they are -- they are authorized to perform within -- within that, you know, or under the umbrella of the general credentialing, you know, is something that's important.

And -- and -- and -- and it -- it -- it -- you know, one could argue that you know, given the relatively limited number of skills that -- that are available to our prehospital colleagues that, you know, that credentialing and privileging are essentially the same.

But, you know, when you get down to an issue, for example, in a -- in an area where there are relatively few, you know, advanced life support providers, as an example. You know, and there's an issue with a particular privilege or performing a

particular privilege, you know -- you know, it's -- it at the present time.

We kind of have an all or none situation that, you know, you're de credentialed or you or -- or not, where -- whereas maybe, you know, you -- you -- what you really want to do is say, listen, we need a restriction on this particular privilege until such time as there some kind of retraining, what have you, what have you, you know.

So, I think that whatever we do with this, I think that distinction needs to be squarely addressed. And I don't know that we've actually really gotten into the -- the -- the subtle differences between credentialing and privileging, you know, in this -- in this, you know, body at the -- in the past.

But it's something, I think as we become ever more sophisticated, you know, with the -- with the, you know, the -- the broadening scope of practice with which, you know, we're all familiar, I think that's an issue that really does need to be addressed at some -- in some way. Thank you.

CHAIRMAN RABRICH: And I think you're right. We've -- we've kind of circled around this

issue for a couple years now with credentialing and what is credential, but you're right, right. Like a -- if you want to look at this at like the physician level, there's a D.O.P., right?

There's a delineation of privileges and a hospital can set, you know, these are requirements for you to be privileged for this particular procedure or technique, right? So, yes, that's a good point.

And I think that we could look at R.S.I. as this is a privilege, right? That you -- you can practice as a paramedic, but this privilege has to meet the standard set by the region. And then, you know, I -- we're not going to solve it today, but, you know, maybe there needs to be a discussion about, you know, Ryan, if we -- if there is some regulatory change we need to advocate for, because I think we all believe that there should be a standard, right? That's set by a group across the region.

But if there's something limiting us from doing that, and we need to go in a different direction, whether it's regulatory or -- or legislative or something, then I think that's

something we need to know and -- and move forward with.

DR. GREENBERG: And I -- I got to -- I'll say, I think this is, you know, the right time and there's a number of things that keep coming up, but also related to more advanced skills, more things that are moving forward, the -- the timing of the different things -- look at that, the alarm's gone off for the time.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: That it's the right time and place for it. So, if you'd like, we can also at the bureau side, we can look at that between now and next meeting and then --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- maybe get back to you.

CHAIRMAN RABRICH: I think that would be good. And if we need to set up a small working group or something to report back, I think we can do that as well so.

DR. GREENBERG: That'd be great. Thanks.

CHAIRMAN RABRICH: Dr. Berkowitz?

DR. GREENBERG: Dr. Berkowitz?

CHAIRMAN RABRICH: Yeah

DR. BERKOWITZ: Just -- I just think that the -- every time we talk about this, I always think the national scope of practice model is the -- the -- a foundational document to help guide us. And I would recommend that, you know, any -- anyone, you know, wanting to explore this -- the, you know, look at that because that is, I think that's -- that sets out a lot of clarity. I think it's helpful.

CHAIRMAN RABRICH: I think it is. And I think it'd be helpful to have a member of training at ED on that group as well. Mr. Hudson, you were going to say?

DR. BERKOWITZ: It's amazing how training is --

DR. HUDSON: Yeah. I mean, admittedly, right, we've all been dancing around this for way too long so.

CHAIRMAN RABRICH: Uh-huh.

DR. HUDSON: Nassau specifically is waiting on a D.L.A. opinion for very much like this. And again, it's to read between the lines and be a little bit, probably terse, the question is not one

of the duties of REMAC, but the authority of REMAC. And not when everyone will cooperate, but what happens when somebody goes rogue.

So, we need an answer to that. And I know everything's been held up understandably by budget and everything else, but now's the time.

DR. GREENBERG: I would agree. Just to fully understand or have clarity from this group as a body, the understanding or the part that we're trying to achieve is for a REMAC to set a standard, fill in the blank, whatever that might be for, and for the opportunity for credentialing or applications, fill the blank, whatever you want to use that word to be, to be done either by a region if they're doing it collectively, or an agency medical director who is agreeing to follow the standard set by the region.

DR. HUDSON: I -- I -- I would suggest to the group, and again, remove the medicine from it. Just -- I think somewhere is, right, there's -- there's the authority for a region to make an emblem or a patch.

UNIDENTIFIED MALE: No more patches.

DR. HUDSON: But -- well, only because

it's such a material thing that we can all just say, okay, so here's the regional patch. That's not the problem. It's what -- what happens then when somebody won't wear the patch?

What is the authority of that region to enforce that? And then that would touch not only uniform operations medicine oversight. I mean, it's the same answer, regardless. What do we do when somebody won't?

DR. GREENBERG: And -- and I think that's the -- the second part of it that comes with it. I just want make sure what we're looking in to follow that we're on the same page.

CHAIRMAN RABRICH: I -- I think what you stated is correct.

DR. DORSETT: I think it's a little bit modification and I'm just going to open the can of worms bigger. I think if we're going to reopen this, I think we need to look. I know there's lawsuits and stuff about their ability of the region to credential, because like, for example, there is multiple levels of credentialing.

So, as an agency medical director, I can credential people to do things at the agency.

But I think having regional oversight about the safety of people to practice, because right now the reality of what happens is somebody gets put -- does dangerous things, they get put on a performance improvement plan, even if it's referred to regional patient safety and they identify things, they can make recommendations, but they don't have the power to do credential. They have to go and it has to go through a state thing.

And so, people who are doing dangerous things, demonstrating poor clinical judgment, who are not complying with plans that are about patient safety, just rotate amongst different agencies because everybody wants somebody with a pulse who's going to respond to a call.

And I think we are so afraid of like things because of things that have happened that we haven't given REMACs, like at least regional oversight who actually like, know these people have data, have -- right, these patient safety issues to say, you are not safe to practice and you cannot practice until you comply and have a good cooperation from that regional level to the state. Which, I mean --

CHAIRMAN RABRICH: Right.

DR. DORSETT: -- like the state, I've had cases, right, where the state has been effective in restricting somebody's privileges. But it took a long time and that person circulated in our system doing things that were not safe for patients --

CHAIRMAN RABRICH: Right.

DR. DORSETT: -- for a long time. And I was not the medical director of those agencies. And there's also a limitation and liability as a medical director of me calling another medical director and saying, don't hire that person, right? There's a deprivation of liberty, potential risk and so on.

CHAIRMAN RABRICH: Yeah.

DR. DORSETT: I -- I think we have to be -- we have to give, say, we're here to ensure safe and effective and quality patient care and what are the safeguards that we have to be able to do that.

CHAIRMAN RABRICH: Yeah. I -- I think that's a key point. And I think, you know, to your other point, there is a process, right? The state has a process to -- but it takes time, right? Because there's a whole due process and

investigation, right? And it takes them time.

So, I think what we're saying is how does a region safeguard their patients in the interim, right? While that -- the state will be going through that process. But the regional concern is we -- patient safety while that's going on, where one agency medical director may know this is a real problem and I've restricted him here, but I can't stop it anywhere else.

And I know the state's doing what the state does, but it's going to take time. Ryan?

DR. GREENBERG: Did anyone else have a comment first? No? So, there is a process in the state. It does take time depending on what it is because it is due process.

There is a faster process for significant things that happens several times a year when things are more egregious than what it is. And I -- I've had this -- and I understand the frustration that comes with this, right?

I'm not -- I'm not going to argue the frustration. I'm not going to argue the frustration of sometimes how long something can take. But what often comes up is, you know, the way that -- that we

look in -- in several different things.

You know, if -- if any of you are a physician in one hospital and something happens in that hospital and you moonlight at a second hospital, what happens when you do something wrong at one hospital?

And I'm asking the question, do you immediately get restricted at all of them, even though you might be a bad provider? And I don't mean you might, just in general, if -- if -- if there's -- if there's a doctor who's a bad provider and they get restricted at one hospital, my question for this group, and I -- I would like you enlighten me, what happens to the job that you moonlight at?

DR. DORSETT: It's only when you apply for a new one. But I don't think -- I think that there's things that are dangerous in physician credentialing, and there's people who shouldn't be doctors who still get to be doctors, but I have no control over that.

But I do have, right, around the region, we know people who are doing, and I think it's -- there has to be due process at the region. It's not like the region just decides. I think for

the -- the REMAC to take the responsibility on this, right?

Like, it goes through a regional patient safety. There is a due process review, there is a concern. It's brought to the regional medical director. It's discussed. And it's -- it's by no means super-fast, but I think you need to be able to have a temporary restriction of privileges to safeguard patient safety.

And I don't think that regions take this lightly --

CHAIRMAN RABRICH: So, the commissioner has that power, right? And that's usually where that happens if it's egregious, right? Whether it's a physician, a paramedic. The commissioner can immediately suspend someone's ability to -- to practice. But --

DR. GREENBERG: Very quickly.

CHAIRMAN RABRICH: Well, right.

DR. GREENBERG: Within --

CHAIRMAN RABRICH: Well, not -- not in a normal process.

DR. GREENBERG: Not months, absolutely.

CHAIRMAN RABRICH: Very fast. Yes.

DR. GREENBERG: And -- and by the way, and happens a couple times a year.

CHAIRMAN RABRICH: Right. But you know, that's -- that something has to rise to a certain level for that to happen. I think there's concerns about these people that, you know, we know there's issues and it's dangerous, but --

DR. DORSETT: Yeah, I'm talking about the people who beat people up on video.

CHAIRMAN RABRICH: Yeah.

DR. DORSETT: I'm talking about people who have consistent issues with their clinical judgment or procedural skills or something that is a clear pattern who say, we need to work on this because we have to take better care of patients.

And when you say, we need to work on this, they're like, see you, I'm going someplace else, and they continue and there's no way to say like, no, you actually need to work on this, it's a consistent problem.

CHAIRMAN RABRICH: Yeah.

DR. BLACK: Specifically, the physicians though. If a physician has their

privileges suspended at a hospital greater than thirty days, it's reported to the National Practitioner Data Bank. And that is pushed to all hospitals who subscribe to that physician.

So typically, when a physician is credentialed, their medical staff office is subscribing to that physician and they get notified. Any lawsuit action that is finalized also goes to that. So, a hospital will be notified if an action is taken at different hospital, greater than thirty days.

COURT REPORTER: Can you say your name, please?

DR. BLACK: Dr. Black. Kirby Black.

COURT REPORTER: Thank you.

DR. BLACK: SEMAC member.

DR. GREENBERG: And if an action is taken against a paramedic as well, just in case you know, we report that same database as well.

DR. DOYNOW: So, just one quick comment here. Mike and I have been around for a long time, and for years -- no, I hate to say how long.

CHAIRMAN RABRICH: You're saying they're old.

DR. DOYNOW: Yes. Unfortunately. For years, REMAC basically had the power to credential paramedics, credentialed medical directors. And then for regions aren't quite clear, a few years ago that power was more or less removed, and the way the law was interpreted that the medical director had the ultimate authority.

I think we really need to think about moving back to the REMACs having that authority because it's a group of knowledgeable physicians, not just one person. And probably would give the paramedic better due process anyway because it'd be more than one opinion.

So, I don't know, Ryan, if there's a way to -- to go back to that model.

CHAIRMAN RABRICH: Yeah. I think that's part of what we have to kind of look into before the next meeting, right? And that -- that plan of discussion --

DR. GREENBERG: I think that would all be inclusive in that and looking at that and things like that. I just -- again, I -- I bring it up is, you know, whether it's a nurse, a physician or something else, there -- there's very few other

medical professions that, you know, can get restricted on a dime, you know, immediately in multiple places.

And -- and we really need to look at it at the more global level. And -- and I would even say at the state level, because look, reality is -- is that -- that -- that -- let's say you had the authority. Let's say tomorrow, we say, you have the authority, somebody does something wrong, whatever that might be, you can restrict them.

It doesn't stop them from going to next county over. But yet, if they lose their state certification or restrict their state certification or something of that nature, it does from a state level, so.

CHAIRMAN RABRICH: I want to -- yeah, I want -- I know Dr. Winslow has had his hand up for a while, so Dr. Winslow and then we'll get back over here.

DR. COOPER: Yeah. I've been in -- I've been on Suffolk and the REMAC for twenty-four years. And the way the process used to work was, if there was a serious patient harm concern, such that the agency medical director notified the bureau and

began an investigation, that case was brought to the REMAC Q.I. subcommittee for a closed-door discussion and every agency medical director is a member of that group.

They're allowed to make an independent assessment of that case, even if it was in a different agency for the next patient that that person should take care of. That has been put on pause after the policy statement was rescinded with, quite frankly, no information attached to it.

Ryan, if there's been a legal case for which we can then learn something, it needs to be shared with the group, so that we can adjust our regional policies.

DR. GREENBERG: I think that all falls in line with --

CHAIRMAN RABRICH: Yup.

DR. GREENBERG: -- kind of the discussion and happy to come back with it.

CHAIRMAN RABRICH: Dr. Berkowitz, Dr. Dailey.

DR. BERKOWITZ: So, just real quick. So, I have the pleasure of being involved in -- in multiple regions and being in involved in, you know,

quality concerns in -- in all -- in all of them, frankly. And one of -- one of the things I can say from my experience is that, there is a tremendous amount of heterogeneity between the different regions and how they approach concerns regarding patient safety and quality.

And this -- this -- we -- there should not be heterogeneity, you know, although I -- you know, that the -- the -- there should be a common approach that is similar and everyone does it differently. And I don't know how that's in the interests of our patients, nor in the interests of our providers if every region approaches it with their own way.

CHAIRMAN RABRICH: Dr. Cooper. Well, sorry. Go ahead.

DR. GREENBERG: And I will also stress, and I know it's come up a couple times. If ever there's a patient harm issue, it should immediately be reported to the state. So, just want to make sure that's out there.

DR. COOPER: Thank you. The statement was just made a few moments ago that -- that if there is a physician, you know, harm issue, that it gets

reported immediately to the National Practitioner Data Bank. That is true.

However, unless one is up for, you know, re-credentialing, as Dr. Dorsett pointed out, even the hospital across the street may not -- may -- may not have a clue that something has changed in the National Practitioner Data Bank, right?

So, they would have to become aware that -- that that had been reported. And it -- it's, you know, that's sort of similar to what we do, you know, at the beginning of every REMAC and REMSCO meeting where we report on the, you know, the -- the disciplinary actions that have been taken, you know, by the state.

That's the requirement to do that at every, you know, REMAC, REMSCO meeting now, as we all know. But again, how many of the, you know, agency medical directors necessarily, you know, are aware of what took place at a REMAC, REMSCO meeting or read the minutes.

So, it may not be the case that -- that -- that folks in the region necessarily understand that there has been, you know, some sort of restriction placed. I -- I just point that out

because it's not as though there's no mechanism, but it's also not as though it's a mechanism that necessarily moves as quickly as it needs to move in certain circumstances.

So, I -- I -- I'm just adding my voice to all of those who say, we need a resolution to this, and we need it as soon as we can get it. Thank you.

CHAIRMAN RABRICH: Yeah. Yup. I think -- I think we've gotten some good feedback about kind of the focus on this, and between now and the fall, we will do some work offline to see what recommendations we can come back with to accomplish what everyone's saying, so.

All right. Next item is, there was an offline discussion over the last couple months about Cyanokit shortages, and they're really not being an effective alternative. So, I don't know how much of a discussion we want to have. I think it's more just for awareness. I mean, people want to share as -- or if it's particularly bad in certain regions or what people are doing right now, or -- or you know, how the current supply is. I don't know. If anyone wants to comment on the Cyanokit. Yeah, Doug?

DR. ISAACS: My understanding from speaking with the manufacturer directly several times over the past month or two, they're up to -- up to speed in the manufacturing. So, that really -- that shortage should really -- should not be so much anymore. Are there regions still having trouble acquiring the medication or?

CHAIRMAN RABRICH: I think there are, but I'm seeing a lot of nodding around the room.

DR. GREENBERG: I think there are, but I think if that change has happened recently where they're back up to, I think --

DR. ISAACS: It started at the end of January, but I just spoke to them yesterday. And they -- they said that really -- there really shouldn't be any more shortages.

DR. GREENBERG: So, I think -- I think the -- the word back would be to, if any region is having a problem to maybe follow-up with them and maybe they can move up in the priority list. I know we've gotten some ask related to it, and we said without, you know, an F.D.A. approval to use an expired medication or something of that nature, then you have to go based on what is on the -- the

documents., but I know that there was also supply chain issues.

DR. ISAACS: Yeah. One of the things manufacturers sends them to the distributor, so really, that might be kind of like the -- the middle middleman issue potentially.

DR. GREENBERG: So, maybe a follow up in --

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: -- in the fall?

CHAIRMAN RABRICH: In the fall and see where we're -- how people are doing. Yeah.

DR. GREENBERG: Yeah. I -- I think your information could be critical though. I'm just -- now is the time to follow up with your distributor or whomever, because they might have the stuff back in stock.

CHAIRMAN RABRICH: Yup. Thanks, Doug. All right. Next, before we get to the training and that input thing, there was a -- there was a also offline discussion regarding the glucagon pilot. And then the kind of the discussion that was had at the last meeting of this group before this meeting was, you know, is this a pilot?

Do we continue with it as a pilot? Or because I.M. injection as a B.L.S. skill already is this something that could just be added as a protocol? So, I don't know. Did you want to add -- maybe if you give a little background about kind of how this came up and what the need really is?

DR. COOPER: We've -- we didn't -- so, this came from Suffolk County, and we would have to apply to the bureau for permission to be a pilot program.

But instead of going through an approval process for something as simple as moving the scope of practice from the A.E.M.T., which gives I.M. glucagon to the E.M.T. if equipped and trained, maybe it's easiest to move it in protocol as opposed to going through the process of what happened with the Hudson Valley and the i-gel project, which was a lot more involved, but I didn't want to delay the ability to give I.M. glucagon to our B.L.S. providers who already have the ability to check a blood sugar, give I.M. injection and do this in seven other states.

So, it was a discussion I'm gathering from the way the previous discussion about the

collaborative rollout is it is too late in this cycle. So, I'm going to recommend that the collaborative protocol group add this to the next generation to make it in protocol. And we will do the pilot program for one year and report back to the group. But that was -- should chunk it to the discussion.

CHAIRMAN RABRICH: Okay. Any comments? Feedback? I did, you know, because in my own experience, right, I haven't given -- it hasn't been that often that I've needed to give glucagon.

So I was, you know, I had a question like, what's the need? Like, how often is this happening around the state? So, I -- I did actually ask Peter to -- to take a look at some 2024 date if he could.

And I just think those num -- what he was able to find is a little interesting that I thought maybe we would just share that with the group just for perspective, and then we certainly can -- can move that forward.

So, I will wait for Peter to come to a microphone and then basically just give us some -- again, it's -- it's not perfect data, but it's just

an idea of utilization that we've had.

DR. BROODY: It was a fun exercise for a Tuesday night though.

CHAIRMAN RABRICH: We appreciate your efforts.

DR. BROODY: And for the record, I'm Peter Brody, the Branch Chief of Data and Informatics in the Bureau. We looked at this from two different perspectives.

The first was, how much glucagon was administered in 2024 as documented. Currently there are one thousand five hundred and sixty encounters that we identified across the state as receiving glucagon. We looked to see what the triggers were. For that, we followed the protocol backwards to be able to identify that.

When looking at how many B.L.S. transporting agencies, we kept it to transporting because there might be some reimbursement to cover the cost of glucagon. From June until December, we found approximately eight hundred and ninety encounters where a patient had a blood sugar of sixty or less and had a G.C.S. of twelve or less for about eight hundred and ninety.

If you project that back a little closer to January, you might run upwards of slightly over a thousand statewide.

CHAIRMAN RABRICH: Thank you. So again, numbers that I think are a little higher than I initially thought we'd see, but just -- just informational for the group and something to think about. Yeah, we'll go to the collaborative for discussion, and I believe Suffolk is going to proceed with the -- the one year -- no, will it only be Suffolk County or similar to i-gel? Could other regions participate if they chose to?

DR. WINSLOW: When we -- when we put the application into the bureau, we'll open it up to other regions. I'm just going to put a one-year timestamp on it --

CHAIRMAN RABRICH: Uh-huh.

DR. WINSLOW: -- so I don't run into multiple years. I will tell you, in our region we looked at this; there were twenty-six patients who would have benefited. It is small numbers, but it's in scope of practice, and I don't think this is a huge lift. What's the downside?

CHAIRMAN RABRICH: Yeah, I think it's

-- I think it's training on the medication, right, and the cost because glucagon's not cheap, but again, it's if -- if equipped and trained, right?

So, any other comments on the glucagon? Or if not, we'll move on to the next item.

It came up in discussion about having training ED input specifically to that issue, speaking to scope of practice and any specific training needs with protocol rollouts to have a -- a more formalized process for T&E kind of review and input into the protocol updates.

And while we -- the collaborative group does have some members of training an ED who also participate in the collaborative group, we thought that timing would be, you know, maybe after the December SEMAC SEMSCO meeting of each year when the protocols are generally first introduced and discussed, and prior to the February meeting where they get voted on, that we'd have a -- a formal review of the draft protocols by training an ED to offer any feedback on knowledge gaps, training requirements, scope of practice issues, et cetera. I don't know.

Don, did you want to add anything to

that?

DR. HUDSON: Yeah, so I mean, that's the recommendation. It's just -- it's just a checkbox in the process. So, I think it's an easy addition and an easy lift. And just to illustrate how that works is, so the question of B.L.S. intramuscular glucagon, right? We're over the hump with, we know E.M.T.s can safely use syringes and reconstitute and utilize vials, drawing off medications. Thank you, COVID.

If anything good came of that, we had that come out of that for immunizations at the E.M.T. level. Then following that through the E.M.S. education standards and, you know, the publishers and what's commonly out there, the only nuance of the missing piece would be glucagon's not really mentioned per se in the indications contraindications, right, all -- all the rights and wrongs.

So, that's where, if trained and equipped, would regionalize that process, which is what I think we all want and assure that there's some education where those voids can be filled. So, I -- I think we're in a good place.

DR. GREENBERG: Dr. Chair?

CHAIRMAN RABRICH: Yes, sir.

DR. GREENBERG: On that same front, I would say that the division would greatly appreciate it, a more streamlined process. I know that as these protocols come out, we get asked on a regular basis. Is Dr. Dailey or Jeremy coming out with anything anytime soon?

And, you know, we wait for what the region decided to do for that rollout. I will also say that we are happy to help support in any of those initiatives providing Vital Science Academy as a platform for everyone, which all providers can access and things of that nature and move forward from that front.

CHAIRMAN RABRICH: Thank you.

DR. HUDSON: Well, and -- and to that, I mean, it's this validation through training an ED and national scope of practice and E.M.S. education standards that we can weigh, you know, so this has got to be a statewide rollout per se, or is this not a huge substantive change?

It's just a, you know, procedural one, and that can be regionalized or agency based if they

so, you know, are compelled.

CHAIRMAN RABRICH: Yeah, no, I think that'll be helpful to streamline the process. Thank you. We do have a little time left and we happen to have a group of paramedic students here. So, we thought I'll let Ryan introduce them, but we thought it would be good to give them the opportunity to pose some questions to this group and to the physicians of this group regarding E.M.S. practice, so.

DR. GREENBERG: So, we have had a lot of input in yesterday, but one of the things is, so B.M.C.C., Bureau of Manhattan Community College, Megan's program is here, the paramedic students, that's this whole wing of uniform personnel over here.

Our half of her paramedic class who have come up to state council, the other half is actually sitting in the classroom watching us live from The OWL.

And you know, yesterday there were a lot of really good questions. I had the opportunity to speak to them outside what their thoughts were, you know, what's some input. And at the end of the day yesterday, we asked them to say, can you pick one

or two people to come up and ask one or two questions that you may have after watching this to our medical standards group? This is the future of our paramedics.

This is, you know, we're excited to have them here to see the regulatory process and the things of how things change and how, you know, approval processes happen and everything else. And so, we thought the opportunity to speak to the -- the medical standards group at a state level, they've been to, I think, their REMAC and their REMSCO as well.

And so, this is their exposure to the state standard. And so, if you don't mind, we'd like to invite, I'm not sure who they decided to come --

CHAIRMAN RABRICH: Yup.

DR. GREENBERG: -- speak. Tucker -- Tucker spoke yesterday, so he wasn't allowed to speak today.

CHAIRMAN RABRICH: Yeah.

DR. GREENBERG: So, I just wanted to come up --

CHAIRMAN RABRICH: Yes, we -- we welcome you and we are, you know, it's great to have

you here participating, and this is your opportunity to speak to the E.M.S. physicians of the state and ask your questions. So, we look forward to -- to hearing what you guys have.

DR. GREENBERG: Just please make sure when you first speak, to state your first name and last name.

CHAIRMAN RABRICH: Yeah.

DR. HUDSON: I like it already that you have a pen and pencil rather than a tablet, so I like it.

MR. WONG: Well, the -- the paper was free, so why not?

DR. HUDSON: I'm on board. Go with it.

MR. WONG: My name is Jeremy Wong. As stated before, I'm part of the B.M.C.C. paramedic program. Just give me one second. Sorry. It's a -- it's a little -- it's a little scary talking in front of so many people.

DR. GREENBERG: The paper has to reboot, so.

MR. WONG: Yeah. It's --

DR. GREENBERG: He's going to turn the

page.

MR. WONG: It ran out of battery. So, I -- I guess I'll start with my takeaways from yesterday and this morning. Coming from my experience as -- as an E.M.S. provider, which is not extensive by any means, it's nice to see the process of change and, you know, that change does, in fact, happen.

A lot of the times we're in the field, you know, we ask questions like, why can't we do this? Why can't we do that? You know, and a -- a lot of the frustration ends up being, it's not that hard to make change, right?

So, it's -- it's good to see the process and understand why sometimes it takes a longer time for -- for these protocol updates to come out and everything like that. Yeah. And it's a -- it's a good experience. I feel like a lot of paramedic programs should be doing, you know, be part of the meetings to some degree, whether or not in person or back at home. You know, it's -- it's a good experience for medics to have just to see what -- what, you know, they are doing and how it works.

My question to the group is, in my --

my experience and my colleague's experience, A.L.S. providers are required to attend in-person C.M.E.s to -- with a physician to recertify their cards. And that kind of brought up the idea of, on the flip side, should there be a requirement for medical directors to be involved in the field -- actually in the field work with the providers that they are overseeing?

CHAIRMAN RABRICH: It's a good question. Yeah. Yeah.

MR. WONG: I know it's not the easiest thing to implement. And I -- I trust that you guys have a hard enough job as it is, but a lot of our thought was, if we can see our medical directors in person, if we can work with them in the field, then we kind of get a better sense of what should we be doing --

CHAIRMAN RABRICH: Uh-huh.

MR. WONG: -- in these very difficult calls. Like, sometimes I'll get calls with my preceptors and they're like, that's a great question you asked. I don't know the answer.

CHAIRMAN RABRICH: Uh-huh.

MR. WONG: And then we'll just mull

over it for a little bit, and then I'll forget about it the next week.

CHAIRMAN RABRICH: Yup.

MR. WONG: So, I just want -- want to get your input on it.

CHAIRMAN RABRICH: Yeah, yeah. So, that's a great question. I think there are several medical directors on this table that tell you they do that and want to do that, but you know, I'll open it up for discussion.

But I -- I personally would agree that that is the best way to interact with providers and to understand what they're dealing with in the field and you know, it's like live C.M.E., right? Like, you do a call together and discuss it. And it -- it's interesting that, you know, you bring that up, which is a great question.

I think sometimes we -- we tend to just our presence can be intimidating to some providers, or they're -- maybe not all -- all field providers agree with what you just said, but I do think it is a best practice and I'll -- I'll open -- I -- I knew Maia was going to have a comment on this, but I'll open it up for discussion.

DR. DORSETT: I -- I have, sir, two comments. I think requirement is a hard thing to get to, but I think it's something to aspire to. I can say for part of the process of board certification, E.M.S., which is not a requirement because a lot of agencies wouldn't have a medical director right now because of the -- the number of E.M.S. physicians.

Part of that is actually you have to do time in the field. And that just like you have to log procedures that you have to do in the field. People who go through an E.M.S. fellowship actually have to log things that they have actually done in the out of hospital environment.

And as somebody, I'm a little bit of a -- aware, lots of times when you become an E.M.S. medical director, you were a paramedic or an E.M.T., and that's what drew you to that. I was never that.

And so, there was no more valuable experience that I had during my training than being in the field with the people who are actually doing the work because there's -- and so, I totally agree with you.

To the intimidation comment, I think that there's some degree of that, but I think

actually one of the things, the value of having a medical director in the field is that if we can behave ourselves, we can actually teach and -- and we also make mistakes all the time.

I think it's actually one of the ways to break down the barrier that we're actually just humans. We make mistakes too, that there's things that we don't know. And that really our primary job is to support you in taking the best possible care of patients.

So, a requirement today, I -- I think that would be a tough one, but something to aspire to, for sure.

CHAIRMAN RABRICH: Yeah, I think that's a great comment. Others have comments on this or -- or feedback? It's a great question.

DR. HALLINAN: I love the question. I have to say I'm a volunteer interior firefighter and the experience that I get to see. And I was an E.M.T. way back in college, so -- but to be on a scene with where the car has just rolled over, and the patient is still entrapped or you're on a fire scene and they're pulling the person out.

And you know, I am very cognizant of

the fact that there are paramedics and E.M.T.s doing their job, and my chief was like, you know, on a scene, you're -- you're a firefighter, you're not a physician. I was like, well, kind of. So, it's a very interesting role to juggle.

And I like to just, you know, watch everything. And if I'm needed for anything, then I'm there. But the -- I agree fully with you that the experience and getting to see the chaos pre-hospital is crucial because in -- in a controlled setting in an E.D. or whatever, that's way different than when, like the -- you know, what's hitting the fan and, you know, you're -- you're trying to pull somebody out of a really bad place.

So, I agree with you. I think it's invaluable.

CHAIRMAN RABRICH: Thanks. And -- sorry, go ahead.

DR. BERKOWITZ: So, just, you know, I think is from the perspective, we built up a program over the past few years for our -- our medical directors to participate. And it took a lot of -- a lot of effort. It's a lot harder than -- than -- than we expected and we didn't expect it to be easy.

I do think that one thing that -- that we can do to support this -- this -- this request is probably provide maybe, as a group, some standards or guidance to agencies that want to -- to do this so that they can get it off, you know, get it off the ground in the -- in the -- in the -- in the way that's most provider centric to helping the crews in the field and making it supporting -- supporting them.

So, that's something that maybe we could talk offline about, is there some guidance we can -- we can provide to agencies that want to develop a program to do the right way.

CHAIRMAN RABRICH: Thanks. Dr. Cooper.

DR. COOPER: Thank you. As a quick aside, the two most recent speakers, so both use the word support. There were a number of years ago, you'll all remember in the -- I think, the first edition of the N.A.E.M.S.P. Medical Directors, you know, a handbook, Dr. Alexander Quill who many of us from New York City remember fondly, really got into helping to define, you know, the concept of medical oversight and to include both direct and indirect

medical control.

But I -- I -- I've always felt that that -- that that paradigm was lacking the crucial element of medical support, because as Dr. -- Dr. Dorsett and -- and others have pointed out, that's our primary function.

Yes, we sit -- we sit here, whether we're here at the SEMAC or whether at -- whether we are at our individual REMACs, you know -- you know, defining, you know, the -- the practice that takes place within our region or state, the fact of the matter is that the most important thing that we do is to support our pre-hospital colleagues in -- in -- in every way that we can.

We're -- so, I -- I -- I laude my colleague from, you know, from the -- the Borough of Manhattan Community College Program and hope that all of us can embrace the -- the -- the wishes that he has put forward for us. Thank you.

CHAIRMAN RABRICH: Yup. Thanks. Did you have --

DR. HUDSON: So --

CHAIRMAN RABRICH: Go ahead.

DR. HUDSON: Just one. So, there was

a time where the medics and doctors knew each other's first names and were handpicked by our medical directors to be paramedics that wasn't just an old T.V. show. And I agree, we need to get back to that.

CHAIRMAN RABRICH: Thanks, Don. Okay. We have -- yup. Second question.

MR. ALAN: Well, my question isn't as difficult as his, but.

CHAIRMAN RABRICH: Just say you're -- just for the -- say your name for the --

MR. ALAN: My name is Alan. First and foremost, thank you very much for this opportunity. And my question is, given the increase in pediatric behavioral health emergencies, does the current L -- New York State B.L.S. and A.L.S. protocol provide enough guidance in managing, assessing, and safely transporting with them?

CHAIRMAN RABRICH: Good. All right. I will turn it over to our pediatric expert.

DR. COOPER: We are so glad that you asked.

CHAIRMAN RABRICH: Yes. Where did Harris go?

DR. COOPER: The short answer -- the

short answer is yes, there's been a -- a major focus on this, that the E.M.S.C. committee and -- and elsewhere, nationally, of course, in the last -- a few years.

I would encourage everyone, you know, not just our paramedic student colleagues, but also all of us to visit the E.I.I.C. website, the -- the E.M.S.C. innovation and implementation center based in -- out of Texas, that has extraordinary resources available in terms of dealing with behavioral emergencies and children.

And I'll just further add -- and I -- I don't know whether Dr. Rabrich wants me to comment -- comment on the other issues that took place at E.M.S.C. at this meeting or wait for SEMAC.

But -- but the -- there is a major project ongoing, which we hope to get wrapped up by the fall that deals with the agitated pediatric patient and educational materials that are being developed by some of your peers right around the table.

And I, of course, thank Chief Pataki of -- of the fire department of the City of New York, as well as Matt Harris at Northwell and Maia Dorsett

in Rochester, together with other colleagues from around the state who are putting together some really crackerjack educational videos based upon scripts that have already been prepared and are available.

So, stay tuned, you know, and we should have some happy surprises for you within the next several months. Thanks for bringing it up. Thanks.

CHAIRMAN RABRICH: Yeah -- these -- these are great questions. You must have like a really good instructor or something, but great questions. And Dr. Harris, did you want to add anything? I know this is a major issue that we're all dealing with, but.

CHAIRMAN RABRICH: No, I -- I think that these videos are really going to be instrumental. I think that these are really challenging cases and the incidence has gone up, as you mentioned, right? These are challenging cases for B.L.S. providers, A.L.S. providers, physicians.

I mean, these are really generally challenging cases, and they're high consequence cases to the patient as well. So, I do think that these videos that are being produced, you know, under

leadership of Dr. Cooper and E.M.S.C. are really going to be, I think, a fundamental part of your education moving forward.

DR. COOPER: I might add that Amy Eisenhauer who has, you know, assumed a huge role in supporting the E.M.S.C. for children program over the years, reminded me of a resource that's available on the state website right now.

Amy, would you like to make a comment about that, so that everyone hears it from, you know, you rather than me?

DR. EISENHAVER: Thank you, Dr. Cooper. So, New York State is one of the states that participates in the E.M.S. for Children program, which Dr. Cooper mentioned, the E.I.I.C., and a larger umbrella of resources for pediatric patients.

And in line with the updated protocols, I think three years ago, two or three years ago, we created a pediatric de-escalation document, and that's available on the New York State E.M.S.C. site. You can order it, it's laminated, so it's safe for ambulances. And so, I know a lot of students have been ordering them, so you guys are welcome to order as well.

DR. COOPER: We've also been working closely with the team from the Department of Health that's -- that's supporting the crisis stabilization centers to ensure that they are appropriately prepared for -- for pediatric patients under appropriate circumstances. So, more to come on that in the next few months as well.

CHAIRMAN RABRICH: Thank you. And thank you for your -- thank you for your questions. Very insightful. We're very pleased that you made the trip here and that, you know, you have the opportunity to kind of see the process and -- and interact with us, and we really appreciate it.

And best of luck in your -- in your course and your career. So, thank you.

DR. COOPER: Thank you.

CHAIRMAN RABRICH: All right. Is there -- I -- is there any -- yes. So, any other items of new business? Go ahead.

DR. WINSLOW: Thanks. Yeah, Dr. Doynow at the last meeting, a SEMAC asked me to look at the agency medical director credentialing issue. We had a boardable discussion group. And I will say that I think this is best a regional REMAC issue.

So, I'd just like to make the following motion. In order to serve as a New York State E.M.S. agency medical director, the physician must be credentialed as an online medical control physician by their regional REMAC. Can I have a second?

CHAIRMAN RABRICH: Say a second. Dr. Dailey seconded. Discussion on the motion.

DR. WINSLOW: So, we thought that was like the cleanest language because then it ties it to Article 30. Right now, regional REMACs are credentialing all over the state, but it's been questioned by some physicians. You know, what right do you have? So, this seems to me a clean fix and I -- I hope there's some support for it.

CHAIRMAN RABRICH: Okay. Other --

DR. WINSLOW: I should say E.M.S.

CHAIRMAN RABRICH: E.M.S. Yeah.

DR. WINSLOW: Sorry.

CHAIRMAN RABRICH: So, the motion reads an order for a physician to serve as an E.M.S. agency service medical director in New York State. The physician shall be approved by the regional REMAC as an online medical control physician.

DR. WINSLOW: Right. I, on purpose, forgive me, Winslow. I, on purpose steered away from the word credential --

CHAIRMAN RABRICH: Uh-huh.

DR. WINSLOW: -- because I think that's a contentious one. The approved language is also what Article 30 states.

CHAIRMAN RABRICH: Yup. Other discussion on this motion? No? All in favor.

DR. HUDSON: Just -- I'm sorry.

CHAIRMAN RABRICH: Yeah, sorry. Go ahead.

DR. HUDSON: A question, do you want to keep it online or is that too restrictive? Should it just be --

DR. WINSLOW: The -- the intent is that they meet the qualifications --

CHAIRMAN RABRICH: Right.

DR. WINSLOW: -- to be online.

CHAIRMAN RABRICH: To provide online medical.

DR. WINSLOW: Correct. Each agency REMAC decides who can be an online medical control position --

CHAIRMAN RABRICH: Uh-huh.

DR. WINSLOW: -- by Article 30. So, now an agency medical director would be held to the REMAC.

CHAIRMAN RABRICH: Yeah. And I think there are regions that kind of do this already. So, yeah.

DR. HUDSON: I -- I'm just thinking, to me, online means on the phone. What if they're on scene? Do you want to just --

DR. GREENBERG: So, I think there's Article 30 wording that relates to this because the -- it is the -- it is specifically say in there that for medical control, and I believe they used the word online. I'd have to go back and check.

CHAIRMAN RABRICH: Yeah. The intent here was to mirror that language.

DR. GREENBERG: Right.

CHAIRMAN RABRICH: But if it's -- yeah, if it needs to be changed, we can change it. The motion.

DR. GREENBERG: We can go back. I don't have it specifically right now, but we can go back and look at those.

CHAIRMAN RABRICH: All right. Other discussion, Dr. Dailey?

DR. COOPER: The only thing I would add to this is, I think this is again, something that's very different in our more populous areas of the state. Quite frankly, I think that this is equally important in our less populous areas of the state, but this now gets even more complicated, right?

Because I would very much like to make sure that all of our small basic life support agencies have online medical control physicians as their medical directors. I'm not sure that we have the statutory authority to require that. I think we do at the A.L.S. level.

And the other thing in terms of that then becomes REMAC participation, which then gets back to the ability for us to have, sort of, blended meetings which allow participation for people who are remote.

So, I think this one very quickly ends up with many additional components to it, unless we add the term A.L.S. agency medical director.

DR. WINSLOW: I accept that change.

DR. COOPER: Okay.

DR. WINSLOW: Because I got to tell you, I think the way our -- the law was intended was that A.L.S. was at the purview of the REMAC, but it's a less clear situation when it comes to B.L.S.

CHAIRMAN RABRICH: So, you're saying, so before E.M.S., if we say to serve as an A.L.S., E.M.S. agency service medical director?

DR. WINSLOW: Correct. You can just make it clean language. Just say advanced life support, I guess.

CHAIRMAN RABRICH: Yup. Dr. Cooper?

DR. COOPER: Would that apply to any associate or assistant medical directors as well?

DR. WINSLOW: Yes.

DR. COOPER: Thank you.

CHAIRMAN RABRICH: Any other discussion? All right. All in favor of this motion, raise your hand. Anyone opposed? Abstentions? All right, the motion is approved unanimously. Anything else, Dr. Winslow? Okay. Anyone else have any other --

DR. GREENBERG: It wasn't unanimous. No.

CHAIRMAN RABRICH: Oh, just -- I didn't see anyone opposed. Of the people who voted. Everyone voted for it.

DR. GREENBERG: Did everybody vote? You might want to try that one again.

CHAIRMAN RABRICH: All right. All in favor, raise your hand. Okay. Anyone opposed? Any abstentions?

UNIDENTIFIED MALE: I'm not --.

CHAIRMAN RABRICH: Then we're right. So, of the people who were able to vote, they all voted affirmatively. There are members of the committee who are not voting, right? So, yes. The motion carries. Any other business?

MS. SWEENEY: I just wanted to circle back to something that Don was saying earlier that I felt was over shadowed, which was enforcement by the REMSCOs and --

DR. GREENBERG: Do me a favor, state your name first and bring the mic a little bit closer down so the sonographer can hear you.

MS. SWEENEY: Leah Sweeney, paramedic in the Hudson Mohawk region. I just wanted to circle back to something that Don was saying earlier about

more generally enforcement in REMSCOs. I know that this is really not the purview of this subcommittee, but I just wanted to make sure that this was touched on and something that could be discussed later when there are more appropriate subcommittee.

And sort of making sure that, because I think that's something that in general is something that I've been seeing as a theme in the last day or two, is kind of, if we want to have like, data integrity standards or REMAC credentialing standards, that the enforcement is something that seems to be a little bit not as clear as Don was mentioning earlier.

CHAIRMAN RABRICH: Yup. Okay. We appreciate the feedback. Anything else? All right. Seeing nothing else, I'll entertain a motion to adjourn.

DR. WINSLOW: Motion.

CHAIRMAN RABRICH: Motion. All right. All in favor of adjourning. There we go. We are -- we are adjourned.

DR. COOPER: Thank you, Dan.

(The meeting adjourned at 10:06 a.m.)

STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 135, inclusive, is a true record prepared by Associated Reporters Int'l., Inc. from materials provided by me.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 30th day of May, 2025.

DANIELLE CHRISTIAN, Reporter

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