

12/10/2025 - Medical Standards - Troy, New York
 NEW YORK STATE
 DEPARTMENT OF HEALTH
 MEDICAL STANDARDS COMMITTEE MEETING
 DATE: DECEMBER 10, 2025
 TIME: 8:03 a.m. to 9:37 a.m.
 CHAIR: BRIAN WALTERS
 LOCATION: Hilton Garden Inn
 235 Hoosick Street
 Troy, New York 12180

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 2 (The meeting commenced at 8:03 a.m.)
 3 **CHAIRMAN WALTERS:** As you can tell, I
 4 am not Dr. Rabrich. He could not be here today. So
 5 I'm standing in and running Med Standards today.
 6 Just to be clear, I did this once before and I am not
 7 the Vice Chairman of Medical Standards, nor am I
 8 aspiring to become the chairman one day. Dr. Rabrich
 9 said he had a very prestigious offer for me, and I
 10 misunderstood and thought I was the Assistant Medical
 11 Standards Chairman, and he made it clear that I was
 12 the Assistant to the Medical Standards Chairman and
 13 here I am. So that said, the attendance record is
 14 going around to make sure that everybody signs in
 15 who's on this committee. And with that, we'll move
 16 into our agenda and start with the old business. The
 17 first two items on there are the update on the B.L.S.
 18 Supraglottic Airway policy, which is now out and then
 19 Blood Implementation update. And Gina, would you be
 20 willing to give an update for us, please?
 21 **MS. WIERZBOWSKI:** Absolutely, Dr.
 22 Walters. Good morning, everybody. The long awaited
 23 Supraglottic Airway was finally published on our web
 24 policy webpage in November of this year. It has a
 25 few things that I think are worth mentioning. So we

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 2 **APPEARANCES:**
 3 ARTHUR COOPER
 4 BRIAN CLEMENCY
 5 DANIEL OLSSON
 6 DAVID KUGLER
 7 DAVID VIOLANTE
 8 DONALD DOYNOW
 9 DONALD HUDSON
 10 DOUG ISAACS
 11 ERIN REESE
 12 EUGENE HESLIN
 13 GINA WIERZBOWSKI
 14 HOWARD HUTH
 15 JASON WINSLOW
 16 KATHLEEN HALLINAN
 17 KIRBY BLACK
 18 MAIA DORSETT
 19 MERRY RUDRINGER
 20 MICHAEL DAILEY
 21 MIKE MCEVOY
 22 RYAN GREENBERG
 23 STEVEN DZIURA
 24 THERESA ALLEN
 25

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 2 did things a little bit differently than we have in
 3 the past with past special implementation for certain
 4 adjuncts. So when an agency decides they would like
 5 to participate and implement B.L.S. S.G.A., they
 6 figure out what training they want to do. Their
 7 medical director needs to approve it and then it goes
 8 to the region for the approval of their education
 9 plan. And then it comes to the division where we
 10 will implement the final approval for the policy --
 11 or for the -- the device. A couple other things of
 12 note within the policy statement, you are not limited
 13 to just the i-gel, which was the pilot program. If
 14 there's another supraglottic airway that you would
 15 like to implement, you do need to seek approval from
 16 your region for any implementation of any type of
 17 device, even in -- including an i-gel. In addition,
 18 if you wish to change, if you say, well, I like the
 19 i-gel, but something better came along and you'd like
 20 to change your device, you may do that as well,
 21 again, with regional approval for that device. And
 22 obviously you would have to have the appropriate
 23 training in place as well for that. But you can do
 24 that. You may not implement the new device until
 25 such time as you receive approval for it.

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 2 Lastly, I think the last thing that's
 3 of note is we at the division updated our Vital Signs
 4 Academy and much thanks to Amy Eisenhauer. We have
 5 two trainings available for agencies. The first one
 6 is Supraglottic imp -- Supraglottic Airway
 7 Implementation for B.L.S. practitioners. That is the
 8 original i-gel pilot training that we renamed, so
 9 that if you want to implement that device, that
 10 training is available to you for free. And I would
 11 like to also thank Doctors Dorsett and Cushman for
 12 allowing us to take their capnography for B.L.S.
 13 presentation that they had on their training
 14 platform. They allowed us to take it and put it up
 15 on Vital Signs Academy because capnography is a
 16 requirement of the policy statement if you're going
 17 to implement an S.G.A. at the B.L.S. level.
 18 So we'd -- you know, we're still
 19 working out some of the kinks. I know there's been a
 20 couple of questions on the process and how things
 21 work. Just know that, you know, when you implement
 22 something new, sometimes you have a little bit of
 23 growing pains and we just ask for your patience. And
 24 if you have any specific questions, our agency
 25 licensure department or area is the place where you

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 2 should start because there -- that's where the
 3 applications are going and they are the people who
 4 can at least best help you initially. I'm going to
 5 pause there because I'm -- there may be questions for
 6 S.G.A.
 7 **MR. VIOLANTE:** Gina, if you could just
 8 quickly go over that process that's on the website.
 9 What happens when someone actually submits something
 10 to the State that -- yeah.
 11 **MS. WIERZBOWSKI:** Of course. Thank
 12 you, Mr. Chairman. I'd be happy to. So we have a
 13 form on the webpage that we -- you can submit your
 14 application. It also has a drag and drop area. So
 15 if there's documentation you need to submit, you can
 16 submit it all in one packet. When you press the send
 17 button, it simultaneously goes to the appropriate
 18 region that you select. And it also comes to the
 19 division so that we have kind of like dual
 20 notification that this application is coming through.
 21 There was a question with regard to the medical
 22 director update form -- verification form. So you
 23 need to send it with your original packet. And then
 24 once you are approved, you need to send it again
 25 because when you're sending it in with your

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 2 application, you're requesting the permission and
 3 then it's -- we were informed that we need to have
 4 that -- we need to have it resubmitted again because
 5 when you're resubmitting it, that shows you have the
 6 approval for the program. So I know it might seem a
 7 little clunky, but that's the way that we have to do
 8 things. Any other questions?
 9 **MR. DOYNOW:** Gina, there was another
 10 question -
 11 **MS. WIERZBOWSKI:** Yes.
 12 **MR. DOYNOW:** -- from another physician
 13 who's not here -
 14 **MS. WIERZBOWSKI:** Uh-huh.
 15 **MR. DOYNOW:** -- about expanding this
 16 to B.L.S. first responder agencies rather than just
 17 advanced life support first responder agencies with
 18 B.L.S. level providers. What's the thought on that?
 19 **MS. WIERZBOWSKI:** So for A.L.S.F.R.s
 20 that have B.L.S. practitioners, they can certainly
 21 implement the i-gel -- or excuse me, S.G.A. for their
 22 practitioners at the B.L.S. level, there is no
 23 barrier to that. And the policy does include
 24 A.L.S.F.R.s in the agencies that are -- that would be
 25 able to implement that. As far as B.L.S.F.R.s, we've

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 2 gotten that question many times, Dr. Doynow. And at
 3 this time, we do not have a path to implement it for
 4 B.L.S.F.R.s, but it is on our radar to work towards
 5 the path because we recognize that B.L.S.F.R.s, while
 6 we don't -- typically -- we don't regulate them, they
 7 are an important part of our pre-hospital care
 8 environment.
 9 **MR. DOYNOW:** Thank you, Gina.
 10 **MS. WIERZBOWSKI:** You're welcome, Dr.
 11 Doynow. Are there any other questions on S.G.A.?
 12 **MR. DAILEY:** Gina two -- two
 13 questions. The first comes off the B.L.S.F.R. You
 14 and I have spoken about it before. You know, this is
 15 -- is a drastic change for the Department of Health
 16 to actually be regulating the interventions available
 17 at the actual agency level. This is something that
 18 was always a regional -- regional level decision
 19 making. How did the department make that leap that
 20 suddenly there was going to be something that the
 21 control was going to be brought centrally? Because
 22 this also does hinge to B.L.S.F.R. -
 23 **MS. WIERZBOWSKI:** Uh-huh.
 24 **MR. DAILEY:** -- who the agencies of
 25 our regions, we manage quite well according to our

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 2 regional needs and the demonstration of our systems
 3 design, which is our mandate in Article Thirty. So
 4 I'm not quite sure how that leap was -- was achieved
 5 by the department. And if this isn't a question for
 6 you, and really this should be held for D.L.A. to
 7 explain during the SEMAC, that would be fine.
 8 **COURT REPORTER:** Sorry. Could I just
 9 get your name please? The one who just asked the
 10 question?
 11 **MR. DAILEY:** Sorry. Michael Dailey.
 12 **COURT REPORTER:** Thank you.
 13 **MS. WIERZBOWSKI:** And did you need my
 14 name spelled because it's a little bit confusing?
 15 **COURT REPORTER:** Yes, please.
 16 **MS. WIERZBOWSKI:** It's Gina G-I-N-A,
 17 last name W-I-E-R-Z-B-O-W-S-K-I.
 18 **COURT REPORTER:** Thank you.
 19 **MS. WIERZBOWSKI:** And I'm with the
 20 division of C.D.M.S. okay. So, I can -- I can answer
 21 some of that and it may -- it may be a question
 22 better explored in more depth in terms of when
 23 Director Greenberg comes in because he might want to
 24 add some additional information. So when we -- as
 25 every -- as -- has been discussed before, regions

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 2 don't necessarily have the ability to credential
 3 providers. So the pathway is an agency medical
 4 director can credential the individual practitioners
 5 that are -- are authorized to perform skills across
 6 the board. The region does have a role in the
 7 education of our practitioners and that's why the
 8 applications go to the region for a review of your
 9 education plans and confirmation that you have
 10 submitted all of the documentation that you need to
 11 submit and all of your things are in order. And then
 12 -- and then the final approval does come from the
 13 division.
 14 Now a couple of things. Number one,
 15 in the past we hadn't done a particularly good job of
 16 collecting information on projects such as these and
 17 I think everybody can recognize that if we want to
 18 include B.L.S.F.R.s in the future, then we probably
 19 ought to have some ability to really track success
 20 rates and implementation and agencies and things like
 21 that. So it's kind of like a -- a dual edge, but I -
 22 - I don't know that I would want to go any further in
 23 the discussion than this and would defer to Director
 24 Greenberg or Deputy Director Dziura when -- when they
 25 come in. So that -- that's about as much as I would

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 2 like to say on that.
 3 **MR. DAILEY:** Thank you.
 4 **MS. WIERZBOWSKI:** You're welcome, Dr.
 5 Dailey.
 6 **CHAIRMAN WALTERS:** Any other questions
 7 for Gina? And -- and I would say, I think Dr.
 8 Dailey, to your question about -- one question is
 9 about why this approval process is different. The
 10 other one that I get asked all the time is these,
 11 quote, Optional skills, or if you know, trained and
 12 equipped is there's some slightly different
 13 processes. They're not all exactly the same, whether
 14 it's B.L.S. Twelve Lead or CPAP or -- or these and --
 15 and it just is confusing as far as how they're
 16 supposed to apply, who does the training, those types
 17 of things. If we can make those policies, make it
 18 more standardized, I think is another -- another
 19 issue. I know it's not what you're asking, but I
 20 think it's just part of the -- the bigger picture of
 21 -- of these going forward, so.
 22 **MS. WIERZBOWSKI:** Yes, that's a good
 23 point, Dr. Walter. So you know, as I alluded to
 24 before, there -- there -- there has in the past been
 25 times where we probably wanted to have a little bit

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 2 better situational awareness of what -- of what
 3 agencies and practitioners are doing. And so this is
 4 a change, yes. But I think it's a positive change
 5 and I think it's one that will help us all work a
 6 little bit better together.
 7 **CHAIRMAN WALTERS:** Thank you. And
 8 would you like to talk about Blood Implementation as
 9 well?
 10 **MS. WIERZBOWSKI:** Yes. I would love
 11 to talk about pre-hospital blood program
 12 implementation. So that is one of the two regulatory
 13 packages that have been pushed to the forefront. The
 14 -- we are doing things a little bit differently than
 15 we have in the past. So when the blood regulations
 16 go out for public comment, we will also be publishing
 17 a draft of the program manual for pre-hospital blood
 18 administration. So you will be able to see, when you
 19 look at the regulation, you'll also be able to see
 20 like more of like the whole cloth of -- of what that
 21 program is going to look like. So you will be able
 22 to submit comment on both the regulation that's been
 23 proposed and also the -- the program manual. Because
 24 as we've seen with several other comment periods, we
 25 have had many good suggestions come out of them that

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 2 have improved both the regulation and then the policy
 3 statements and such that follow afterwards.
 4 As a reminder to the group, we did
 5 talk about this yesterday, but I know some might not
 6 have been here. In terms of regulation, when a
 7 regulation is approved for public comment and it goes
 8 out for public comment, the first public comment
 9 period is sixty days. And then the division takes
 10 the comments, we assess them, we decide what we want
 11 -- what can be implemented, what should be
 12 implemented. If they have what's called a
 13 substantive change, which some -- means that there
 14 has been a change to the regulation that
 15 significantly changes the intent, or the language, or
 16 the content, then we must go back out for a second
 17 public comment period and that's forty-five days.
 18 So like with the equipment and vehicle
 19 regulations, we did go out -- back out for a second
 20 public comment period because we had changes that
 21 improved the regulation, but also required us to do
 22 that. So that will be the pathway. As always, when
 23 we have this package come out for public comment, we
 24 will widely disseminate it so that we can receive
 25 comments from as many of you that wish to do so.

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 2 **CHAIRMAN WALTERS:** And do you have any
 3 updates on the timeline of when we think these will
 4 be out for public comment?
 5 **MS. WIERZBOWSKI:** Probably in this --
 6 early 2026. I wouldn't want to go any more specific
 7 than that though.
 8 **CHAIRMAN WALTERS:** Any other questions
 9 for Gina? No. Thank you very much.
 10 **MS. WIERZBOWSKI:** Thank you, Dr.
 11 Walters.
 12 **CHAIRMAN WALTERS:** All right. And
 13 then moving on, the next item on the agenda is the
 14 Clinical Data Integrity TAG. And Dr. Dorsett, would
 15 you be willing to update us, please?
 16 **MS. DORSETT:** Sure. I'm just going to
 17 do a rehash of the updating quality metrics
 18 yesterday. So, to give everybody a little bit of
 19 context on what we're working on in the Clinical Data
 20 Integrity TAG, the problem that we're trying to solve
 21 is how do we -- if we want to ask a question,
 22 particularly at the State or the regional level using
 23 registry data, how do we get an accurate answer to
 24 that question? And this be -- came to head as a link
 25 in the B.L.S. i-gel project. One of the issues is in

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 2 E.M.S. right, we use NEMESIS, which defines the
 3 different fields of the data that goes up. But for
 4 some of those things like procedures, or medications,
 5 or impressions, the drop-down menu of what can end up
 6 there comes from a different data set. So, for
 7 example, for procedures, it comes from a SNOMED
 8 codes, which have like a -- a plethora of different
 9 options. And at an individual agency level, we don't
 10 have really any control that if I set up my E.P.C.R.,
 11 I can have it so that when somebody enters a
 12 medication, it goes to a particular code.
 13 But what that means is that when I
 14 look at State registry data, if I want to say, when
 15 did I give Tylenol? There was like ten different
 16 ways that Tylenol is actually documented and so it
 17 makes it really hard to write reports at the State
 18 level. So, in trying to solve this problem, we
 19 realized that what we really wanted to do was fix
 20 this mapping issue so that in MILRAMS, one of the
 21 providers documents, they gave aspirin for chest
 22 pain and one of the other providers documents that
 23 they have aspirin for chest pain. And I want to ask
 24 at a State level how often we're giving aspirin for
 25 chest pain? It's the same thing. So we've been

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 2 working on initially getting defined lists of
 3 procedures, medications, and impressions. There's
 4 one other State that is doing this. So, I think
 5 we're going to learn as they go to implement this,
 6 which is California.
 7 The process that we've taken, we've
 8 worked on procedures and medications. I was able to
 9 get a list of -- for example, every single procedure
 10 that's been documented within the State for the last
 11 year, and the frequency of those impressions. We
 12 compare those with the NEMESIS recommended codes. So
 13 NEMESIS actually has a list of recommended codes, just
 14 nobody uses them. Like, I mean, somebody uses them,
 15 but it's not like the -- the most commonly used
 16 codes. Also compared those with those California
 17 codes because we don't need to be special in New
 18 York, right? If they've already defined something.
 19 And then went through every single procedure and said
 20 that we -- these should be the defined procedure list
 21 within New York State.
 22 For medications, it's a little bit
 23 different. Because for S.C.T., right? There's like
 24 a million medications. We can't define what RxNorm
 25 codes are going to use for all those medications.

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 2 But so what we decided is looking at the frequency of
 3 all the ways that it's used, is every medication that
 4 is on formulary, either in the collaborative
 5 protocols or the unified protocols, as well as the
 6 alternatives, that we would have a -- a defined
 7 RxNorm code that that medication should be mapped to.
 8 The -- we haven't even -- impressions
 9 is going to be the most complicated. The fundamental
 10 problem is going to be implementation in a way that
 11 actually makes things better rather than makes things
 12 worse. Because if -- for example, we told an
 13 individual, like -- like if we said, may it part of
 14 the Schematron, the -- the -- the result would be
 15 that we'd actually just miss a bunch of data, right?
 16 Because the data wouldn't pass. So, we're working
 17 and putting those lists out soon to vendors, getting
 18 their feedback about how this might actually be
 19 implemented on the vendor side, at least with
 20 implementation.
 21 And then thinking like, long term, how
 22 you do this, because most agencies, if I went to say
 23 like, what does your stuff map too? Like we don't
 24 know, like I didn't even know. But this all came out
 25 from actually trying to just like map airways for

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 2 Airway Eighteen in our region and figuring that out.
 3 So that's where we are. It's going to be -- it's not
 4 going to be a quick process because I think we have
 5 to be really thoughtful about how we implement it.
 6 Because there's a danger that you make things worse
 7 really easily. That's all I got.
 8 **CHAIRMAN WALTERS:** Great. Thank you.
 9 Any questions on that for Dr. Dorsett? All right.
 10 Moving right along then we'll move into the S.C.T.
 11 TAG. And Erin Reese, would you like to give us an
 12 update please?
 13 **MS. REESE:** Yes, absolutely. Good
 14 morning. Our group has been meeting monthly, and
 15 we've got a -- a decent sized group. And given the
 16 size of the group, we've -- we're broken into three
 17 different work groups. Those three different work
 18 groups are focusing on guidelines, education, and
 19 governance, and looking at what exists already within
 20 the -- within the State and within the country as far
 21 as other -- other systems, that are providing
 22 specialty care transport.
 23 The education piece is looking at a
 24 gap analysis amongst the existing agencies that are
 25 providing specialty care, and governance is looking

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 2 at regulatory opportunities and some reimbursement
 3 opportunities. And collectively, the group has been
 4 working on just as of this last meeting, putting
 5 together a survey that will go out to all paramedics
 6 throughout the State to gain some insight into their
 7 perspective on providing specialty care transport,
 8 so. Fairly new and -- and as far as the -- the TAG
 9 goes, what we've been meeting monthly and -- and
 10 working through. So, if there's any other -- anyone
 11 else that's interested in participating, please let
 12 me know. But we'll continue to work on this.
 13 **CHAIRMAN WALTERS:** Okay, thank you.
 14 Any questions or comments for Erin? All right,
 15 hearing none then next item is the rapid sequence
 16 intubation training and credentialing process. I
 17 know there's been a little bit of movement and
 18 discussion on that and Dr. Winslow, would you like to
 19 speak to that?
 20 **MR. WINSLOW:** Thank you. So, there
 21 are several areas in New York State currently
 22 performing rapid sequence intubation and several of
 23 the regional policies were posted on the Boardable
 24 for the group. I'm not sure if we're a TAG or just a
 25 group, but we'll call ourselves a group. The group

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 2 plans to meet and discuss this in January and bring a
 3 formal report back to the med standards at the
 4 February meeting. Currently we have Suffolk, Nassau
 5 and -- and Melrose and I think I'll discuss with
 6 anyone else offline if there's other areas that would
 7 like to join the group.
 8 **CHAIRMAN WALTERS:** Great. Thank you
 9 very much. And as we're trucking right along here,
 10 that takes us into a new business, which is the
 11 collaborative protocol update. Now, just as a
 12 reminder, these items of proposed changes are coming
 13 up for discussion. They will not be voted on at this
 14 meeting but will come up for vote at the February
 15 meeting and then take -- not take effect until July
 16 1st. So that said, maybe we can go through some of
 17 the biggest changes. I know the -- the change log
 18 was sent out, but Dr. Dorsett, if you mind hitting
 19 some of the highlights of this and then we can go
 20 through and have any discussion or comments. And I
 21 know maybe training and ed has some thoughts that
 22 they'd like to share and we can discuss as well after
 23 that.
 24 **MS. DORSETT:** I'd like to start by
 25 thanking Jeremy Cushman, who continues to do a huge

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 2 amount of work to and --
 3 **CHAIRMAN WALTERS:** Chris Fullagar.
 4 **MS. DORSETT:** And Chris Fullagar to
 5 move these forward. Just hitting some of the overall
 6 highlights. Because everybody has the change logs.
 7 There's two new O.B. protocols suggested. And the
 8 motivation for these is ACOG had a initiative for
 9 model guidelines in non-obstetric environments. And
 10 there was a set of model guidelines per E.M.S. So
 11 there's two new protocols, one on pre-
 12 eclampsia/eclampsia, and the other one which is
 13 hemorrhagic shock. Which includes blood, which has
 14 been in the protocols for a while T.X.A. which we've
 15 also had. But it also adds the additional option of
 16 Oxytocin. In the arena of pain management there's a
 17 move for Ibuprofen and Tylenol at the B.L.S. level
 18 for adults. So following Tiff Bombards grandma
 19 principle, I think that if your grandma could do it.
 20 And -- and the move of the addition of I.V.
 21 Acetaminophen at the A.E.M.T. level additional things
 22 to the A.E.M.T. level is moving ondansetron by all
 23 routes to the A.E.M.T. level for nausea and vomiting.
 24 There's the additional indication of push-dose
 25 vasopressors for post-procedure hypotension and

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 2 R.S.I. which is great because that's I think one of
 3 the best clinical indications for a push-dose
 4 vasopressor. Olanzapine, which was added for
 5 agitation in the last round is moved to standing
 6 order. And importantly, I think adjusted dosing for
 7 older adults to meet with the geriatric E. D.
 8 Guidelines for management of agitation in older
 9 adults. And then change the default vasopressor drip
 10 in bradycardia to epinephrine which physiologically
 11 makes more sense.
 12 **CHAIRMAN WALTERS:** Thank you for
 13 summarizing those changes. Again, the change log is
 14 out there and anybody who didn't get it wants it, we
 15 can make sure you get a copy of that. So, with that,
 16 I guess I will open it up for some questions,
 17 comments. I know the collaborative protocol group
 18 has met and discussed a lot of these and had some
 19 good discussions and debates. But it's my
 20 understanding is -- Don Hudson here? There he is.
 21 That's the response that I expected. I know there
 22 was some discussion at Training and Ed so maybe if
 23 you want to go through some of that discussion or
 24 things that were brought up at training and ed and
 25 maybe that will then we can then open the floor for

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 2 other comments or discussion. And I don't know if
 3 you want to go through them in mass or maybe one at a
 4 time. We can go through some of the issues and
 5 discuss them. How would that be?

6 **MR. HUDSON:** Yeah, let -- let's tackle
 7 them one at a time. So thank you. Good morning, Don
 8 Hudson, happy holidays. So as we continued to work
 9 on codifying and streamlining the protocol, you know,
 10 drafting and implementation process, part of that ask
 11 was to have Training and Education, look at and
 12 compare the proposed -- any proposed changes to both
 13 National E.M.S. Education Standards, National Scope
 14 of Practice, and then the New York State Scope --
 15 Scope of Practice documents to assure consistency
 16 across the nation as much as is intended. And more
 17 importantly to make sure that we have consistency
 18 across the State.

19 So, in doing that I think it's worthy
 20 of note that we'll just, you know, explore the
 21 background of both of those foundational documents
 22 and what -- what their intent was. So, both of them
 23 were most recently published in 2021 or updated in
 24 2021 right around COVID. And, you know, to remind
 25 everyone of what that meant the most striking change

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 2 was the availability due to the worldwide pandemic of
 3 E.M.T.s giving intramuscular immunizations as needed
 4 in a public health crisis. So that was probably the
 5 most striking national update to that.

6 Not surprisingly, New York State was
 7 ahead of that curve based on the B.L.S. pilot
 8 program. And then in subsequent Statewide
 9 implementation of check and inject, our E.M.T.s
 10 already had been trained and verified in drawing
 11 medications from a vial, whether it be immunizations
 12 or not, or epinephrine or not, utilizing a standard
 13 syringe. So, we were well ahead of that and
 14 prepared, thankfully. But that's the background of
 15 how the documents are. Now, you know, one might ask,
 16 you know, are they frozen in time then in 2021? Or
 17 what is the intended update schedule to those
 18 documents? Are we pushing the envelope? Are we too
 19 far ahead? You know, are we out over our skis, so to
 20 speak?

21 So, I think it's important to discuss
 22 that for a moment. Both of those documents have
 23 phrasing in them, such as -- while each State has the
 24 right to establish its own levels of E.M.S. personnel
 25 in their scope of practice, staying as close to this

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 2 model as possible, and especially not going below it
 3 for any level, will increase the consistency of the
 4 nomenclature and competencies of E.M.S. personnel,
 5 facilitate reciprocity, improve professional
 6 mobility, standardize professional recognition, and
 7 decrease the necessity of each state developing an --
 8 its own education and certification materials. So,
 9 they're meant to be living documents. So, I want to
 10 throw that out there.

11 You know, as we look at these, if the
 12 impetus or the discussion revolves around, well,
 13 where does it say in the 2021 document that an E.M.T.
 14 or an A.E.M.T. or a paramedic can do X and, you know,
 15 that's why we bring this here, to make sure that the
 16 education and the scope, whether it be on a State
 17 level or a regional level, if equipped and trained as
 18 we know here in New York, what does all that mean?
 19 And -- and is it having the intended effect of
 20 putting highly trained, highly, you know, experienced
 21 patient providers in front of the patients that
 22 require them. And I know that's all of our intents.

23 So that being said, let's get some
 24 specifics. So, there's -- I -- I labeled them
 25 friction points because I don't think they're

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 2 problems. I think they're just something that we
 3 need to discuss. And as -- does the committee, so
 4 the committee put the protocols side by side with
 5 those documents and then broke them down into --
 6 where there might be differences. And then why are
 7 those differences? So, difficulty breathing,
 8 pediatric asthma wheezing. So, it clarified
 9 epinephrine dosing for E.M.T. level to mirror that
 10 for anaphylaxis, right? So as much as possible, we
 11 like to have consistent dosing across the protocols,
 12 you know, less errors, less to remember, especially
 13 when under stress.

14 So, if you look specifically at the
 15 National E.M.S. Education Standards for 2021, I.M.
 16 injections, intermuscular injections are not in the
 17 E.M.T. level of care where auto injector is, its
 18 partner document. Then the national scope of
 19 practice model, as we just mentioned for pandemic,
 20 does include intramuscular injections at the E.M.T.
 21 level. So right there, without that understanding or
 22 that background and managing that expectation, you --
 23 one might think, oh -- oh, the two documents are in
 24 conflict, that's it. End of discussion. We can't do
 25 this or it's the wrong thing to do.

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 2 And I don't -- I don't think that's
 3 anyone's intent here, but I guess I would hand that
 4 back to the group is using that as sort of the touch
 5 point as the example. Does anyone have a significant
 6 concern here that we're departing from the norm and,
 7 you know, forging too far ahead?

8 **MR. DAILEY:** Don, can you even
 9 reference those doc -- sorry, Michael Dailey. Can
 10 you even reference those documents as long as we
 11 still have cer -- certification of critical care tax
 12 in the State?

13 **MR. HUDSON:** So --

14 **MR. DAILEY:** Directly in opposition to
 15 all of the things that you just read.

16 **MR. HUDSON:** Oh boy, here we go.
 17 Right. So yes, I mean, I think it's a valid question
 18 and -- and it's the crux of any discussion and
 19 decision that we make. You know, whether it be medic
 20 -- medical, you know, oversight from the physicians
 21 or operation or anything like that is, so what are
 22 the foundational documents, right? So, provide me
 23 the reference and then justify your hypothesis,
 24 right? Scientific theory. So, in doing so, yeah, I
 25 think the -- the little snippet I read is part of the

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 2 crux of that decision for the E.M.T.C.C. level of
 3 care.

4 And in acknowledging that and then
 5 embracing that, that the goal there from many years
 6 ago was to do just what that statement says, which is
 7 to increase consistency in nomenclature and
 8 competencies of E.M.S. personnel, facilitate
 9 reciprocity, improve professional mobility,
 10 standardize professional recognition, and decrease
 11 the necessity of each State developing its own
 12 education certification materials, right? We
 13 acknowledged many years ago that we're not as good as
 14 we would like to be in maintaining our own
 15 curriculums and our own skill sheets.

16 And then having that fracture as it
 17 goes down, you know, the chain to the regions and
 18 there's an Upstate version and a Downstate version
 19 when -- essentially patients are patients and
 20 medicines is medicine. And if it's good medicine
 21 Downstate, why is it different Upstate? Unless
 22 there's some real compelling referenceable reason for
 23 that. And sometimes there is, and that's why, you
 24 know, I've been -- and will continue to be a huge
 25 proponent of regional control or regional variation

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 2 when appropriate and justified. And that's what I
 3 think we are looking for is just that, is this
 4 reasonable and justified and here it comes before us
 5 as a Statewide protocol.
 6 So, I guess the question I would have
 7 to the group is educationally, I don't see that as a
 8 sticking point. I guess does any particular region
 9 medical director or otherwise see this as the hill to
 10 die on.
 11 **MS. DORSETT:** Definitely not the hill.
 12 **MR. HUDSON:** Does that answer your
 13 question, doc? I'm sorry.
 14 **MS. DORSETT:** Yeah. So, and I think
 15 also in the order -- there's an order to those
 16 documents, they're just not updated. The foundation
 17 is the scope of practice model. The E.M.S. core
 18 content and the national education standards are
 19 updated according to updates of the scope of practice
 20 model. But we also know that the federal government
 21 does not move at a facile pace. And so, things like
 22 the new E.M.S. education agenda, which was slated and
 23 they had started the process, is now on hold. So, we
 24 can't say that we're going to wait to update things
 25 based on when the federal government updates these,

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 2 because there's a -- there's a process.
 3 So, the reason that there is a -- a
 4 difference between scope of practice and education
 5 standards is the education standards were updated
 6 before there was an addendum to the scope of practice
 7 due to COVID. So, we should be working off ideally a
 8 floor that is in a scope of practice model that's the
 9 floor, not the ceiling, and then updating our
 10 education standards locally. Plus within the scope
 11 of practice model, there's local credentialing,
 12 right? So, the -- the whole process of local
 13 education and the education standards, I think the
 14 most important figure there is there's an input into
 15 your local curriculum, which has the national scope
 16 of practice model, national core content, which
 17 hasn't been updated in forever.
 18 But there's also local input. So for
 19 example, nowhere in education standards does it say
 20 you teach video laryngoscopy. I teach video
 21 laryngoscopy in my paramedic program because there's
 22 local input that it is something that most of my
 23 paramedic students will be using in the field. And
 24 so I must update my curriculum according to the
 25 update in evidence. And we tend to forget that

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 2 that's part of the education standards, because of
 3 the way that there's no way that they will ever be
 4 updated at the rate of which medicine is updated.
 5 **MR. HUDSON:** Right. And in
 6 anticipation of, you know, this discussion, which is
 7 exactly what I think we wanted was this back and
 8 forth and open exchange of, you know, hey, this is
 9 where we're moving. Anyone have a concern with that
 10 is based in both of these documents particularly in
 11 the National E.M.S. Education standards is phrasing
 12 such as some States permit licensed E.M.S. personnel
 13 to perform skills and roles beyond the minimum skill
 14 set as they gain knowledge, additional education,
 15 experience, and possibly additional certification.
 16 Care must be taken to consider the level of recognin
 17 -- I'm sorry, of cognition and critical thinking
 18 necessary to perform a skill safely. For instance,
 19 some skills may be simple to perform but require
 20 significant or considerable clinical judgment to know
 21 when they should be performed and should not be
 22 performed, and hence the education and you know, all
 23 of the stuff that we're looking to put together. So,
 24 in keeping with both those concepts as foundational
 25 documents, the floor, if you will, not the ceiling, I

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 2 think we're good, but it's not up to me.
 3 **MR. DAILEY:** I -- I think now is
 4 probably a pretty good time to point out where New
 5 York State has actually carried the scope of practice
 6 model, right? B.L.S. naloxone actually was carried
 7 from this State in -- in great part, not because we
 8 were first, but because we created a Statewide
 9 implementation and frankly did it -- did it very
 10 well. We worked from, you know, the things that
 11 Sophie Dyer and the people in -- in Boston had done.
 12 But it was because of that and our review of the
 13 potential for harm that carried that forward. And
 14 then the scope of practice group actually reached
 15 back to us. The same thing happened with check and
 16 inject. And the same thing has happened also with
 17 patella reduction. So, moving the skills that are
 18 available for B.L.S. providers has been something
 19 that New York State has been doing and doing quite
 20 well and doing safely, which is the most important
 21 part of all of that.
 22 **MR. HUDSON:** And, you know, to you and
 23 your compatriots doing videos and, you know, protocol
 24 rollouts to assure, you know, the continuation of
 25 those concepts and the assurance of those standards

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 2 across the board has helped. You know, we don't live
 3 in a day where we have to wait till somebody
 4 publishes a new textbook and then I can point to it
 5 and say, no, it's here. You know, we're a lot more
 6 dynamic and as has been pointed out, you know, can
 7 really keep up with our patient need and or drive
 8 medicine forward rather than wait to be dragged along
 9 by somebody else who might not move as fast as we do
 10 here in New York State. And I know that's a shocking
 11 statement that New York State is moving faster than
 12 anybody else, but sometimes we do. And that's a good
 13 thing as long as it's done appropriately.

14 So, we'll give another example. So,
 15 and -- and this is, you know, like any other
 16 discussion when I'm arguing with my wife or child,
 17 you know, if we get too granular, you -- you sort of
 18 get off the initial intent of what the exchange of
 19 information was supposed to be. So, I suggest that
 20 only because you tell me if this rises to that
 21 occasion. So nowhere in either the National E.M.S.
 22 Education Standards or the scope of practice or the
 23 New York State scope of practice, is there any
 24 educational material or even any discussion about
 25 allowing a patient to -- for lack of a better term,

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 2 sniff an alcohol pad. And, you know, if that's too
 3 far ahead of our education and our physician medical
 4 directors were unaware of that, well then, we
 5 shouldn't, you know, if sniffing an alcohol pad for
 6 nausea is pushing the envelope too far because some
 7 antiquated document doesn't say it, I -- I don't know
 8 where that leaves us. So, does anyone have a concern
 9 that, you know, the patient may be given an isopropyl
 10 alcohol pad for self-administered inhalation is
 11 either too complex or requires a level of critical
 12 thinking that would not be available at the E.M.T.
 13 level?

14 **CHAIRMAN WALTERS:** We -- we are
 15 allowing the patients to breathe through their nose,
 16 correct?

17 **MR. HUDSON:** I believe that's still
 18 mostly up to their preference, although you've
 19 recently given us drugs where I can decide that for
 20 them. So thankfully, yes.

21 **MR. DAILEY:** One of the things I
 22 actually point out, Don, is the way we wrote that
 23 specifically was to not leave it to the clinician,
 24 but to the patient to do the procedure, right?

25 **MR. HUDSON:** Correct.

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 2 **MR. DAILEY:** And that was some careful
 3 work around as -- as part of conversations both
 4 through the collaborative group as well as at this
 5 table.

6 **MR. HUDSON:** And -- and I'm glad, you
 7 know, we -- we've talked about this, it seems
 8 somewhat juvenile, but I think we're all mindful of
 9 what we're doing and not departing too much from the
 10 foundations as appropriate, right. We're not out in
 11 the weeds here with wild ideas that are
 12 unsubstantiated or medically unnecessary. You want
 13 me to keep going down the list or do you think you
 14 have the gist of it?

15 **CHAIRMAN WALTERS:** Yeah, if you have a
 16 list of things you identified -

17 **MR. HUDSON:** Yeah.

18 **MR. WALTER:** -- I think we should
 19 bring them up and then discuss them and make sure
 20 there's no heartburn or have some debate on whether
 21 we should keep it in here or take it out as we move
 22 forward.

23 **MR. HUDSON:** Good. All right. So --

24 **CHAIRMAN WALTERS:** In February, yeah.

25 **MR. HUDSON:** We'll do them one at a

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 2 time and it'll go quicker that way. So now that
 3 we've, you know, gotten all of that background out of
 4 the way, so the intramuscular injections for
 5 anaphylaxis at the E.M.T. level, I -- I think --
 6 check and inject sort of solved that in that two
 7 years ago. If anyone sees it differently, I think
 8 now's, you know, now's the time to discuss that. All
 9 right. As we do, we'll continue going. Your silence
 10 is acknowledgements.

11 **CHAIRMAN WALTERS:** Don, just to
 12 clarify wait, like that's already in the protocol,
 13 you're -- this is just clarifying epinephrine use at
 14 the E.M.T. level for pediatric asthma, right?

15 **MR. HUDSON:** Correct.

16 **CHAIRMAN WALTERS:** You know what I'm
 17 saying? Right. So -- so it's saying they're already
 18 giving I.M. epinephrine check and inject. They can
 19 do that, now we're just applying it to a different
 20 protocol, the same skill, the same medication, we're
 21 just adding it somewhere else?

22 **MR. HUDSON:** Correct.

23 **CHAIRMAN WALTERS:** Okay.

24 **MR. HUDSON:** So next would then be
 25 fever for the adults, moved oral acetaminophen and

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 2 ibuprofen to E.M.T. or higher and then moved I.V.
 3 acetaminophen to A.E.M.T. or higher. The -- the
 4 friction point there is A.E.M.T.s in the 2021 scope
 5 of practice document are, quote, Limited to P.O. over
 6 the counter antipyretics, limited to analgesia, anti-
 7 nausea, antiemetics, dextrose, epinephrine, glucagon,
 8 naloxone. And if you stop there up where over the
 9 skis here, it's not listed, but the sentence
 10 continues and others defined by State or local
 11 protocol. So again, an illustration of this is
 12 exactly the intent of these documents was to allow us
 13 to do the things that we're doing.
 14 **CHAIRMAN WALTERS:** And -- and what's
 15 the friction point there? Is it the A.E.M.T. giving
 16 I.V. acetaminophen?
 17 **MR. HUDSON:** Y -- yes. Deviate,
 18 medicated -- let's see the A.E.M.T. I.V.
 19 acetaminophen. Yeah. Hearing no opposition will
 20 continue.
 21 **CHAIRMAN WALTERS:** I mean they can
 22 already give it orally, right? So it's -- and they
 23 can give I.V. medication --
 24 **MR. HUDSON:** And they have the I.V.
 25 skill, right.

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 2 **CHAIRMAN WALTERS:** It's a medication
 3 that they can give and they're giving that medication
 4 by a different route, which they can already perform,
 5 correct?
 6 **MR. HUDSON:** Yes.
 7 **CHAIRMAN WALTERS:** Okay. So --
 8 **MR. GREENBERG:** Just a question on
 9 this one is -- is kind of some of the discussion
 10 that's happening, and it goes back to, you know, just
 11 on both sides of things, that you believe some of the
 12 things as they advance in the protocol or things like
 13 that should be highlighted more as a pilot at first
 14 so that there's additional research or information
 15 gathered on it or -- and so that to Dr. Dailey's
 16 point, you can start to show other states that might
 17 want to mimic or follow those similar things or if
 18 there's additional education or things that come with
 19 it, you know, in order to progress on that. I'm just
 20 trying to, because it --
 21 **MS. DORSETT:** I think the
 22 distinguished thing is that what does need to be a
 23 pilot versus what can we just do now because it makes
 24 sense based on scope of practice. So, I think the --
 25 the question is here is, is it safe and appropriate

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 2 and not an undue burden to put I.V. acetaminophen at
 3 the A.E.M.T. level and by the LOF syllogism or
 4 whatever, right? I can do this thing, I can do this
 5 thing, I should be able to put these things together.
 6 The answer is, it does not need to be
 7 a pilot. We can just do it in protocol without doing
 8 any pilot at all. When there's something where we
 9 say, uh-huh that's actually fundamentally a change in
 10 scope of practice, like let's put i-gels and
 11 capnography at the B.L.S. level. The idea is that
 12 those things would need to be tested as a pilot for
 13 safety and what the implementation process looks
 14 like. So, I think this is the sniff test of is this
 15 premise just be a protocol change versus does this
 16 need to be a pilot? And I think most of these just -
 17 - this can be a protocol change. It doesn't smell
 18 like a pilot.
 19 **MR. MCEVOY:** Could I point out --
 20 could I point out something? I'm Mike McEvoy and
 21 current Chairman of the Board of the National
 22 Registry of E.M.T.s used by forty-eight States, not
 23 including New York. When I speak to -- when I speak
 24 to educators in those forty-eight states, we tell
 25 them to ignore the educational standards because

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 2 they're horribly outdated. We tell them to ignore
 3 the scope of practice because that also is horribly
 4 outdated and we suggest that they use the two
 5 documents that are prepared specifically for
 6 educators.
 7 One being the National Association of
 8 State E.M.S. officials model clinical guidelines,
 9 which included alcohol pads for nausea in version
 10 03/2022, and included oral antipyretics and pain
 11 medicine for E.M.T.s in version 03/2022. And
 12 probably everything else that's on this list as
 13 things that should be taught at the E.M.T., A.E.M.T.
 14 and paramedic level as well as to keep up to date for
 15 educators. The pre-hospital guidelines consortium,
 16 which is done to look at evidence every two years
 17 paid for by the National Registry and made available
 18 to educators across the country to update their
 19 curriculum, to keep people up to date. The exams
 20 that the National Registry does don't incorporate as
 21 much these two outdated federal documents as they do
 22 practice analysis.
 23 And those two documents I just
 24 mentioned, and I would suggest that we refer to the
 25 National Model Clinical Guidelines when we're making

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 2 considerations about protocols because many of these
 3 things that we're doing, if you compare to the
 4 national mono clinical guidelines, are not ahead of
 5 the time we're behind the time. Thank you.
 6 **MR. HUDSON:** And I was trying to be
 7 nice. That was Mike McEvoy who said New York's
 8 behind. Some -- sometimes yes, sometimes no, but I -
 9 - I think we're all saying the same thing, which is
 10 these appear sensible and appropriate and not rise to
 11 the level of pilot programs because they're not novel
 12 or new or unheard of or untried, you know, and not to
 13 belabor the conversation, but, you know, I remember a
 14 time as a paramedic where I had to make at -- what at
 15 the time seemed an arduous medical control phone call
 16 to give a nitroglycerin. Meanwhile, the patient had
 17 popped them like PEZ before my arrival, like, you
 18 know, and I needed permission to crack the, you know,
 19 seal on the bottle and pull the cotton out. I didn't
 20 understand it at the time, so thankfully those days
 21 are long gone. And I -- I think we're all mindful of
 22 not deviating too far from that.
 23 So yeah, next would be the alcohol
 24 pads. So, I think that appears twice in nausea
 25 vomiting adult and nausea vomiting pediatric. If

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 2 anyone wants to have the conversation offline,
 3 whether we should carry pediatric sized alcohol pads.
 4 I don't even know if that's a thing. But you know,
 5 again, it -- the more granular you get, sometimes the
 6 more outlandish the conversation becomes. So, if no
 7 one has a problem with that --
 8 **MS. DORSETT:** Is that what you shares
 9 are for?
 10 **MR. HUDSON:** Infection would then
 11 appear clarified to consider either, Cefazolin or
 12 Moxifloxacin, if equipped and trained. So in -- in
 13 the foundational documents, right, as we've said,
 14 P.O. is not covered for either of those antibiotics.
 15 So again, I guess the question would be do we feel
 16 confident that based on the protocol our providers
 17 would know when to give it, how to give it. And that
 18 when we say P.O. it means by mouth, not by nose or
 19 anywhere else. Again, going to clinical judgment
 20 complexity. And is this a departure from the norm.
 21 Two more and then we're done. So,
 22 burns clarified fluid for pediatric administration is
 23 paramedic level and is normal saline, twenty
 24 milliliters per kilogram, which may be repeated once,
 25 and clarified that tetracaine is paramedic only if

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 2 equipped and trained and trained as is Morgan Lens,
 3 which is inserted as paramedic only. So, eye drops
 4 don't appear in either one of the National Corporate
 5 Practice or the E.M.S. Education Standards. So, I
 6 would suggest to the group that the instructions are
 7 in the name eye drops, if that, again, is deemed too
 8 complex, I think we need to talk about it here. And
 9 if I'm snarky, you're welcome.
 10 **MR. GREENBERG:** I'm going to C.V.S. to
 11 look for the pediatric alcohol prep afterwards.
 12 **MR. HUDSON:** Yeah. And then the last
 13 one is tetracaine and eye injuries. Same concept.
 14 And that's -- that's really it. So I think if
 15 everyone's comfortable, the -- the real question
 16 educationally is, so then we'll use acetaminophen.
 17 So how much education has to come along with giving
 18 an E.M.T. acetaminophen? Is it just how to pronounce
 19 it? Is it a four-hundred-page PowerPoint that goes
 20 through the, you know, medical patent process to get
 21 your branded name of Tylenol, which is, you know, now
 22 generic is acetaminophen, i.e. how much is too much
 23 and how much is sensible?
 24 **MR. HUTH:** Don, may I for a second?
 25 **MR. HUDSON:** It's Dr. Walters

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 2 meeting. So yeah.
 3 **MR. HUTH:** Dr. Walters, may I for a
 4 second?
 5 **CHAIRMAN WALTERS:** Please.
 6 **MR. HUTH:** Howard Huth from SUNY
 7 Cobleskill. I have the luxury of sitting on the
 8 Protocol Committee, the Exam Writing Group and
 9 Training and Ed and I love this discussion, but what
 10 we really need to do is just make sure that all three
 11 of those are tied together. So, you know, in 2019,
 12 this -- this body and really this SEMSCO pushed us to
 13 align with National Education Standards, thinking
 14 that that was the right thing to do. And now we've
 15 realized that we just are moving faster and probably
 16 better than the National Education Standards, which
 17 is fine, but when we make decisions for protocols, we
 18 have to realize that then that needs to get filtered
 19 down and communicated to the education staff.
 20 And we should probably start back up
 21 another New York State Education Guidelines document
 22 so that we have the protocols aligned with what
 23 should be taught and tested. Because right now I can
 24 tell you that, you know, the things that we're
 25 talking about aren't even being mapped to entry level

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 2 certification exams. And some of them probably
 3 should be, and some are being mapped incorrectly
 4 because we may have a regional variance. So, in one
 5 area, somebody gets taught, if this happens, you do
 6 this, and in another area, you're being taught, if
 7 this happens, you do this instead.

8 So, we just need to make sure that
 9 wherever these changes are happening, we have them
 10 aligned and can give education time to catch up and
 11 certification time to catch up for implementation.
 12 Otherwise, we're literally going to be testing
 13 material that we're not teaching and or vice versa.

14 **CHAIRMAN WALTERS:** I think that's a
 15 good point. And I -- I think the other thing that
 16 question I get from some of our educators is some of
 17 these, quote, Optional skills or if equipped and
 18 trained and at what point, you know, maybe right now
 19 not everybody is doing S.G.A.s, for example. So
 20 maybe that's not the time that it's routinely taught
 21 in every single E.M.T. class or needs to. Maybe
 22 there are regions that are doing it in most of their
 23 agencies, and so they do want to teach it in there,
 24 but at what point does that go from an optional skill
 25 to something that we should be teaching to everybody,

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 2 write a test question towards that? The answer is
 3 you don't because you can't. Because now you have
 4 two different populations to try and test. So that's
 5 all I have. Dr. Walters. Thank you.

6 **CHAIRMAN WALTERS:** Well, what I heard
 7 was Howard was suggesting that Training and Ed was
 8 going to come up with this -- this document for the
 9 educators. Is that not what you heard?

10 **MR. HUTH:** We'd be happy.

11 **MR. HUDSON:** I believe the physicians
 12 are better qualified for that. Right? I agree. I
 13 believe this is a medical oversight function and
 14 Training and Ed would be happy to look at whatever
 15 this body produces to assure its compliance with
 16 education standards.

17 **CHAIRMAN WALTERS:** So, what I hear you
 18 saying is that this is something Dr. Rabrich should
 19 pick up when he's chairing the next Med Standards
 20 Committee meeting and we'll focus on the protocols
 21 today.

22 **MR. HUDSON:** And I have no doubt Dr.
 23 Rabrich will task his assistant with that. I am
 24 sure.

25 **MS. DORSETT:** I -- all joking aside, I

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 2 right? Such as glucometry or albuterol at this
 3 point. Right? And I think that distinction when
 4 that happens and when it evolves, is something we
 5 don't always pay attention to. And so, it's taught
 6 variably across the State.

7 **MR. HUTH:** I -- I completely agree Dr.
 8 Walters, I -- I almost envision like a list of
 9 minimum education and then optional education. So
 10 that if a course sponsorship really wants to teach
 11 the pieces above and beyond, they can teach the extra
 12 components to it. But that's going to take a fair
 13 amount of work for the folks in black shirts across
 14 the room and or upstairs. And that's just time.
 15 It's doable and it's probably a great approach to it
 16 because it would keep us active here. And then when
 17 we do something here in these rooms, we just let them
 18 know and we upgrade and bridge from there. But it's
 19 about -- it's about making sure that the educators
 20 know what they're supposed to be teaching.

21 And when a prime example of this is we
 22 were looking at questions regarding nuchal cord
 23 movement for C.F.R.s. And in New York City, they're
 24 allowed to move the nuchal cord, which makes sense
 25 and the rest of the State they're not. So how do you

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 2 think this is such a document would be nearly
 3 impossible to keep up to date. So, if you create a
 4 document and you give it to a bunch of black, white
 5 thinkers who say, this is the thing that I must
 6 teach, you're going to miss out on the opportunity.
 7 So, I mean Mike McEvoy highlighted it that the
 8 Prehospital Guidelines Consortium puts out, every
 9 single year a list of the updated evidence-based
 10 guidelines in pre-hospital care. They also put out
 11 something called the E.M.S. Professionals Reading
 12 List, which is a list of a bunch of experts saying
 13 these are the most important publications that
 14 everybody who's practicing in E.M.S. should read.
 15 And not only that they give access to most of those
 16 publications. But there's also a summary and key
 17 points to take away.

18 I think the main thing is we should be
 19 directing our educators to read the evidence, right?
 20 Like I know that we don't use the National Registry.
 21 I mean, I expect my students to take the National
 22 Registry, but there's something called the Table of
 23 Evidence, which they put out a publication that says
 24 how do we update what we're teaching, right? Because
 25 it describes how we update on the exam.

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 2 I tell my students there's no
 3 difference between, honestly, like I teach this, but
 4 it's different on the test. No, like I teach what's
 5 on the test. Because the test should be testing the
 6 evidence and I'm not going to spend time teaching you
 7 stuff that you should then forget when you actually
 8 take care of a patient. Like, I don't have enough
 9 time for that in an education program. I got to
 10 teach you the things that actually matter.
 11 So, I -- I would respectfully disagree
 12 and say like, we should be directing educators to
 13 resources on how to update their knowledge, not
 14 giving them black and white things of like, this is
 15 what you should teach. And those resources exist and
 16 somebody is already doing the work that we don't need
 17 to do and duplicate.
 18 **MR. HUTH:** So, my -- you're right down
 19 here, keep going to the left. Hi. And at a
 20 paramedic level we do the same thing. We teach to --
 21 to medicine and then they'll pass the test without a
 22 problem and we expect that they'll take the registry
 23 and pass also. On lower levels of education, it
 24 really becomes black and white stuff. And you have
 25 people that aren't career educators and they're

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 2 literally doing this as a side job at night once a
 3 year. And that level of -- of prep and education is
 4 almost unrealistic to ask of them at this point. So,
 5 we have to give the smaller course or C. F. R.,
 6 E.M.T. something as a guideline to go on because I
 7 don't think that they're going to make that lift.
 8 The last time we went through the update -- just for
 9 the State update in 2014, we actually had to go back
 10 down and do rollouts on how to teach pathophys of
 11 shock. And that was -- that was a stretch then.
 12 **MS. DORSETT:** But that's exactly it,
 13 right? Like what they need is not necessarily an
 14 outline. This is the stuff that you have to teach,
 15 especially if you don't understand it. They need the
 16 resources on how to teach it. So, like in our own
 17 region, when we identify that there was an issue with
 18 pre-hospital diagnostic error on stroke, right? And
 19 that most of the missed strokes, a posterior
 20 circulation strokes that come out as B.L.S. calls,
 21 like nausea, dizzy, weakness, I fell down. What we
 22 did was develop education.
 23 I don't expect to say if I told a
 24 bunch of E.M.T. educators, all right, I want you to
 25 educate on the identifying posterior circulation

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 2 stroke. The reality is most of them don't have the
 3 expertise on identifying, it's a hard thing to teach.
 4 So, we developed a toolbox, right? That we
 5 distributed to all our B.L.S. educators, which is a
 6 curriculum that I wrote with a stroke neurologist
 7 tested with B.L.S. educators and has actual real
 8 patient videos that we make available for them to
 9 teach.
 10 They don't need an outline that says
 11 this is what you should be teaching. They need us to
 12 give them the resources to teach the things that
 13 matter to patients well, which help them develop as
 14 educators. And I think when we have advancements
 15 saying collaboratively, how do we develop resources
 16 and distribute those throughout the State to the
 17 people who are doing the work, that makes a lot more
 18 sense than writing a guideline that we can't keep up
 19 with.
 20 **MR. HUTH:** I -- I can agree with that.
 21 I can -- I can agree with they need both though.
 22 Because if you've seen some of what's coming out of -
 23 - some of our E.M.T. classes across the State, right?
 24 So, like I'm trying to be -- I'm trying to be tactful
 25 and delicate. Mark your calendars. So -- so you

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 2 know, when you see some of this going on, like we'll
 3 -- we'll we do pre testing when they come into a
 4 paramedic class and almost none of our students that
 5 come in for paramedic class -- I'm sure you do the
 6 same thing, even meet close to a -- a baseline
 7 minimum competency off of current testing that's
 8 available. But when you look at folks that are still
 9 teaching -- either not teaching things that should be
 10 taught or -- or are teaching things that are
 11 literally a decade or more old as far as medicine, I
 12 think we have to start somewhere.
 13 And while you're right, I think an
 14 ideal world, it'd be great if we had partnerships
 15 where we could actually reach out, give them
 16 educational materials, train the trainers too and
 17 then let them teach. I don't know if we have the
 18 resources or management to be able to do that in a
 19 timeframe that would allow us to continue to evolve
 20 with medicine. So, I'd love to work with you on it,
 21 if there's something we can help with or open stuff
 22 up and share Statewide, that's fine. But I think we
 23 need to start somewhere. And unfortunately, I think
 24 some of low hanging fruit here is just some of the
 25 instructors just need to know. No, you shouldn't be

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 2 teaching that you're putting sandbags on a chest for
 3 a flail segment.
 4 **MS. DORSETT:** I think they can teach
 5 that. You almost never see a flail segment and you
 6 just manage the respiratory distress.
 7 **MR. HUTH:** Completely. Right? But --
 8 but --
 9 **MS. DORSETT:** I'm just saying.
 10 **MR. HUTH:** Right? Exactly. But I'm
 11 telling you --
 12 **MS. DORSETT:** Almost ever.
 13 **MR. HUTH:** Literally this year I had
 14 an E.M.T. tell me that that's what they were told in
 15 their E.M.T. class last year.
 16 **MR. HUDSON:** So, we all have stories
 17 like that, I think.
 18 **MR. HUTH:** Do we?
 19 **MR. HUDSON:** We did last night.
 20 That's all I can tell you. So anyway, inside joke.
 21 But we have a foundational or we have a guidance
 22 document that sort of tells us what the students
 23 should know. And although it's not intended as a
 24 teaching document, I think those are the protocols
 25 and you know, by going through them with the student

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 2 and then having the student explain them back to the
 3 class, really would cover that base and say, you
 4 know, hey, I don't know how to pronounce this big
 5 word. What do you mean it's an antibiotic? When did
 6 that change? And there we go. We've learned
 7 something. So, I don't want to overthink this. So
 8 go ahead.
 9 **MR. GREENBERG:** Two things on -- on
 10 it. Doctors, I think it'd be challenging to keep up
 11 with the list of something that goes along with it.
 12 However, I will also say we have a hundred and fifty
 13 educational institutions across the State, with a
 14 depth and breadth of a variety of expertise and
 15 specialties and kind of teaching styles, I will say
 16 not teaching abilities, that certain -- that some
 17 sort of collaborative document from this group and
 18 the education group may be valuable to say, hey,
 19 these are things you should consider focusing on.
 20 These are things you should know if
 21 it's emphasized within your region or not, or things
 22 from that component to be able to give to an
 23 educational institution and let them know. And I
 24 also think it would be valuable for the actual
 25 agencies to be aware of that an agency knows if they

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 2 went to X institution that these five things were
 3 taught, but these five weren't. So that they know if
 4 they have the base knowledge and things like that so
 5 that they, you know, have additional information or
 6 do they have to incorporate that completely into
 7 their onboarding program. And so there -- there
 8 could be, you know, as you talk about this going back
 9 and forth, there could be value here in multiple ways
 10 of having some sort of document that helps both the
 11 medical directors of the agencies, the E.M.S. agency
 12 leaders, the training coordinators know what's been
 13 taught and what hasn't so that they can best prepare
 14 and maybe even guide certain continuing education
 15 based on it or -- or different things that come on
 16 that front or collaborative educational institution,
 17 you know, programs that kind of drive those.
 18 **CHAIRMAN WALTERS:** So, I -- I think
 19 one of the questions or that I hear from our
 20 instructors in -- in my area that comes up frequently
 21 is when there's a question about what they should be
 22 teaching. I mean, talk about basic E.M.T. class
 23 even, and they're, you know, especially about
 24 optional skills or certain things and they reach out
 25 to the division and this is how it's relayed to me.

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 2 So, I'm not -- this is not a -- a shot at the
 3 division or any one person in the division in that,
 4 but they're often taught -- told, well you need to
 5 teach to the -- the national education standards.
 6 And now I'm kind of hearing in -- in
 7 this discussion from what Dr. Dorsett and Mike McEvoy
 8 and Howard even said, you know, maybe that's not the
 9 right answer and that's not the guidance we should be
 10 giving. And so, if it's not, then maybe we need to
 11 clarify what that guidance is. And maybe it's as
 12 simple as giving them the links and references to
 13 things they should be doing but trying to standardize
 14 that. Maybe that's not a heavy lift of coming up
 15 with a whole list of things but making sure that
 16 everyone is aligned from the -- the division down to
 17 that basic E.M.T. instructor of what the expectation
 18 is and what they're teaching.
 19 And it sounds like just hearing this
 20 discussion, it -- it's clear there's some variance
 21 across the State and -- and that we're -- something
 22 that we might need to address but do it in a way
 23 that's not time intensive that's nimble enough. And
 24 -- and obviously it can't be so comprehensive that it
 25 becomes another outdated document like the ones that

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 2 we're talking about. And I don't know necessarily
 3 how to crack that nut, but I think that that's
 4 something we -- we maybe should be looking at.
 5 **MR. GREENBERG:** The one thing I'll
 6 say, and -- and like you said Dr. Walters, from the
 7 discussion here and from what registry might be
 8 putting out there I will remind everybody that data
 9 entry point twenty you know, does state that students
 10 who have met the requirements of the current National
 11 Emergency Medical Services Educational Standards of
 12 2021 and incorporated from eight hundred point one
 13 five as well. So, if we are looking to make a change
 14 in what we think should be followed in the education
 15 that's being delivered, these regulations were just
 16 updated last year -- year-and-a-half ago maybe and
 17 went out for public comment. I don't believe we got
 18 any public comments back on this component of it.
 19 Went out I -- I think these actually went out for
 20 public comment twice, and then was voted on by this
 21 body. So --
 22 **CHAIRMAN WALTERS:** Well, I think that
 23 --
 24 **MR. GREENBERG:** It doesn't mean they
 25 can't change just saying.

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 2 **CHAIRMAN WALTERS:** But I think that
 3 we've already just established in this conversation
 4 that those set a floor, not a ceiling. And so, if we
 5 go above those, right? You are still meeting that
 6 minimum threshold that's in the regulation.
 7 **MR. GREENBERG:** Yes, absolutely.
 8 **MS. DORSETT:** And the education
 9 standards, right? When they updated the education
 10 standards, they got rid of the instructional
 11 guidelines. They used to be paired and the
 12 instructional guidelines had the education standards
 13 and then a list of like, this is the actual stuff
 14 that you should teach, like an outline of what you
 15 should be teaching in a classroom. The education
 16 standards is essentially a list of topics with depth
 17 and breadth with a whole bunch of variability. And
 18 in the education standards, I think it's okay to
 19 reference that in that there always has to be input
 20 of updated evidence. It's in the figure updated
 21 evidence as well as local standard.
 22 I propose that we do something kind of
 23 more like with the pediatric pre-hospital
 24 preparedness project. I can never say it because
 25 there's too many goddamn p s in the thing, but they

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 2 did something called the toolbox, right? So, they
 3 had the checklist where at the individual agencies
 4 you could do a checklist of, these are the things
 5 that I needed. And then together E.M.S. for
 6 children, the innovation center put together a
 7 toolbox. So, you can go and I say, I don't actually
 8 have much on this and I go to their website and they
 9 literally have like a whole thing and I can pull a
 10 bunch of skills evaluation, checklists for my
 11 providers on pediatric skills. I can pull child
 12 abuse education on recognition of child mass --
 13 maltreatment that was built by University of
 14 Colorado.
 15 And so, I think if we break down what
 16 are the -- the core content areas and what you should
 17 be teaching, we could build a toolbox like that that
 18 people can actually put up quality education on how
 19 to do that. Because I can say you should be teaching
 20 somebody how to ventilate somebody. I can tell you
 21 as a medical director, I don't trust that anybody was
 22 taught how to face mask ventilate any patient
 23 correctly. Because I cannot take it for granted even
 24 though that it's a skill. Because when I watched it
 25 and I watch the capno waveforms, it is done poorly.

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 2 And so, I verify that and I think about how I teach
 3 that. But if I could give people a video that shows
 4 them a different technique to do it and the things
 5 and incorporation and have that taught in E.M.T.
 6 programs, I'd much prefer that because then I'm also
 7 educating the instructors to update their knowledge.
 8 **CHAIRMAN WALTERS:** And, you know, I
 9 think we are in a position these days to be able to
 10 put together not only toolkits, but we have a
 11 centralized learning management platform that, you
 12 know, people that -- many of our providers go on to
 13 regardless, that could become an additional tool for
 14 agencies to say, here's your toolkit, here's the
 15 education in one centralized place. You can put in
 16 other places as well, but it is there if you want it.
 17 And here's your skill sessions and things. So, I
 18 think the model of having guidance documents and
 19 toolkits and things like that can be an excellent one
 20 both for the educational institutions as well as the
 21 operational individual agencies as well.
 22 **MR. CLEMENCY:** Dr. Walters, it seems
 23 like a lot of this would be moot if we just moved to
 24 the national registry. Thank you.
 25 **CHAIRMAN WALTERS:** Thank you, Dr.

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 2 Clemency, that sounds like another Training and
 3 Education issue, but I appreciate that comment and so
 4 does Don Hudson. With that said, I -- I want to
 5 bring this back because I think this was an
 6 excellent, joking aside, an excellent conversation on
 7 -- on the education in that and maybe some things we
 8 can talk about going forward in the future. But I do
 9 want to come back to what sparked the discussion,
 10 which was the proposed protocol updates. And given
 11 the things that we've gone through and discussed that
 12 Don pointed out, and I don't think there's really any
 13 opposition or any substantive changes to what was
 14 proposed from anybody in this group. And so, if
 15 they're -- if I'm correct in that, then I think that
 16 -- these will obviously just be discussed. They'll
 17 be discussed at SEMAC and SEMSCO as well. But I
 18 don't hear anybody from this group, from medical
 19 standards having any issues with -- with anything
 20 that's in the proposed protocols. If you do speak up
 21 now.
 22 **MR. WINSLOW:** Motion to approve them.
 23 **CHAIRMAN WALTERS:** Well, we're not
 24 voting on them and moving them forward. This is just
 25 for discussion. The -- the motion will come at the

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 2 February meeting to approve and move them to SEMAC
 3 and SEMSCO. This is just more of a discussion. Am I
 4 --- correct me if I'm wrong, Dr. Dailey, right?
 5 **MR. DAILEY:** Yes, that's fine.
 6 **CHAIRMAN WALTERS:** No. But thank you
 7 anyways. Before we move on, any other questions on
 8 the protocol -- on the protocols?
 9 **MR. GREENBERG:** So, the only other
 10 thing I would say on the protocol, so in -- in
 11 theory, could you today? Yes, you could.
 12 **MR. DAILEY:** They -- they're an
 13 approved document. It sounds like the desire
 14 possibly, maybe the -- the desire of the chair. I
 15 don't know where the instructions came from, was to
 16 sit there. I will say the -- the one easiest part of
 17 having it sit till February is that if anybody didn't
 18 get a chance to fully read it today, and something
 19 comes up between now and February, a document that
 20 isn't fully approved yet is easier to make a
 21 modification, a change, anything else. So, if
 22 anybody during these period of time has changes or
 23 things, I think they go to --
 24 **CHAIRMAN WALTERS:** So really if
 25 there's any starts Michael Dailey, if -- if there are

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 2 any changes that anybody notices, bring them back to
 3 -- to this committee to discuss prior to it being
 4 moved forward to SEMAC and then counsel next and --
 5 **MR. GREENBERG:** Bring back the changes
 6 during the break so that we can fix the documents and
 7 have it separate.
 8 **MR. DAILEY:** And we can start -- and
 9 then we can also discuss them, you know, at the -- at
 10 the next meeting as they should be. So --
 11 **MR. HUDSON:** So just two questions, I
 12 guess. Procedurally there is a proposed or a draft
 13 protocol change process, which sets out a timeline.
 14 My opinion is that hasn't been as widely circulated
 15 as I would've hoped. I think there's an opportunity
 16 to include that as either an appendix or a preamble
 17 to the current protocol manual, the same way that our
 18 by-laws embedded in them explain the process to -- to
 19 change the by-laws, right? So, I don't know that it
 20 helps us maintaining two disconnected references, the
 21 protocol manual, and then a separate somewhat elusive
 22 document that explains how to change it. When in my
 23 mind it should either be the first page of the last
 24 page of the protocol manual is here's the changes
 25 over the years, here's that process to do so. And

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 2 that lays out the timeframe where they come up in
 3 December, they sit till February, and then they vote
 4 and are implemented July 1st.
 5 **MR. GREENBERG:** Just to clarify, so
 6 are you referring to the process to change something?
 7 You're talking about the change log being included in
 8 the document? Or both?
 9 **MR. HUDSON:** I would say both. It
 10 seems sensible.
 11 **MR. GREENBERG:** I'm just -- that's
 12 just a point of clarification.
 13 **MR. HUDSON:** And then if -- if that's,
 14 you know, an agreed upon intent in order to get the
 15 drafted protocols out to the masses, knowing that
 16 this isn't a public -- technically a public or a
 17 televised meeting, would it be proper to move them
 18 out of this committee up to the SEMAC level so that
 19 they -- they then are, quote unquote, Public
 20 documents. I'm looking also move -- move the
 21 protocols out of here if there's no problems with
 22 them.
 23 **MR. GREENBERG:** They're public
 24 documents now. Moving them out of here doesn't
 25 change whether or not they're public or not. They're

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2 public documents because they came to the meeting.

3 **MR. HUDSON:** I only say that knowing
4 that I'm currently getting texts that people can't
5 find the links for this afternoon's public meeting, I
6 don't have high hopes that those same people know
7 where to look for the public protocol documents. I -
8 - I don't want to be --

9 **MR. GREENBERG:** That's a different
10 story. Well, yes and no. So, but you know, I -- I
11 would second Dr. Winslow's motion.

12 **CHAIRMAN WALTERS:** Winslow?

13 **MR. WINSLOW:** Yeah. I mean the more
14 advanced notice we get out to regions to work in
15 education, the better. And I think this is a great
16 discussion to have. I -- I'm okay with -- with
17 withdrawing my motion. Thank you, anyway, Don, and
18 have it done in February. But I -- I strongly
19 recommend we move faster because it gives our
20 educators time to plan.

21 **MR. HUDSON:** And I -- I'll echo that.
22 I think as long as something says draft on it, people
23 don't feel like it's happening, you know, and we know
24 what the intent is that their draft until they're
25 not. And that happens June 30th for June -- July 1st

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2 implementation. But you know, people need time to
3 see that, yes, they're draft, but they're happening.

4 **CHAIRMAN WALTERS:** So, I -- I can kind
5 of see both sides of it. The intent was -- was that
6 these were just going to be discussion and not voted
7 on at this meeting, but there seems to not be any
8 dissent and -- and at least amongst the -- I think
9 physicians, the Collaborative Protocol Group, these
10 have certainly been out there for -- for a while and
11 we've all sat on those meetings and been involved in
12 that. So, I'm happy either way and -- and if we
13 think we should move these forward, then we can
14 entertain that motion and we can move them forward.
15 if we want to wait till February, I think I'm okay
16 with that as well, but I'm just going to open it up
17 to the group for not necessarily a motion, but a
18 discussion or a straw poll here. Go ahead.

19 **MR. CLEMENCY:** What was last year's
20 process?

21 **CHAIRMAN WALTERS:** I think we should
22 just do the same. And I can't remember honestly.

23 **MR. DAILEY:** I -- I believe -- I
24 believe the intent, the --

25 **CHAIRMAN WALTERS:** The process that we

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2 had come up with was that it gets approved at the
3 first meeting of the year and implementation would be
4 in July, right? July one. I don't know that there's
5 a great difference between us approving it now and
6 giving an additional couple of months for Training
7 and Ed to work on all of the things that Don wants to
8 do around pediatric alcohol pad placement. But it's
9 certainly options.

10 **MR. GREENBERG:** You realize I'm going
11 to have agencies calling us, asking us where we're
12 supposed to locate these pediatric alcohol prep pads
13 to buy? I'm sending them to you.

14 **MR. HUDSON:** They can include that in
15 the same emails about the length of decompression
16 needles to Ed Major.

17 **MR. GREENBERG:** So, I -- I think there
18 was a secondary thing and -- and this actually does
19 have to go with the, you know, is related to the
20 document and would get updated. So, there's a
21 question of whether or not there should be what I
22 would call two different appendixes, one appendix
23 related to the change process, what is the process
24 and a second appendix that would be really -- that
25 would be the change log. So currently today the

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2 change log that's there is attached as a separate
3 document, which means it is up on our website, and
4 directly below it. It is a change log for any
5 changes that were made since the previous version.

6 I think, you know, we've always felt
7 that that was sufficient. I -- I think from what I'm
8 hearing from Don is more providers on a regular basis
9 access the protocol set itself in one shape, way, or
10 form, whether that be through an app, whether that be
11 through, hey, I, you know, I have a copy of it. And
12 may not always have a copy of the change log, right?
13 Or may not be in the same place to look for it. And
14 so, is there value in putting that in? I sit neutral
15 on it.

16 I'm just putting it out there because
17 this would be a change to a document that we would
18 have to make for the February meeting in order to
19 approve it. And then the second question of did we
20 want to add, you know, the page in there related to
21 how do protocol changes happen, recommendations for
22 protocol changes, things of that nature for the
23 collaborative protocols?

24 **MR. CLEMENCY:** I think the suggestion
25 to put a page at the end about the process is a good

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 2 one. And how providers can provide suggestions. I
 3 would not recommend embedding the change log in the
 4 protocol though, but I think it's a great discussion.
 5 **MR. GREENBERG:** Can I ask why?
 6 **MR. CLEMENCY:** It's a giant P.D.F.
 7 that's just becoming a giant-er P.D.F.
 8 **MR. GREENBERG:** I don't know if we've
 9 referenced it or not. It might be an opportunity in
 10 the intro or something else to note that there is a
 11 change log and where to find the change log. Maybe
 12 that would be the compromise on that one. I would
 13 still put in the end of how changes are made and I
 14 think that's a single page and can be really good. I
 15 -- I think to be honest, and -- and Don, thank you
 16 for bringing up, because I'd be curious to see if we
 17 get more provider -- field provider input if they
 18 have a Q.R. code sitting on the last page that says,
 19 don't like something or think something should be
 20 changed, click here. So, it'd be -- I'd be curious
 21 in that one. I think putting a link or you know,
 22 just documentation saying, hey, you can find where
 23 the change logs are, could be a good one too. Which
 24 also would also make you look for the most current
 25 change log, which is important too.

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 2 **MR. HUDSON:** Just to clarify by change
 3 log, I don't mean, you know, a fourteen-page document
 4 that says we added a comma on page three. I'm just
 5 saying that, you know, Supraglottic Airway added to
 6 B.L.S. level 2025.
 7 **MR. DAILEY:** So, all of that said, I
 8 actually have one addition to the protocols that I'm
 9 just getting texts about right now, But -- but it's
 10 actually a very simple one and it's moved back to
 11 where we were previously. Which is for the
 12 medication infusion reference. We currently have
 13 moved to two hundred and fifty milliliter bags of
 14 fluid to mix our infusions in. Previously we've used
 15 liter bags on a regional basis in REMO we always had
 16 saline in one hundreds. We had D ten and two fifties
 17 and then we had normal saline again in liter bags.
 18 And we did that just so we'd make sure that there was
 19 never any question as to what patients were getting
 20 and we would make it as simple as possible. Request
 21 was from a number of our different agencies to have
 22 an alternative reference for liter bags as well as
 23 the two fifties, not taking out the two fifties, just
 24 also having it for liter bags.
 25 **MS. DORSETT:** I think that -- Mike, I

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 2 think that was done. It's in the change log.
 3 **MR. DAILEY:** It was supposed to be.
 4 **MS. DORSETT:** It wasn't done?
 5 **MR. DAILEY:** I didn't see it there.
 6 **MS. DORSETT:** Okay.
 7 **CHAIRMAN WALTERS:** I am glad that we
 8 could fix that for you so quickly. All right. So
 9 based on that I -- I hear is the consensus then that
 10 we would like -- like an appendix that outlines the
 11 protocol change process and timeframes and a link for
 12 suggestions in the protocol but keep the change log
 13 out of it. Is that the will of the group?
 14 **MS. DORSETT:** Sounds good.
 15 **MR. HUDSON:** Yes.
 16 **CHAIRMAN WALTERS:** Okay. Then -- then
 17 it would it be appropriate then to make those changes
 18 and put them in -- into the protocol that comes up
 19 then to vote at the February meeting? Is that the
 20 right process then? Since we're going to add that?
 21 **MR. HUDSON:** Perfect.
 22 **CHAIRMAN WALTERS:** Then I think that
 23 settles it. Well that was the longest part of the
 24 meeting today, I think. And there's just a couple
 25 things left, so I'm going to move on in the interest

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 2 of time here. There on the agenda you'll see LifeNet
 3 Air medical protocols and I believe that those were
 4 not formally approved by the REMO to come here for a
 5 vote today. Is that correct Dr. Dailey?
 6 **MR. DAILEY:** Actually, in the review
 7 of the process that we followed there we were not
 8 fully in compliance with the open meetings law at the
 9 time of those protocols were passed. So, they will
 10 be coming to -- to this group in February.
 11 **CHAIRMAN WALTERS:** Very good. I also
 12 believe there was another region, maybe Dr. Doynow,
 13 you can speak to it, that submitted, I don't know if
 14 it was New York City or that submitted some protocol
 15 changes, but I don't believe they were in in time and
 16 they did not get circulated to the group. So --
 17 **MR. DOYNOW:** Yes, they were sent to me
 18 via the department two weeks ago. So, we can discuss
 19 them, but it's not enough time to -- to vote on them.
 20 **MR. ISAACS:** We -- we can push to next
 21 meeting. Understand they were not submitted in
 22 times.
 23 **CHAIRMAN WALTERS:** I think that'll be
 24 best because they weren't circulated, so no one's
 25 seen them or had a chance to review them, but we'll

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 2 certainly get them out and -- and put them on the
 3 agenda for February. So that's it. Go ahead Dr. Wi
 4 -- Winslow.
 5 **MR. WINSLOW:** Can we just state for
 6 the record how much time is needed? I believe it's
 7 six weeks is requested, but if that can be clarified
 8 please?
 9 **MR. GREENBERG:** Documents normally
 10 have to come in about six weeks out. It's about six
 11 weeks out to get everything to go into the packet and
 12 then get everything approved and up. I think those -
 13 - the protocol changes got put in last week and so we
 14 put them in the document for February.
 15 **CHAIRMAN WALTERS:** All right. Then as
 16 we get to the end of our agenda here, I have one item
 17 and then I'll open up for any other new business that
 18 anyone wants to bring forward. At the last meeting
 19 and I forget if it came up at SEMAC or SEMSCO where
 20 the discussion was exactly, maybe it was med
 21 standards. There was some brief discussion about
 22 cervical spine mobilization, if you remember when we
 23 talked about that. And Dr. Clemency, I think you
 24 brought up what N.A.E.M.S.P. was working on and --
 25 and -- and some of that.

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 2 For those of you that that don't know,
 3 the New York chapter of the National Association of
 4 E.M.S. Physicians does monthly Empire State Grand
 5 Rounds for the E.M.S. fellowships and that. And puts
 6 together a zoom meeting, brings in different speakers
 7 from across the country. This past -- just a few
 8 weeks ago before Thanksgiving, they brought in Dr.
 9 Mike Millen to speak, who was the lead author on the
 10 N.A.E.M.S.P. review and analysis of the literature
 11 regarding spinal cord injuries and -- and that -- and
 12 I thought it was a very good topic and conversation
 13 that he did and went through the literature review
 14 and -- and presentation and then had time for -- for
 15 questions and discussion in that.
 16 And so if this is something that we
 17 want to start looking at from a State perspective,
 18 and I'm not looking to open up a -- a debate on that
 19 topic today, but if it's something that we want to at
 20 least look at and decide where we stand one way or
 21 the other, Dr. Millen has been -- said he would be
 22 agreeable to meeting and doing a presentation for
 23 this group for SEMAC, SEMSCO, Med Standards, or we
 24 could include STAC in that discussion as well in the
 25 future.

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 2 And so I want to open that up to see
 3 if this is something we want to pursue, and then the
 4 best format to do that, whether we have him do a hour
 5 presentation somewhere during the committee days like
 6 yesterday or during Med Standards, or do it during,
 7 you know, a televised meeting of SEMAC or do it at a
 8 meeting in between Zoom and we can involve STAC and
 9 get some more discussion and -- and just education on
 10 that. So that is something that he has been willing
 11 to do, and so I bring it forth for conversation to
 12 see what the feeling of the group is.
 13 **MR. HUTH:** Sounds like a good idea.
 14 **MS. DORSETT:** So I -- I want to
 15 clarify also that that was a review published in pre-
 16 hospital emergency care that was not a physician
 17 statement of the National Association of E.M.S.
 18 Physicians. For those who are interested, actually,
 19 N.A.E.M.S.P. is doing a town hall specifically on
 20 this subject this Friday at noon. And I can share
 21 the link if people want to do that. That's talking
 22 about a discussion of how do you change standards of
 23 care around this. While I have my own personal
 24 feelings about the utility of cervical spine care
 25 that we use in the field, I think having a -- a

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 2 discussion of how do we change practice in a way that
 3 actually collaborates with the entire continuum of
 4 care is really important. Because, well, the absence
 5 of evidence is not the evidence of absence, right?
 6 Which is -- just because I don't have a ton of
 7 evidence for what they do, I have to like think about
 8 how I'm going to change practice in a way that
 9 doesn't put our E.M.S. clinicians in a bad spot when
 10 they're bringing patients to the emergency
 11 department. And I think we should follow a process
 12 that looks like what we did for backboards, and how
 13 we change practice there. So, I -- I think we can
 14 have this discussion, but I don't think it should be
 15 one person with a very strong opinion on one side of
 16 the story to present that material.
 17 **CHAIRMAN WALTERS:** Go ahead.
 18 **MR. CLEMENCY:** Yeah, I -- I agree with
 19 Dr. Dorsett. I think Dr. Millen is an important
 20 advocate in this discussion, but I think this
 21 discussion is too young to bring to this committee
 22 yet. And I think we need to let the dust settle a
 23 little more first.
 24 **CHAIRMAN WALTERS:** And so, what I
 25 think you both are saying, or I think that down the

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 2 road there will probably be some type of joint
 3 position statement, whatever that may be, and we're
 4 waiting -- maybe perhaps we wait for this -- this
 5 type of conversation. Wait until that happens. Is
 6 that what I read between the lines?

7 **MS. DORSETT:** Yeah. So, the National
 8 Association of E.M.S. Physicians is working together
 9 with the American College of Surgeons as well as
 10 A.S.E.P. and actually, like some spine organization
 11 is actually funding a systematic review and
 12 development of evidence-based guidelines. And that's
 13 actually something that's been budgeted for in the
 14 next year. It takes a lot of work and time to bring
 15 every single person to the table, but I think when
 16 you're changing practice in a way that affects every
 17 single clinician at the table that's the way it needs
 18 to be done. It needs to be done collaboratively. So
 19 that is something that the organization is working on
 20 towards developing a joint position statement and
 21 essentially updating the existing guidance on spinal
 22 motion restriction.

23 **MR. DAILEY:** So, all that said,
 24 there's already a small group from the SEMAC and the
 25 STAC that's working towards this. I was actually

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 2 going to talk to Don about having an addition of
 3 somebody from Training and Ed to -- to sit and talk
 4 to us. Our current spinal motion restriction process
 5 is clearly too inclusive. We are putting collars on
 6 a lot of people that probably don't need them. Mike
 7 would argue that nobody needs them, but that's a
 8 different story. I think both Brian and Meyer are
 9 speaking appropriately to the fact that we have to
 10 act within the house of medicine rather than outside
 11 it, even though we practice outside it.

12 So, the biggest concern that comes
 13 from members of the STAC is what we do about our
 14 geriatric patients who are most likely to have
 15 challenging exams and cervical fractures. Yet at the
 16 same time, they're also the people that are most
 17 likely to have challenging anatomy where you can't
 18 put a collar on them anyway. So, all of this stuff
 19 is -- is coming together. There will be some minor
 20 changes that will be relatively minor changes that
 21 will be a part of the collaborative protocol update,
 22 that will come forward for February. But that's
 23 working with the STAC, so at least we're starting
 24 inside the house of medicine.

25 **CHAIRMAN WALTERS:** Thanks. Dr.

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 2 Cooper.

3 **MR. COOPER:** I guess I see this just a
 4 little bit differently, in the sense that I was
 5 hearing your suggestion as an opportunity to, you
 6 know, hear someone, you know, who has, you know,
 7 views on this particular subject. Is a recognized
 8 voice, you know, and, you know, I kind of saw this
 9 almost as an opportunity for us to -- as a group to
 10 say, well, why don't we organize, you know, a series
 11 of -- shall we say SEMAC Grand Rounds or something
 12 along those lines, that -- that, you know, doesn't
 13 carry the information of a protocol change or
 14 anything like that, you know, but just -- just a sort
 15 of a -- a fun educational thing to do, you know, for
 16 the, you know, not only for ourselves, but for, you
 17 know, for members of our, you know, larger
 18 constituency.

19 You know, certainly that I would see
 20 that as being something, you know, that would not be
 21 done in conjunction with a meeting because -- but in
 22 doing it in conjunction with the meeting does sort of
 23 suggest that it's, you know, something more or less
 24 official. Whereas it is just an opportunity for us
 25 to, you know, to hear a -- to hear a, you know,

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 2 perhaps a -- a different voice than, you know, than -
 3 - than we've heard in the past.

4 And I think there are other
 5 individuals, you know, that have similar sorts of --
 6 out of the box views in other, you know, areas of
 7 pre-hospital care that might -- might also be, you
 8 know, tapped to sort of share their -- their views
 9 with us. So -- I sort of thought -- sort of saw it
 10 as a, you know, as an opportunity for us rather than,
 11 you know, something that we should hold off and wait
 12 until there's an official pronouncement from, you
 13 know, from an A.M.S.P. or any other group. Just --
 14 just my thoughts.

15 **CHAIRMAN WALTERS:** That was -- that
 16 was my intent. And I guess in hearing some of the
 17 comments though, I think it is important to maybe
 18 make sure it's the right timing and -- and right, we
 19 don't want to move in one direction, then a position
 20 statement comes out that moves slightly the opposite
 21 direction. And -- and so -- so maybe we just look at
 22 the timing and -- and how we do -- do those things.
 23 I think the -- what's going on with STAC is also
 24 important. So maybe it's just the coordination of
 25 all those. And Dr. Dailey, you have some thoughts?

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 2 **MR. DAILEY:** No, the thing I was going
 3 to just follow up on to Dr. Cooper is that if anybody
 4 is interested in -- in Dr. Millen's thoughts on this,
 5 the N.A.E.M.S.P., New York State Grand Rounds that
 6 Dr. Millen did is available on YouTube. I have the
 7 link and can disseminate it to anybody that's
 8 interested in it. I watched last night. It's great.
 9 **CHAIRMAN WALTERS:** Well then maybe
 10 that's a place to start. I mean, this is something
 11 we -- we just put on the back burner and circle back
 12 to once we the N.A.E.M.S.P. position statement comes
 13 out once STAC s working group has some -- I guess
 14 more concrete direction or suggested recommendations,
 15 Dr. Dailey. So --
 16 **MS. DORSETT:** You could do it as a
 17 joint thing with STAC. Right. I mean, that's the
 18 starting point, is that -- if he wants to present, I
 19 would motion that it's a joint presentation, not just
 20 to one segment, but to be joint with STAC. Because
 21 that's, I think the, I mean, I don't think they do
 22 anything, right, but I can't change practice because
 23 Meyer doesn't -- like Meyer doesn't think that, or
 24 that's like, there isn't much evidence, right. Like
 25 I have to do it together on a continuum of care. And

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 2 so, I would, if we do that, it should be joint with
 3 STAC, which are the -- our partners in management of
 4 trauma.
 5 **MR. DAILEY:** Sure. Absolutely.
 6 **CHAIRMAN WALTERS:** Very good. Then
 7 maybe I'll speak with Dr. Dailey after the meeting
 8 about this offline and in interest of time to move
 9 forward. Is there any other items -- I think that
 10 takes us to the end of our agenda here. Any other
 11 items for new business that anybody wants to bring up
 12 before we adjourn? Dr. Winslow?
 13 **MR. WINSLOW:** Thank you. I -- I have
 14 one thing. I wanted to bring up a joint pilot
 15 program with Suffolk and Nassau County REMACS in the
 16 last two weeks. Both Suffolk and Nassau REMACS
 17 approved a pilot project to have paramedics
 18 administering Keppra sixty milligrams per kilogram
 19 I.V. for seizures. Keppra recently has been added to
 20 the protocol for Rhode Island AND New Jersey, and we
 21 have support from several local neurologists, from
 22 multiple healthcare systems that this is a good idea.
 23 I didn't have the ability to have enough time in
 24 advance to send it officially, but I wanted to bring
 25 it up to see if there's support or lack of support

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 2 for this. It's a chance for both Nassau and Suffolk
 3 to work together, which I think is a great idea.
 4 So, I bring it up here for discussion
 5 with the idea being that if there is support, I would
 6 send it next week officially through the channels to
 7 be able to bring it back in February. The proposed
 8 protocol would be as a paramedic level, treat the
 9 seizures with Midazolam and then Keppra sixty
 10 milligrams per kilogram I.V. once with a maximum dose
 11 of forty-five hundred milligrams over three to five
 12 minutes in the event that there is more than one
 13 seizure, as a means of trying to prevent or treat
 14 status epilepticus. And I was hoping to be some
 15 support for this. And I think this -- this does have
 16 TO pass the sniff test for doing a pilot as opposed
 17 to moving it directly into protocol.
 18 **CHAIRMAN WALTERS:** Dr. Kluger?
 19 **MR. KUGLER:** This is David Kugler on
 20 Nassau, this was presented to the Nassau County REMAC
 21 and was wholeheartedly embraced and approved to join
 22 along with Suffolk County in starting this pilot
 23 project. So, there is support at least in one
 24 region. So, we're looking forward to hearing
 25 everybody else's support after you get the

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 2 information.
 3 **MR. WINSLOW:** If -- if it's okay with
 4 the group, I'll -- I'll put it on the board --
 5 Boardable so that the group can read it and I'll send
 6 it officially as an application to the division next
 7 week. Thank you.
 8 **CHAIRMAN WALTERS:** Yeah, I'm not
 9 hearing any big opposition. Just -- remind me again,
 10 the cost of I.V. Keppra?
 11 **MR. WINSLOW:** It's five dollars.
 12 **CHAIRMAN WALTERS:** So not cost
 13 prohibitive?
 14 **MR. WINSLOW:** No.
 15 **CHAIRMAN WALTERS:** Very good. Any
 16 other new business anybody wishes to bring forward?
 17 Dr. Cooper?
 18 **MR. COOPER:** The -- in order to raise
 19 additional funds for our -- for our work at the
 20 E.M.S.C. sub-committee, we will be arranging for a
 21 fundraiser for a five-millimeter alcohol pads to be
 22 available to who wants to buy them. And those will
 23 be appropriately sized for pediatrics, absolutely
 24 weight based, just not, that will be the neonatal
 25 size, but there will also be other sizes as well.

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 2 **CHAIRMAN WALTERS:** And that'll be
 3 available in time for Christmas.
 4 **MR. COOPER:** Absolutely.
 5 **CHAIRMAN WALTERS:** Thank you. All
 6 right. And on that note, I think I'll entertain a
 7 motion to adjourn. So moved. Thank you.
 8 (The meeting adjourned at 9:37 a.m.)
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 2 STATE OF NEW YORK
 3 I, MONIQUE HINES, do hereby certify that the foregoing
 4 was reported by me, in the cause, at the time and place,
 5 as stated in the caption hereto, at Page hereof; that
 6 the foregoing typewritten transcription consisting of
 7 pages 1 through 85, is a true record of all proceedings
 8 had at the hearing.
 9 IN WITNESS WHEREOF, I have hereunto subscribed
 10 my name, this the 31st day of December, 2025.
 11
 12 MONIQUE HINES, Reporter
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