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

12/10/2025 - Medical Standards - Troy, New York

APPEARANCES:

ARTHUR COOPER
BRIAN CLEMENCY
DANIEL OLSSON
DAVID KUGLER
DAVID VIOLANTE
DONALD DOYNOW
DONALD HUDSON
DOUG ISAACS
ERIN REESE
EUGENE HESLIN
GINA WIERZBOWSKI
HOWARD HUTH
JASON WINSLOW
KATHLEEN HALLINAN
KIRBY BLACK
MAIA DORSETT
MERRY RUDRINGER
MICHAEL DAILEY
MIKE MCEVOY
RYAN GREENBERG
STEVEN DZIURA
THERESA ALLEN

12/10/2025 - Medical Standards - Troy, New York

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

CHAIRMAN WALTERS: As you can tell, I am not Dr. Rabrich. He could not be here today. So I'm standing in and running Med Standards today. Just to be clear, I did this once before and I am not the Vice Chairman of Medical Standards, nor am I aspiring to become the chairman one day. Dr. Rabrich said he had a very prestigious offer for me, and I misunderstood and thought I was the Assistant Medical Standards Chairman, and he made it clear that I was the Assistant to the Medical Standards Chairman and here I am. So that said, the attendance record is going around to make sure that everybody signs in who's on this committee. And with that, we'll move into our agenda and start with the old business. The first two items on there are the update on the B.L.S. Supraglottic Airway policy, which is now out and then Blood Implementation update. And Gina, would you be willing to give an update for us, please?

MS. WIERZBOWSKI: Absolutely, Dr. Walters. Good morning, everybody. The long awaited Supraglottic Airway was finally published on our web policy webpage in November of this year. It has a few things that I think are worth mentioning. So we

12/10/2025 - Medical Standards - Troy, New York

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

Lastly, I think the last thing that's of note is we at the division updated our Vital Signs Academy and much thanks to Amy Eisenhauer. We have two trainings available for agencies. The first one is Supraglottic imp -- Supraglottic Airway Implementation for B.L.S. practitioners. That is the original i-gel pilot training that we renamed, so that if you want to implement that device, that training is available to you for free. And I would like to also thank Doctors Dorsett and Cushman for allowing us to take their capnography for B.L.S. presentation that they had on their training platform. They allowed us to take it and put it up on Vital Signs Academy because capnography is a requirement of the policy statement if you're going to implement an S.G.A. at the B.L.S. level.

So we'd -- you know, we're still working out some of the kinks. I know there's been a couple of questions on the process and how things work. Just know that, you know, when you implement something new, sometimes you have a little bit of growing pains and we just ask for your patience. And if you have any specific questions, our agency licensure department or area is the place where you

should start because there -- that's where the applications are going and they are the people who can at least best help you initially. I'm going to pause there because I'm -- there may be questions for S.G.A.

MR. VIOLANTE: Gina, if you could just quickly go over that process that's on the website. What happens when someone actually submits something to the State that -- yeah.

MS. WIERZBOWSKI: Of course. Thank you, Mr. Chairman. I'd be happy to. So we have a form on the webpage that we -- you can submit your application. It also has a drag and drop area. So if there's documentation you need to submit, you can submit it all in one packet. When you press the send button, it simultaneously goes to the appropriate region that you select. And it also comes to the division so that we have kind of like dual notification that this application is coming through. There was a question with regard to the medical director update form -- verification form. So you need to send it with your original packet. And then once you are approved, you need to send it again because when you're sending it in with your

application, you're requesting the permission and then it's -- we were informed that we need to have that -- we need to have it resubmitted again because when you're resubmitting it, that shows you have the approval for the program. So I know it might seem a little clunky, but that's the way that we have to do things. Any other questions?

MR. DOYNOW: Gina, there was another question -

MS. WIERZBOWSKI: Yes.

MR. DOYNOW: -- from another physician who's not here -

MS. WIERZBOWSKI: Uh-huh.

MR. DOYNOW: -- about expanding this to B.L.S. first responder agencies rather than just advanced life support first responder agencies with B.L.S. level providers. What's the thought on that?

MS. WIERZBOWSKI: So for A.L.S.F.R.s that have B.L.S. practitioners, they can certainly implement the i-gel -- or excuse me, S.G.A. for their practitioners at the B.L.S. level, there is no barrier to that. And the policy does include A.L.S.F.R.s in the agencies that are -- that would be able to implement that. As far as B.L.S.F.R.s, we've

gotten that question many times, Dr. Doynow. And at this time, we do not have a path to implement it for B.L.S.F.R.s, but it is on our radar to work towards the path because we recognize that B.L.S.F.R.s, while we don't -- typically -- we don't regulate them, they are an important part of our pre-hospital care environment.

MR. DOYNOW: Thank you, Gina.

MS. WIERZBOWSKI: You're welcome, Dr. Doynow. Are there any other questions on S.G.A.?

MR. DAILEY: Gina two -- two questions. The first comes off the B.L.S.F.R. You and I have spoken about it before. You know, this is -- is a drastic change for the Department of Health to actually be regulating the interventions available at the actual agency level. This is something that was always a regional -- regional level decision making. How did the department make that leap that suddenly there was going to be something that the control was going to be brought centrally? Because this also does hinge to B.L.S.F.R. -

MS. WIERZBOWSKI: Uh-huh.

MR. DAILEY: -- who the agencies of our regions, we manage quite well according to our

regional needs and the demonstration of our systems design, which is our mandate in Article Thirty. So I'm not quite sure how that leap was -- was achieved by the department. And if this isn't a question for you, and really this should be held for D.L.A. to explain during the SEMAC, that would be fine.

COURT REPORTER: Sorry. Could I just get your name please? The one who just asked the question?

MR. DAILEY: Sorry. Michael Dailey.

COURT REPORTER: Thank you.

MS. WIERZBOWSKI: And did you need my name spelled because it's a little bit confusing?

COURT REPORTER: Yes, please.

MS. WIERZBOWSKI: It's Gina G-I-N-A, last name W-I-E-R-Z-B-O-W-S-K-I.

COURT REPORTER: Thank you.

MS. WIERZBOWSKI: And I'm with the division of C.D.M.S. okay. So, I can -- I can answer some of that and it may -- it may be a question better explored in more depth in terms of when Director Greenberg comes in because he might want to add some additional information. So when we -- as every -- as -- has been discussed before, regions

don't necessarily have the ability to credential providers. So the pathway is an agency medical director can credential the individual practitioners that are -- are authorized to perform skills across the board. The region does have a role in the education of our practitioners and that's why the applications go to the region for a review of your education plans and confirmation that you have submitted all of the documentation that you need to submit and all of your things are in order. And then -- and then the final approval does come from the division.

Now a couple of things. Number one, in the past we hadn't done a particularly good job of collecting information on projects such as these and I think everybody can recognize that if we want to include B.L.S.F.R.s in the future, then we probably ought to have some ability to really track success rates and implementation and agencies and things like that. So it's kind of like a -- a dual edge, but I -- I don't know that I would want to go any further in the discussion than this and would defer to Director Greenberg or Deputy Director Dziura when -- when they come in. So that -- that's about as much as I would

like to say on that.

MR. DAILEY: Thank you.

MS. WIERZBOWSKI: You're welcome, Dr. Dailey.

CHAIRMAN WALTERS: Any other questions for Gina? And -- and I would say, I think Dr. Dailey, to your question about -- one question is about why this approval process is different. The other one that I get asked all the time is these, quote, Optional skills, or if you know, trained and equipped is there's some slightly different processes. They're not all exactly the same, whether it's B.L.S. Twelve Lead or CPAP or -- or these and -- and it just is confusing as far as how they're supposed to apply, who does the training, those types of things. If we can make those policies, make it more standardized, I think is another -- another issue. I know it's not what you're asking, but I think it's just part of the -- the bigger picture of -- of these going forward, so.

MS. WIERZBOWSKI: Yes, that's a good point, Dr. Walter. So you know, as I alluded to before, there -- there -- there has in the past been times where we probably wanted to have a little bit

better situational awareness of what -- of what agencies and practitioners are doing. And so this is a change, yes. But I think it's a positive change and I think it's one that will help us all work a little bit better together.

CHAIRMAN WALTERS: Thank you. And would you like to talk about Blood Implementation as well?

MS. WIERZBOWSKI: Yes. I would love to talk about pre-hospital blood program implementation. So that is one of the two regulatory packages that have been pushed to the forefront. The -- we are doing things a little bit differently than we have in the past. So when the blood regulations go out for public comment, we will also be publishing a draft of the program manual for pre-hospital blood administration. So you will be able to see, when you look at the regulation, you'll also be able to see like more of like the whole cloth of -- of what that program is going to look like. So you will be able to submit comment on both the regulation that's been proposed and also the -- the program manual. Because as we've seen with several other comment periods, we have had many good suggestions come out of them that

12/10/2025 - Medical Standards - Troy, New York

have improved both the regulation and then the policy statements and such that follow afterwards.

As a reminder to the group, we did talk about this yesterday, but I know some might not have been here. In terms of regulation, when a regulation is approved for public comment and it goes out for public comment, the first public comment period is sixty days. And then the division takes the comments, we assess them, we decide what we want -- what can be implemented, what should be implemented. If they have what's called a substantive change, which some -- means that there has been a change to the regulation that significantly changes the intent, or the language, or the content, then we must go back out for a second public comment period and that's forty-five days.

So like with the equipment and vehicle regulations, we did go out -- back out for a second public comment period because we had changes that improved the regulation, but also required us to do that. So that will be the pathway. As always, when we have this package come out for public comment, we will widely disseminate it so that we can receive comments from as many of you that wish to do so.

12/10/2025 - Medical Standards - Troy, New York

CHAIRMAN WALTERS: And do you have any updates on the timeline of when we think these will be out for public comment?

MS. WIERZBOWSKI: Probably in this -- early 2026. I wouldn't want to go any more specific than that though.

CHAIRMAN WALTERS: Any other questions for Gina? No. Thank you very much.

MS. WIERZBOWSKI: Thank you, Dr. Walters.

CHAIRMAN WALTERS: All right. And then moving on, the next item on the agenda is the Clinical Data Integrity TAG. And Dr. Dorsett, would you be willing to update us, please?

MS. DORSETT: Sure. I'm just going to do a rehash of the updating quality metrics yesterday. So, to give everybody a little bit of context on what we're working on in the Clinical Data Integrity TAG, the problem that we're trying to solve is how do we -- if we want to ask a question, particularly at the State or the regional level using registry data, how do we get an accurate answer to that question? And this be -- came to head as a link in the B.L.S. i-gel project. One of the issues is in

12/10/2025 - Medical Standards - Troy, New York

E.M.S. right, we use NEMSIS, which defines the different fields of the data that goes up. But for some of those things like procedures, or medications, or impressions, the drop-down menu of what can end up there comes from a different data set. So, for example, for procedures, it comes from a SNOMED codes, which have like a -- a plethora of different options. And at an individual agency level, we don't have really any control that if I set up my E.P.C.R., I can have it so that when somebody enters a medication, it goes to a particular code.

But what that means is that when I look at State registry data, if I want to say, when did I give Tylenol? There was like ten different ways that Tylenol is actually documented and so it makes it really hard to write reports at the State level. So, in trying to solve this problem, we realized that what we really wanted to do was fix this mapping issue so that in MILRAMS, one of the providers documents, they gave aspirin for chest pain and one of the other providers documents that they have aspirin for chest pain. And I want to ask at a State level how often we're giving aspirin for chest pain? It's the same thing. So we've been

12/10/2025 - Medical Standards - Troy, New York

working on initially getting defined lists of procedures, medications, and impressions. There's one other State that is doing this. So, I think we're going to learn as they go to implement this, which is California.

The process that we've taken, we've worked on procedures and medications. I was able to get a list of -- for example, every single procedure that's been documented within the State for the last year, and the frequency of those impressions. We compare those with the NEMSIS recommended codes. So NEMSIS actually has a list of recommended codes, just nobody uses them. Like, I mean, somebody uses them, but it's not like the -- the most commonly used codes. Also compared those with those California codes because we don't need to be special in New York, right? If they've already defined something. And then went through every single procedure and said that we -- these should be the defined procedure list within New York State.

For medications, it's a little bit different. Because for S.C.T., right? There's like a million medications. We can't define what RxNorm codes are going to use for all those medications.

But so what we decided is looking at the frequency of all the ways that it's used, is every medication that is on formulary, either in the collaborative protocols or the unified protocols, as well as the alternatives, that we would have a -- a defined RxNorm code that that medication should be mapped to.

The -- we haven't even -- impressions is going to be the most complicated. The fundamental problem is going to be implementation in a way that actually makes things better rather than makes things worse. Because if -- for example, we told an individual, like -- like if we said, may it part of the Schematron, the -- the -- the result would be that we'd actually just miss a bunch of data, right? Because the data wouldn't pass. So, we're working and putting those lists out soon to vendors, getting their feedback about how this might actually be implemented on the vendor side, at least with implementation.

And then thinking like, long term, how you do this, because most agencies, if I went to say like, what does your stuff map too? Like we don't know, like I didn't even know. But this all came out from actually trying to just like map airways for

Airway Eighteen in our region and figuring that out. So that's where we are. It's going to be -- it's not going to be a quick process because I think we have to be really thoughtful about how we implement it. Because there's a danger that you make things worse really easily. That's all I got.

CHAIRMAN WALTERS: Great. Thank you. Any questions on that for Dr. Dorsett? All right. Moving right along then we'll move into the S.C.T. TAG. And Erin Reese, would you like to give us an update please?

MS. REESE: Yes, absolutely. Good morning. Our group has been meeting monthly, and we've got a -- a decent sized group. And given the size of the group, we've -- we're broken into three different work groups. Those three different work groups are focusing on guidelines, education ,and governance, and looking at what exists already within the -- within the State and within the country as far as other -- other systems, that are providing specialty care transport.

The education piece is looking at a gap analysis amongst the existing agencies that are providing specialty care, and governance is looking

at regulatory opportunities and some reimbursement opportunities. And collectively, the group has been working on just as of this last meeting, putting together a survey that will go out to all paramedics throughout the State to gain some insight into their perspective on providing specialty care transport, so. Fairly new and -- and as far as the -- the TAG goes, what we've been meeting monthly and -- and working through. So, if there's any other -- anyone else that's interested in participating, please let me know. But we'll continue to work on this.

CHAIRMAN WALTERS: Okay, thank you. Any questions or comments for Erin? All right, hearing none then next item is the rapid sequence intubation training and credentialing process. I know there's been a little bit of movement and discussion on that and Dr. Winslow, would you like to speak to that?

MR. WINSLOW: Thank you. So, there are several areas in New York State currently performing rapid sequence intubation and several of the regional policies were posted on the Boardable for the group. I'm not sure if we're a TAG or just a group, but we'll call ourselves a group. The group

plans to meet and discuss this in January and bring a formal report back to the med standards at the February meeting. Currently we have Suffolk, Nassau and -- and Melrose and I think I'll discuss with anyone else offline if there's other areas that would like to join the group.

CHAIRMAN WALTERS: Great. Thank you very much. And as we're trucking right along here, that takes us into a new business, which is the collaborative protocol update. Now, just as a reminder, these items of proposed changes are coming up for discussion. They will not be voted on at this meeting but will come up for vote at the February meeting and then take -- not take effect until July 1st. So that said, maybe we can go through some of the biggest changes. I know the -- the change log was sent out, but Dr. Dorsett, if you mind hitting some of the highlights of this and then we can go through and have any discussion or comments. And I know maybe training and ed has some thoughts that they'd like to share and we can discuss as well after that.

MS. DORSETT: I'd like to start by thanking Jeremy Cushman, who continues to do a huge

amount of work to and --

CHAIRMAN WALTERS: Chris Fullagar.

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

R.S.I. which is great because that's I think one of the best clinical indications for a push-dose vasopressor. Olanzapine, which was added for agitation in the last round is moved to standing order. And importantly, I think adjusted dosing for older adults to meet with the geriatric E. D. Guidelines for management of agitation in older adults. And then change the default vasopressor drip in bradycardia to epinephrine which physiologically makes more sense.

CHAIRMAN WALTERS: Thank you for summarizing those changes. Again, the change log is out there and anybody who didn't get it wants it, we can make sure you get a copy of that. So, with that, I guess I will open it up for some questions, comments. I know the collaborative protocol group has met and discussed a lot of these and had some good discussions and debates. But it's my understanding is -- Don Hudson here? There he is. That's the response that I expected. I know there was some discussion at Training and Ed so maybe if you want to go through some of that discussion or things that were brought up at training and ed and maybe that will then we can then open the floor for

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HUDSON: So --

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

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

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

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

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

when appropriate and justified. And that's what I think we are looking for is just that, is this reasonable and justified and here it comes before us as a Statewide protocol.

So, I guess the question I would have to the group is educationally, I don't see that as a sticking point. I guess does any particular region medical director or otherwise see this as the hill to die on.

MS. DORSETT: Definitely not the hill.

MR. HUDSON: Does that answer your question, doc? I'm sorry.

MS. DORSETT: Yeah. So, and I think also in the order -- there's an order to those documents, they're just not updated. The foundation is the scope of practice model. The E.M.S. core content and the national education standards are updated according to updates of the scope of practice model. But we also know that the federal government does not move at a facile pace. And so, things like the new E.M.S. education agenda, which was slated and they had started the process, is now on hold. So, we can't say that we're going to wait to update things based on when the federal government updates these,

because there's a -- there's a process.

So, the reason that there is a -- a difference between scope of practice and education standards is the education standards were updated before there was an addendum to the scope of practice due to COVID. So, we should be working off ideally a floor that is in a scope of practice model that's the floor, not the ceiling, and then updating our education standards locally. Plus within the scope of practice model, there's local credentialing, right? So, the -- the whole process of local education and the education standards, I think the most important figure there is there's an input into your local curriculum, which has the national scope of practice model, national core content, which hasn't been updated in forever.

But there's also local input. So for example, nowhere in education standards does it say you teach video laryngoscopy. I teach video laryngoscopy in my paramedic program because there's local input that it is something that most of my paramedic students will be using in the field. And so I must update my curriculum according to the update in evidence. And we tend to forget that

that's part of the education standards, because of the way that there's no way that they will ever be updated at the rate of which medicine is updated.

MR. HUDSON: Right. And in anticipation of, you know, this discussion, which is exactly what I think we wanted was this back and forth and open exchange of, you know, hey, this is where we're moving. Anyone have a concern with that is based in both of these documents particularly in the National E.M.S. Education standards is phrasing such as some States permit licensed E.M.S. personnel to perform skills and roles beyond the minimum skill set as they gain knowledge, additional education, experience, and possibly additional certification. Care must be taken to consider the level of recognin -- I'm sorry, of cognition and critical thinking necessary to perform a skill safely. For instance, some skills may be simple to perform but require significant or considerable clinical judgment to know when they should be performed and should not be performed, and hence the education and you know, all of the stuff that we're looking to put together. So, in keeping with both those concepts as foundational documents, the floor, if you will, not the ceiling, I

think we're good, but it's not up to me.

MR. DAILEY: I -- I think now is probably a pretty good time to point out where New York State has actually carried the scope of practice model, right? B.L.S. naloxone actually was carried from this State in -- in great part, not because we were first, but because we created a Statewide implementation and frankly did it -- did it very well. We worked from, you know, the things that Sophie Dyer and the people in -- in Boston had done. But it was because of that and our review of the potential for harm that carried that forward. And then the scope of practice group actually reached back to us. The same thing happened with check and inject. And the same thing has happened also with patella reduction. So, moving the skills that are available for B.L.S. providers has been something that New York State has been doing and doing quite well and doing safely, which is the most important part of all of that.

MR. HUDSON: And, you know, to you and your compatriots doing videos and, you know, protocol rollouts to assure, you know, the continuation of those concepts and the assurance of those standards

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

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

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

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

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

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

MR. HUDSON: Correct.

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

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

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

MR. HUDSON: Yeah.

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

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

CHAIRMAN WALTERS: In February, yeah.

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

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

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

MR. HUDSON: Correct.

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

MR. HUDSON: Correct.

CHAIRMAN WALTERS: Okay.

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

12/10/2025 - Medical Standards - Troy, New York

ibuprofen to E.M.T. or higher and then moved I.V. acetaminophen to A.E.M.T. or higher. The -- the friction point there is A.E.M.T.s in the 2021 scope of practice document are, quote, Limited to P.O. over the counter antipyretics, limited to analgesia, anti-nausea, antiemetics, dextrose, epinephrine, glucagon, naloxone. And if you stop there up where over the skis here, it's not listed, but the sentence continues and others defined by State or local protocol. So again, an illustration of this is exactly the intent of these documents was to allow us to do the things that we're doing.

CHAIRMAN WALTERS: And -- and what's the friction point there? Is it the A.E.M.T. giving I.V. acetaminophen?

MR. HUDSON: Y -- yes. Deviate, medicated -- let's see the A.E.M.T. I.V. acetaminophen. Yeah. Hearing no opposition will continue.

CHAIRMAN WALTERS: I mean they can already give it orally, right? So it's -- and they can give I.V. medication --

MR. HUDSON: And they have the I.V. skill, right.

12/10/2025 - Medical Standards - Troy, New York

CHAIRMAN WALTERS: It's a medication that they can give and they're giving that medication by a different route, which they can already perform, correct?

MR. HUDSON: Yes.

CHAIRMAN WALTERS: Okay. So --

MR. GREENBERG: Just a question on this one is -- is kind of some of the discussion that's happening, and it goes back to, you know, just on both sides of things, that you believe some of the things as they advance in the protocol or things like that should be highlighted more as a pilot at first so that there's additional research or information gathered on it or -- and so that to Dr. Dailey's point, you can start to show other states that might want to mimic or follow those similar things or if there's additional education or things that come with it, you know, in order to progress on that. I'm just trying to, because it --

MS. DORSETT: I think the distinguished thing is that what does need to be a pilot versus what can we just do now because it makes sense based on scope of practice. So, I think the -- the question is here is, is it safe and appropriate

12/10/2025 - Medical Standards - Troy, New York

and not an undue burden to put I.V. acetaminophen at the A.E.M.T. level and by the LOF syllogism or whatever, right? I can do this thing, I can do this thing, I should be able to put these things together.

The answer is, it does not need to be a pilot. We can just do it in protocol without doing any pilot at all. When there's something where we say, uh-huh that's actually fundamentally a change in scope of practice, like let's put i-gels and capnography at the B.L.S. level. The idea is that those things would need to be tested as a pilot for safety and what the implementation process looks like. So, I think this is the sniff test of is this premise just be a protocol change versus does this need to be a pilot? And I think most of these just -- this can be a protocol change. It doesn't smell like a pilot.

MR. MCEVOY: Could I point out -- could I point out something? I'm Mike McEvoy and current Chairman of the Board of the National Registry of E.M.T.s used by forty-eight States, not including New York. When I speak to -- when I speak to educators in those forty-eight states, we tell them to ignore the educational standards because

12/10/2025 - Medical Standards - Troy, New York

they're horribly outdated. We tell them to ignore the scope of practice because that also is horribly outdated and we suggest that they use the two documents that are prepared specifically for educators.

One being the National Association of State E.M.S. officials model clinical guidelines, which included alcohol pads for nausea in version 03/2022, and included oral antipyretics and pain medicine for E.M.T.s in version 03/2022. And probably everything else that's on this list as things that should be taught at the E.M.T., A.E.M.T. and paramedic level as well as to keep up to date for educators. The pre-hospital guidelines consortium, which is done to look at evidence every two years paid for by the National Registry and made available to educators across the country to update their curriculum, to keep people up to date. The exams that the National Registry does don't incorporate as much these two outdated federal documents as they do practice analysis.

And those two documents I just mentioned, and I would suggest that we refer to the National Model Clinical Guidelines when we're making

12/10/2025 - Medical Standards - Troy, New York

considerations about protocols because many of these things that we're doing, if you compare to the national mono clinical guidelines, are not ahead of the time we're behind the time. Thank you.

MR. HUDSON: And I was trying to be nice. That was Mike McEvoy who said New York's behind. Some -- sometimes yes, sometimes no, but I -- I think we're all saying the same thing, which is these appear sensible and appropriate and not rise to the level of pilot programs because they're not novel or new or unheard of or untried, you know, and not to belabor the conversation, but, you know, I remember a time as a paramedic where I had to make at -- what at the time seemed an arduous medical control phone call to give a nitroglycerin. Meanwhile, the patient had popped them like PEZ before my arrival, like, you know, and I needed permission to crack the, you know, seal on the bottle and pull the cotton out. I didn't understand it at the time, so thankfully those days are long gone. And I -- I think we're all mindful of not deviating too far from that.

So yeah, next would be the alcohol pads. So, I think that appears twice in nausea vomiting adult and nausea vomiting pediatric. If

12/10/2025 - Medical Standards - Troy, New York

anyone wants to have the conversation offline, whether we should carry pediatric sized alcohol pads. I don't even know if that's a thing. But you know, again, it -- the more granular you get, sometimes the more outlandish the conversation becomes. So, if no one has a problem with that --

MS. DORSETT: Is that what your shares are for?

MR. HUDSON: Infection would then appear clarified to consider either, Cefazolin or Moxifloxacin, if equipped and trained. So in -- in the foundational documents, right, as we've said, P.O. is not covered for either of those antibiotics. So again, I guess the question would be do we feel confident that based on the protocol our providers would know when to give it, how to give it. And that when we say P.O. it means by mouth, not by nose or anywhere else. Again, going to clinical judgment complexity. And is this a departure from the norm.

Two more and then we're done. So, burns clarified fluid for pediatric administration is paramedic level and is normal saline, twenty milliliters per kilogram, which may be repeated once, and clarified that tetracaine is paramedic only if

12/10/2025 - Medical Standards - Troy, New York

equipped and trained and trained as is Morgan Lens, which is inserted as paramedic only. So, eye drops don't appear in either one of the National Corporate Practice or the E.M.S. Education Standards. So, I would suggest to the group that the instructions are in the name eye drops, if that, again, is deemed too complex, I think we need to talk about it here. And if I'm snarky, you're welcome.

MR. GREENBERG: I'm going to C.V.S. to look for the pediatric alcohol prep afterwards.

MR. HUDSON: Yeah. And then the last one is tetracaine and eye injuries. Same concept. And that's -- that's really it. So I think if everyone's comfortable, the -- the real question educationally is, so then we'll use acetaminophen. So how much education has to come along with giving an E.M.T. acetaminophen? Is it just how to pronounce it? Is it a four-hundred-page PowerPoint that goes through the, you know, medical patent process to get your branded name of Tylenol, which is, you know, now generic is acetaminophen, i.e. how much is too much and how much is sensible?

MR. HUTH: Don, may I for a second?

MR. HUDSON: It's Dr. Walters

12/10/2025 - Medical Standards - Troy, New York

meeting. So yeah.

MR. HUTH: Dr. Walters, may I for a second?

CHAIRMAN WALTERS: Please.

MR. HUTH: Howard Huth from SUNY Cobleskill. I have the luxury of sitting on the Protocol Committee, the Exam Writing Group and Training and Ed and I love this discussion, but what we really need to do is just make sure that all three of those are tied together. So, you know, in 2019, this -- this body and really this SEMSCO pushed us to align with National Education Standards, thinking that that was the right thing to do. And now we've realized that we just are moving faster and probably better than the National Education Standards, which is fine, but when we make decisions for protocols, we have to realize that then that needs to get filtered down and communicated to the education staff.

And we should probably start back up another New York State Education Guidelines document so that we have the protocols aligned with what should be taught and tested. Because right now I can tell you that, you know, the things that we're talking about aren't even being mapped to entry level

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

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

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

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

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

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

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

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

MR. HUTH: We'd be happy.

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

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

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

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

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

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

I tell my students there's no difference between, honestly, like I teach this, but it's different on the test. No, like I teach what's on the test. Because the test should be testing the evidence and I'm not going to spend time teaching you stuff that you should then forget when you actually take care of a patient. Like, I don't have enough time for that in an education program. I got to teach you the things that actually matter.

So, I -- I would respectfully disagree and say like, we should be directing educators to resources on how to update their knowledge, not giving them black and white things of like, this is what you should teach. And those resources exist and somebody is already doing the work that we don't need to do and duplicate.

MR. HUTH: So, my -- you're right down here, keep going to the left. Hi. And at a paramedic level we do the same thing. We teach to -- to medicine and then they'll pass the test without a problem and we expect that they'll take the registry and pass also. On lower levels of education, it really becomes black and white stuff. And you have people that aren't career educators and they're

literally doing this as a side job at night once a year. And that level of -- of prep and education is almost unrealistic to ask of them at this point. So, we have to give the smaller course or C. F. R., E.M.T. something as a guideline to go on because I don't think that they're going to make that lift. The last time we went through the update -- just for the State update in 2014, we actually had to go back down and do rollouts on how to teach pathophys of shock. And that was -- that was a stretch then.

MS. DORSETT: But that's exactly it, right? Like what they need is not necessarily an outline. This is the stuff that you have to teach, especially if you don't understand it. They need the resources on how to teach it. So, like in our own region, when we identify that there was an issue with pre-hospital diagnostic error on stroke, right? And that most of the missed strokes, a posterior circulation strokes that come out as B.L.S. calls, like nausea, dizzy, weakness, I fell down. What we did was develop education.

I don't expect to say if I told a bunch of E.M.T. educators, all right, I want you to educate on the identifying posterior circulation

stroke. The reality is most of them don't have the expertise on identifying, it's a hard thing to teach. So, we developed a toolbox, right? That we distributed to all our B.L.S. educators, which is a curriculum that I wrote with a stroke neurologist tested with B.L.S. educators and has actual real patient videos that we make available for them to teach.

They don't need an outline that says this is what you should be teaching. They need us to give them the resources to teach the things that matter to patients well, which help them develop as educators. And I think when we have advancements saying collaboratively, how do we develop resources and distribute those throughout the State to the people who are doing the work, that makes a lot more sense than writing a guideline that we can't keep up with.

MR. HUTH: I -- I can agree with that. I can -- I can agree with they need both though. Because if you've seen some of what's coming out of -- some of our E.M.T. classes across the State, right? So, like I'm trying to be -- I'm trying to be tactful and delicate. Mark your calendars. So -- so you

know, when you see some of this going on, like we'll -- we'll we do pre testing when they come into a paramedic class and almost none of our students that come in for paramedic class -- I'm sure you do the same thing, even meet close to a -- a baseline minimum competency off of current testing that's available. But when you look at folks that are still teaching -- either not teaching things that should be taught or -- or are teaching things that are literally a decade or more old as far as medicine, I think we have to start somewhere.

And while you're right, I think an ideal world, it'd be great if we had partnerships where we could actually reach out, give them educational materials, train the trainers too and then let them teach. I don't know if we have the resources or management to be able to do that in a timeframe that would allow us to continue to evolve with medicine. So, I'd love to work with you on it, if there's something we can help with or open stuff up and share Statewide, that's fine. But I think we need to start somewhere. And unfortunately, I think some of low hanging fruit here is just some of the instructors just need to know. No, you shouldn't be

teaching that you're putting sandbags on a chest for a flail segment.

MS. DORSETT: I think they can teach that. You almost never see a flail segment and you just manage the respiratory distress.

MR. HUTH: Completely. Right? But -- but --

MS. DORSETT: I'm just saying.

MR. HUTH: Right? Exactly. But I'm telling you --

MS. DORSETT: Almost ever.

MR. HUTH: Literally this year I had an E.M.T. tell me that that's what they were told in their E.M.T. class last year.

MR. HUDSON: So, we all have stories like that, I think.

MR. HUTH: Do we?

MR. HUDSON: We did last night. That's all I can tell you. So anyway, inside joke. But we have a foundational or we have a guidance document that sort of tells us what the students should know. And although it's not intended as a teaching document, I think those are the protocols and you know, by going through them with the student

and then having the student explain them back to the class, really would cover that base and say, you know, hey, I don't know how to pronounce this big word. What do you mean it's an antibiotic? When did that change? And there we go. We've learned something. So, I don't want to overthink this. So go ahead.

MR. GREENBERG: Two things on -- on it. Doctors, I think it'd be challenging to keep up with the list of something that goes along with it. However, I will also say we have a hundred and fifty educational institutions across the State, with a depth and breadth of a variety of expertise and specialties and kind of teaching styles, I will say not teaching abilities, that certain -- that some sort of collaborative document from this group and the education group may be valuable to say, hey, these are things you should consider focusing on.

These are things you should know if it's emphasized within your region or not, or things from that component to be able to give to an educational institution and let them know. And I also think it would be valuable for the actual agencies to be aware of that an agency knows if they

went to X institution that these five things were taught, but these five weren't. So that they know if they have the base knowledge and things like that so that they, you know, have additional information or do they have to incorporate that completely into their onboarding program. And so there -- there could be, you know, as you talk about this going back and forth, there could be value here in multiple ways of having some sort of document that helps both the medical directors of the agencies, the E.M.S. agency leaders, the training coordinators know what's been taught and what hasn't so that they can best prepare and maybe even guide certain continuing education based on it or -- or different things that come on that front or collaborative educational institution, you know, programs that kind of drive those.

CHAIRMAN WALTERS: So, I -- I think one of the questions or that I hear from our instructors in -- in my area that comes up frequently is when there's a question about what they should be teaching. I mean, talk about basic E.M.T. class even, and they're, you know, especially about optional skills or certain things and they reach out to the division and this is how it's relayed to me.

So, I'm not -- this is not a -- a shot at the division or any one person in the division in that, but they're often taught -- told, well you need to teach to the -- the national education standards.

And now I'm kind of hearing in -- in this discussion from what Dr. Dorsett and Mike McEvoy and Howard even said, you know, maybe that's not the right answer and that's not the guidance we should be giving. And so, if it's not, then maybe we need to clarify what that guidance is. And maybe it's as simple as giving them the links and references to things they should be doing but trying to standardize that. Maybe that's not a heavy lift of coming up with a whole list of things but making sure that everyone is aligned from the -- the division down to that basic E.M.T. instructor of what the expectation is and what they're teaching.

And it sounds like just hearing this discussion, it -- it's clear there's some variance across the State and -- and that we're -- something that we might need to address but do it in a way that's not time intensive that's nimble enough. And -- and obviously it can't be so comprehensive that it becomes another outdated document like the ones that

we're talking about. And I don't know necessarily how to crack that nut, but I think that that's something we -- we maybe should be looking at.

MR. GREENBERG: The one thing I'll say, and -- and like you said Dr. Walters, from the discussion here and from what registry might be putting out there I will remind everybody that data entry point twenty you know, does state that students who have met the requirements of the current National Emergency Medical Services Educational Standards of 2021 and incorporated from eight hundred point one five as well. So, if we are looking to make a change in what we think should be followed in the education that's being delivered, these regulations were just updated last year -- year-and-a-half ago maybe and went out for public comment. I don't believe we got any public comments back on this component of it. Went out I -- I think these actually went out for public comment twice, and then was voted on by this body. So --

CHAIRMAN WALTERS: Well, I think that --

MR. GREENBERG: It doesn't mean they can't change just saying.

CHAIRMAN WALTERS: But I think that we've already just established in this conversation that those set a floor, not a ceiling. And so, if we go above those, right? You are still meeting that minimum threshold that's in the regulation.

MR. GREENBERG: Yes, absolutely.

MS. DORSETT: And the education standards, right? When they updated the education standards, they got rid of the instructional guidelines. They used to be paired and the instructional guidelines had the education standards and then a list of like, this is the actual stuff that you should teach, like an outline of what you should be teaching in a classroom. The education standards is essentially a list of topics with depth and breadth with a whole bunch of variability. And in the education standards, I think it's okay to reference that in that there always has to be input of updated evidence. It's in the figure updated evidence as well as local standard.

I propose that we do something kind of more like with the pediatric pre-hospital preparedness project. I can never say it because there's too many goddamn p s in the thing, but they

did something called the toolbox, right? So, they had the checklist where at the individual agencies you could do a checklist of, these are the things that I needed. And then together E.M.S. for children, the innovation center put together a toolbox. So, you can go and I say, I don't actually have much on this and I go to their website and they literally have like a whole thing and I can pull a bunch of skills evaluation, checklists for my providers on pediatric skills. I can pull child abuse education on recognition of child mass -- maltreatment that was built by University of Colorado.

And so, I think if we break down what are the -- the core content areas and what you should be teaching, we could build a toolbox like that that people can actually put up quality education on how to do that. Because I can say you should be teaching somebody how to ventilate somebody. I can tell you as a medical director, I don't trust that anybody was taught how to face mask ventilate any patient correctly. Because I cannot take it for granted even though that it's a skill. Because when I watched it and I watch the capno waveforms, it is done poorly.

And so, I verify that and I think about how I teach that. But if I could give people a video that shows them a different technique to do it and the things and incorporation and have that taught in E.M.T. programs, I'd much prefer that because then I'm also educating the instructors to update their knowledge.

CHAIRMAN WALTERS: And, you know, I think we are in a position these days to be able to put together not only toolkits, but we have a centralized learning management platform that, you know, people that -- many of our providers go on to regardless, that could become an additional tool for agencies to say, here's your toolkit, here's the education in one centralized place. You can put in other places as well, but it is there if you want it. And here's your skill sessions and things. So, I think the model of having guidance documents and toolkits and things like that can be an excellent one both for the educational institutions as well as the operational individual agencies as well.

MR. CLEMENCY: Dr. Walters, it seems like a lot of this would be moot if we just moved to the national registry. Thank you.

CHAIRMAN WALTERS: Thank you, Dr.

Clemency, that sounds like another Training and Education issue, but I appreciate that comment and so does Don Hudson. With that said, I -- I want to bring this back because I think this was an excellent, joking aside, an excellent conversation on -- on the education in that and maybe some things we can talk about going forward in the future. But I do want to come back to what sparked the discussion, which was the proposed protocol updates. And given the things that we've gone through and discussed that Don pointed out, and I don't think there's really any opposition or any substantive changes to what was proposed from anybody in this group. And so, if they're -- if I'm correct in that, then I think that -- these will obviously just be discussed. They'll be discussed at SEMAC and SEMSCO as well. But I don't hear anybody from this group, from medical standards having any issues with -- with anything that's in the proposed protocols. If you do speak up now.

MR. WINSLOW: Motion to approve them.

CHAIRMAN WALTERS: Well, we're not voting on them and moving them forward. This is just for discussion. The -- the motion will come at the

February meeting to approve and move them to SEMAC and SEMSCO. This is just more of a discussion. Am I --- correct me if I'm wrong, Dr. Dailey, right?

MR. DAILEY: Yes, that's fine.

CHAIRMAN WALTERS: No. But thank you anyways. Before we move on, any other questions on the protocol -- on the protocols?

MR. GREENBERG: So, the only other thing I would say on the protocol, so in -- in theory, could you today? Yes, you could.

MR. DAILEY: They -- they're an approved document. It sounds like the desire possibly, maybe the -- the desire of the chair. I don't know where the instructions came from, was to sit there. I will say the -- the one easiest part of having it sit till February is that if anybody didn't get a chance to fully read it today, and something comes up between now and February, a document that isn't fully approved yet is easier to make a modification, a change, anything else. So, if anybody during these period of time has changes or things, I think they go to --

CHAIRMAN WALTERS: So really if there's any starts Michael Dailey, if -- if there are

any changes that anybody notices, bring them back to -- to this committee to discuss prior to it being moved forward to SEMAC and then counsel next and --

MR. GREENBERG: Bring back the changes during the break so that we can fix the documents and have it separate.

MR. DAILEY: And we can start -- and then we can also discuss them, you know, at the -- at the next meeting as they should be. So --

MR. HUDSON: So just two questions, I guess. Procedurally there is a proposed or a draft protocol change process, which sets out a timeline. My opinion is that hasn't been as widely circulated as I would've hoped. I think there's an opportunity to include that as either an appendix or a preamble to the current protocol manual, the same way that our by-laws embedded in them explain the process to -- to change the by-laws, right? So, I don't know that it helps us maintaining two disconnected references, the protocol manual, and then a separate somewhat elusive document that explains how to change it. When in my mind it should either be the first page of the last page of the protocol manual is here's the changes over the years, here's that process to do so. And

that lays out the timeframe where they come up in December, they sit till February, and then they vote and are implemented July 1st.

MR. GREENBERG: Just to clarify, so are you referring to the process to change something? You're talking about the change log being included in the document? Or both?

MR. HUDSON: I would say both. It seems sensible.

MR. GREENBERG: I'm just -- that's just a point of clarification.

MR. HUDSON: And then if -- if that's, you know, an agreed upon intent in order to get the drafted protocols out to the masses, knowing that this isn't a public -- technically a public or a televised meeting, would it be proper to move them out of this committee up to the SEMAC level so that they -- they then are, quote unquote, Public documents. I'm looking also move -- move the protocols out of here if there's no problems with them.

MR. GREENBERG: They're public documents now. Moving them out of here doesn't change whether or not they're public or not. They're

public documents because they came to the meeting.

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

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

CHAIRMAN WALTERS: Winslow?

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

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

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

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

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

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

MR. DAILEY: I -- I believe -- I believe the intent, the --

CHAIRMAN WALTERS: The process that we

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

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

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

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

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

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

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

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

one. And how providers can provide suggestions. I would not recommend embedding the change log in the protocol though, but I think it's a great discussion.

MR. GREENBERG: Can I ask why?

MR. CLEMENCY: It's a giant P.D.F. that's just becoming a giant-er P.D.F.

MR. GREENBERG: I don't know if we've referenced it or not. It might be an opportunity in the intro or something else to note that there is a change log and where to find the change log. Maybe that would be the compromise on that one. I would still put in the end of how changes are made and I think that's a single page and can be really good. I -- I think to be honest, and -- and Don, thank you for bringing up, because I'd be curious to see if we get more provider -- field provider input if they have a Q.R. code sitting on the last page that says, don't like something or think something should be changed, click here. So, it'd be -- I'd be curious in that one. I think putting a link or you know, just documentation saying, hey, you can find where the change logs are, could be a good one too. Which also would also make you look for the most current change log, which is important too.

MR. HUDSON: Just to clarify by change log, I don't mean, you know, a fourteen-page document that says we added a comma on page three. I'm just saying that, you know, Supraglottic Airway added to B.L.S. level 2025.

MR. DAILEY: So, all of that said, I actually have one addition to the protocols that I'm just getting texts about right now, But -- but it's actually a very simple one and it's moved back to where we were previously. Which is for the medication infusion reference. We currently have moved to two hundred and fifty milliliter bags of fluid to mix our infusions in. Previously we've used liter bags on a regional basis in REMO we always had saline in one hundreds. We had D ten and two fifties and then we had normal saline again in liter bags. And we did that just so we'd make sure that there was never any question as to what patients were getting and we would make it as simple as possible. Request was from a number of our different agencies to have an alternative reference for liter bags as well as the two fifties, not taking out the two fifties, just also having it for liter bags.

MS. DORSETT: I think that -- Mike, I

think that was done. It's in the change log.

MR. DAILEY: It was supposed to be.

MS. DORSETT: It wasn't done?

MR. DAILEY: I didn't see it there.

MS. DORSETT: Okay.

CHAIRMAN WALTERS: I am glad that we could fix that for you so quickly. All right. So based on that I -- I hear is the consensus then that we would like -- like an appendix that outlines the protocol change process and timeframes and a link for suggestions in the protocol but keep the change log out of it. Is that the will of the group?

MS. DORSETT: Sounds good.

MR. HUDSON: Yes.

CHAIRMAN WALTERS: Okay. Then -- then it would it be appropriate then to make those changes and put them in -- into the protocol that comes up then to vote at the February meeting? Is that the right process then? Since we're going to add that?

MR. HUDSON: Perfect.

CHAIRMAN WALTERS: Then I think that settles it. Well that was the longest part of the meeting today, I think. And there's just a couple things left, so I'm going to move on in the interest

of time here. There on the agenda you'll see LifeNet Air medical protocols and I believe that those were not formally approved by the REMO to come here for a vote today. Is that correct Dr. Dailey?

MR. DAILEY: Actually, in the review of the process that we followed there we were not fully in compliance with the open meetings law at the time of those protocols were passed. So, they will be coming to -- to this group in February.

CHAIRMAN WALTERS: Very good. I also believe there was another region, maybe Dr. Doynow, you can speak to it, that submitted, I don't know if it was New York City or that submitted some protocol changes, but I don't believe they were in in time and they did not get circulated to the group. So --

MR. DOYNOW: Yes, they were sent to me via the department two weeks ago. So, we can discuss them, but it's not enough time to -- to vote on them.

MR. ISAACS: We -- we can push to next meeting. Understand they were not submitted in times.

CHAIRMAN WALTERS: I think that'll be best because they weren't circulated, so no one's seen them or had a chance to review them, but we'll

certainly get them out and -- and put them on the agenda for February. So that's it. Go ahead Dr. Wi -- Winslow.

MR. WINSLOW: Can we just state for the record how much time is needed? I believe it's six weeks is requested, but if that can be clarified please?

MR. GREENBERG: Documents normally have to come in about six weeks out. It's about six weeks out to get everything to go into the packet and then get everything approved and up. I think those -- the protocol changes got put in last week and so we put them in the document for February.

CHAIRMAN WALTERS: All right. Then as we get to the end of our agenda here, I have one item and then I'll open up for any other new business that anyone wants to bring forward. At the last meeting and I forget if it came up at SEMAC or SEMSCO where the discussion was exactly, maybe it was med standards. There was some brief discussion about cervical spine mobilization, if you remember when we talked about that. And Dr. Clemency, I think you brought up what N.A.E.M.S.P. was working on and -- and -- and some of that.

For those of you that that don't know, the New York chapter of the National Association of E.M.S. Physicians does monthly Empire State Grand Rounds for the E.M.S. fellowships and that. And puts together a zoom meeting, brings in different speakers from across the country. This past -- just a few weeks ago before Thanksgiving, they brought in Dr. Mike Millen to speak, who was the lead author on the N.A.E.M.S.P. review and analysis of the literature regarding spinal cord injuries and -- and that -- and I thought it was a very good topic and conversation that he did and went through the literature review and -- and presentation and then had time for -- for questions and discussion in that.

And so if this is something that we want to start looking at from a State perspective, and I'm not looking to open up a -- a debate on that topic today, but if it's something that we want to at least look at and decide where we stand one way or the other, Dr. Millen has been -- said he would be agreeable to meeting and doing a presentation for this group for SEMAC, SEMSCO, Med Standards, or we could include STAC in that discussion as well in the future.

And so I want to open that up to see if this is something we want to pursue, and then the best format to do that, whether we have him do a hour presentation somewhere during the committee days like yesterday or during Med Standards, or do it during, you know, a televised meeting of SEMAC or do it at a meeting in between Zoom and we can involve STAC and get some more discussion and -- and just education on that. So that is something that he has been willing to do, and so I bring it forth for conversation to see what the feeling of the group is.

MR. HUTH: Sounds like a good idea.

MS. DORSETT: So I -- I want to clarify also that that was a review published in pre-hospital emergency care that was not a physician statement of the National Association of E.M.S. Physicians. For those who are interested, actually, N.A.E.M.S.P. is doing a town hall specifically on this subject this Friday at noon. And I can share the link if people want to do that. That's talking about a discussion of how do you change standards of care around this. While I have my own personal feelings about the utility of cervical spine care that we use in the field, I think having a -- a

discussion of how do we change practice in a way that actually collaborates with the entire continuum of care is really important. Because, well, the absence of evidence is not the evidence of absence, right? Which is -- just because I don't have a ton of evidence for what they do, I have to like think about how I'm going to change practice in a way that doesn't put our E.M.S. clinicians in a bad spot when they're bringing patients to the emergency department. And I think we should follow a process that looks like what we did for backboards, and how we change practice there. So, I -- I think we can have this discussion, but I don't think it should be one person with a very strong opinion on one side of the story to present that material.

CHAIRMAN WALTERS: Go ahead.

MR. CLEMENCY: Yeah, I -- I agree with Dr. Dorsett. I think Dr. Millen is an important advocate in this discussion, but I think this discussion is too young to bring to this committee yet. And I think we need to let the dust settle a little more first.

CHAIRMAN WALTERS: And so, what I think you both are saying, or I think that down the

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

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

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

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

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

CHAIRMAN WALTERS: Thanks. Dr.

Cooper.

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

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

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

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

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

MR. DAILEY: No, the thing I was going to just follow up on to Dr. Cooper is that if anybody is interested in -- in Dr. Millen's thoughts on this, the N.A.E.M.S.P., New York State Grand Rounds that Dr. Millen did is available on YouTube. I have the link and can disseminate it to anybody that's interested in it. I watched last night. It's great.

CHAIRMAN WALTERS: Well then maybe that's a place to start. I mean, this is something we -- we just put on the back burner and circle back to once we the N.A.E.M.S.P. position statement comes out once STAC s working group has some -- I guess more concrete direction or suggested recommendations, Dr. Dailey. So --

MS. DORSETT: You could do it as a joint thing with STAC. Right. I mean, that's the starting point, is that -- if he wants to present, I would motion that it's a joint presentation, not just to one segment, but to be joint with STAC. Because that's, I think the, I mean, I don't think they do anything, right, but I can't change practice because Meyer doesn't -- like Meyer doesn't think that, or that's like, there isn't much evidence, right. Like I have to do it together on a continuum of care. And

so, I would, if we do that, it should be joint with STAC, which are the -- our partners in management of trauma.

MR. DAILEY: Sure. Absolutely.

CHAIRMAN WALTERS: Very good. Then maybe I'll speak with Dr. Dailey after the meeting about this offline and in interest of time to move forward. Is there any other items -- I think that takes us to the end of our agenda here. Any other items for new business that anybody wants to bring up before we adjourn? Dr. Winslow?

MR. WINSLOW: Thank you. I -- I have one thing. I wanted to bring up a joint pilot program with Suffolk and Nassau County REMACS in the last two weeks. Both Suffolk and Nassau REMACS approved a pilot project to have paramedics administering Keppra sixty milligrams per kilogram I.V. for seizures. Keppra recently has been added to the protocol for Rhode Island AND New Jersey, and we have support from several local neurologists, from multiple healthcare systems that this is a good idea. I didn't have the ability to have enough time in advance to send it officially, but I wanted to bring it up to see if there's support or lack of support

for this. It's a chance for both Nassau and Suffolk to work together, which I think is a great idea.

So, I bring it up here for discussion with the idea being that if there is support, I would send it next week officially through the channels to be able to bring it back in February. The proposed protocol would be as a paramedic level, treat the seizures with Midazolam and then Keppra sixty milligrams per kilogram I.V. once with a maximum dose of forty-five hundred milligrams over three to five minutes in the event that there is more than one seizure, as a means of trying to prevent or treat status epilepticus. And I was hoping to be some support for this. And I think this -- this does have TO pass the sniff test for doing a pilot as opposed to moving it directly into protocol.

CHAIRMAN WALTERS: Dr. Kluger?

MR. KUGLER: This is David Kugler on Nassau, this was presented to the Nassau County REMAC and was wholeheartedly embraced and approved to join along with Suffolk County in starting this pilot project. So, there is support at least in one region. So, we're looking forward to hearing everybody else's support after you get the

information.

MR. WINSLOW: If -- if it's okay with the group, I'll -- I'll put it on the board -- Boardable so that the group can read it and I'll send it officially as an application to the division next week. Thank you.

CHAIRMAN WALTERS: Yeah, I'm not hearing any big opposition. Just -- remind me again, the cost of I.V. Keppra?

MR. WINSLOW: It's five dollars.

CHAIRMAN WALTERS: So not cost prohibitive?

MR. WINSLOW: No.

CHAIRMAN WALTERS: Very good. Any other new business anybody wishes to bring forward? Dr. Cooper?

MR. COOPER: The -- in order to raise additional funds for our -- for our work at the E.M.S.C. sub-committee, we will be arranging for a fundraiser for a five-millimeter alcohol pads to be available to who wants to buy them. And those will be appropriately sized for pediatrics, absolutely weight based, just not, that will be the neonatal size, but there will also be other sizes as well.

12/10/2025 - Medical Standards - Troy, New York

CHAIRMAN WALTERS: And that'll be available in time for Christmas.

MR. COOPER: Absolutely.

CHAIRMAN WALTERS: Thank you. All right. And on that note, I think I'll entertain a motion to adjourn. So moved. Thank you.

(The meeting adjourned at 9:37 a.m.)

12/10/2025 - Medical Standards - Troy, New York

STATE OF NEW YORK

I, MONIQUE HINES, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 85, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 31st day of December, 2025.

MONIQUE HINES, Reporter

D

N

S