

12/7/2022 - Medical Standards - Troy, N.Y.
 NEW YORK STATE
 DEPARTMENT OF HEALTH
 MEDICAL STANDARDS
 DATE: December 7, 2022
 TIME: 8:35 a.m. to 10:05 a.m.
 CHAIR: DR. LEWIS MARSHALL
 LOCATION: Hilton Garden Inn
 235 Hoosick Street
 Troy, New York

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 2 (The meeting commenced at 8:35 a.m.)
 3 **CHAIR MARSHALL:** So a little
 4 housekeeping before we begin. I would just request
 5 that as you make comments please state your name
 6 first, so that we can record your comments accurately
 7 and attribute them to the right person. And then
 8 when you're done speaking, you can say thank you or
 9 I'm done or something or like that, so that we can
 10 move on to the next.
 11 And with that we'll call the meeting
 12 to order. And we're going to record attendance or --
 13 yeah.
 14 **MS. ALLEN:** Dr. Bart?
 15 **MR. BART:** I know how to use this.
 16 I'm here. Here we go.
 17 **CHAIR MARSHALL:** There it is. Good
 18 Morning.
 19 **MS. ALLEN:** Dr. Cushman?
 20 **MR. CUSHMAN:** Good morning.
 21 **MS. ALLEN:** Dr. Dailey?
 22 **MR. DAILEY:** Good morning.
 23 **MS. ALLEN:** Dr. Detraglia (phonetic
 24 spelling)? Dr. Doynow?
 25 **MR. DOYNOW:** Here.

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 2 **APPEARANCES:**
 3 ARTHUR COOPER
 4 BRIAN WALTERS
 5 DANIEL OLSSON
 6 DAVID KUGLER
 7 DEBBIE SINGLETON
 8 DONALD DOYNOW
 9 DONALD HUDSON
 10 DOUG SANDBERG
 11 DOUGLAS ISAACS
 12 JASON WINSLOW
 13
 14 JEFF CALL
 15 JEFFREY RABRICH
 16
 17 JEREMY CUSHMAN
 18 JOSEPH BART
 19 JOSHUA LYNCH
 20 MARK PHILLIPY
 21 MATTHEW TALBOT
 22 MICHAEL DAILEY
 23 MICKEY FORNESS
 24 RYAN GREENBERG
 25 STEVEN BLOCKER
 THERESA ALLEN
 VALARIE OZGA

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 2 **MS. ALLEN:** Michelle Forness?
 3 **MS. FORNESS:** Here.
 4 **MS. ALLEN:** Don Hudson?
 5 **MR. HUDSON:** The medical show the
 6 doctor how to use the mic. Yes, Don Hudson present.
 7 **MS. ALLEN:** Dr. Kugler?
 8 **MR. KUGLER:** Present.
 9 **MS. ALLEN:** Jared Cudson (phonetic
 10 spelling)? Dr. Langsam? Joseph Lynch?
 11 **MR. LYNCH:** Josh Lynch here.
 12 **MS. ALLEN:** Oh, my gosh.
 13 **MR. LYNCH:** Joseph's a good name. But
 14 ...
 15 **MS. ALLEN:** Okay. Lewis Marshall --
 16 Dr. Marshall?
 17 **CHAIR MARSHALL:** Yeah.
 18 **MS. ALLEN:** Dr. Murphy? Dr. Olsson?
 19 **MR. OLSSON:** Here, Olsson.
 20 **MS. ALLEN:** Dr. Rabrich?
 21 **MR. RABRICH:** Here.
 22 **MS. ALLEN:** Dr. Talbot?
 23 **MR. TALBOT:** Here.
 24 **MS. ALLEN:** Dr. Walters.
 25 **MR. WALTERS:** I'm here.

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 2 **MS. ALLEN:** Dr. Winslow?
 3 **MR. WINSLOW:** Present.
 4 **MS. ALLEN:** Dr. Isaacs?
 5 **MR. ISAACS:** Here.
 6 **MS. ALLEN:** Dr. Cooper?
 7 **MR. COOPER:** Here.
 8 **MS. ALLEN:** Roll call complete.
 9 **CHAIR MARSHALL:** Thank you. All
 10 right. So moving right along. So the first protocol
 11 for review and action is New York City Protocol.
 12 Addition of tetracaine to the eye injury protocol in
 13 the collaborative protocols, eye injury protocols, on
 14 page one fifty-four, the collaborative. And it is
 15 already there.
 16 And in the New York City Protocols,
 17 tetracaine is in the burn protocol. So we're just
 18 adding it to the eye injury protocol. Any comments,
 19 recommendations? Seeing none. All those in favor?
 20 **MR. DAILEY:** Aye.
 21 **CHAIR MARSHALL:** All right. Opposed,
 22 abstain, unanimous, thank you. The next item is a
 23 little more tricky, I think. And this has to do with
 24 aligning the state B.L.S. protocols with the
 25 collaborative and the collaborative B.L.S. protocols.

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 2 So we put together the state B.L.S. protocols many
 3 years ago. And the latest version was effective this
 4 past February.
 5 But there are some differences between
 6 the collaborative pediatric protocols and the state
 7 B.L.S. protocol. So everybody should have received a
 8 document which outlines the differences and the
 9 discrepancies. If anybody has any particular
 10 comments, I mean, going through all the
 11 discrepancies, I think based upon the age of the
 12 state B.L.S. protocols and the more current
 13 collaborative B.L.S. protocols that we should adopt.
 14 We should adopt what's in the
 15 collaborative protocols for the state B.L.S.
 16 protocols. But we can talk about any specific area
 17 if anybody has any comments or questions about any of
 18 the specific differences.
 19 **MR. DAILEY:** So I'm happy to clarify
 20 some of that.
 21 **CHAIR MARSHALL:** Yes.
 22 **MR. DAILEY:** There never was any
 23 intention that we would continue to move along and
 24 update two sets of protocols with the State B.L.S.
 25 protocols, but then follow along with collaborative

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 2 protocols, collaborative protocols make change. As a
 3 reminder, the collaborative protocols are put
 4 together by a volunteer group of -- of folks. And
 5 we're doing our best to maintain the one set.
 6 I still would love to see the regions
 7 come together and actually fund a system that would
 8 allow this to work on a compensated manner for some
 9 of the people that were at least doing the -- the
 10 secretarial work in order to bring it all together.
 11 But really the collaborative protocols will be the
 12 marker that we need to continue to advance.
 13 So I agree with your thoughts, advance
 14 ...
 15 **CHAIR MARSHALL:** Thank you. Don't
 16 forget to say your name before you speak. Anybody
 17 else, comments, recommendations?
 18 **MR. CUSHMAN:** Cushman.
 19 **CHAIR MARSHALL:** Yes.
 20 **MR. CUSHMAN:** Cushman, move it. Move
 21 to approve.
 22 **CHAIR MARSHALL:** Okay.
 23 **MR. GREENBERG:** Second.
 24 **CHAIR MARSHALL:** Okay.
 25 **MR. GREENBERG:** So --.

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 2 **CHAIR MARSHALL:** Yes.
 3 **MR. GREENBERG:** Can I make one comment
 4 in there?
 5 **CHAIR MARSHALL:** You can make as many
 6 comments as you like.
 7 **MR. GREENBERG:** Careful about that.
 8 So -- and -- and I've had a conversation with some of
 9 you and this brings up, you know, some of the
 10 discussions that Mike has brought up. And -- and
 11 trying to figure out the best way to move forward.
 12 First, I'll answer Mike's question about compensation
 13 and some of the things I -- I do -- help secretarial
 14 support kind of component not for you.
 15 But support in that component. You
 16 know, one of the initiatives that we are trying to
 17 figure out how to move forward is to have, you know,
 18 something similar to a program agency for the state
 19 council. Hopefully that would be for, you know,
 20 things like this in the secretarial support and
 21 initiatives.
 22 Not just with this particular
 23 committee but now pretty active other committees
 24 which is exciting to see. The issue that comes up,
 25 and I would love to hear some discussion from this

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 2 group, is -- you know, we have the B.L.S. state
 3 protocol which is, you know, that's out there. And
 4 we talk about aligning them with the collaborative
 5 protocols which -- not against.
 6 But then the question becomes what
 7 happens with the other areas that aren't on
 8 collaborative protocols. And how do they align? How
 9 do they move? Whether that be New York City, whether
 10 that be at the moment Suffolk County, although
 11 Suffolk's moving to the collaborative and setting,
 12 you know, that standard for what B.L.S. will be
 13 doing.
 14 One of the biggest -- not biggest, one
 15 of the more comments that we've seen recently is, you
 16 know, the questions from training center. Well, what
 17 protocols are the B.L.S. providers supposed to
 18 follow? Are they supposed to use the collaborative
 19 protocol set and find the B.L.S. protocol that
 20 they're supposed to follow. Or are they supposed to
 21 use the B.L.S. protocol set?
 22 And this should be a quick, you know,
 23 answer of oh it's exactly this. But yet, I think if
 24 we were to go around this room, we probably would
 25 have a series of different answers. So -- you know,

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 2 as we sit here and kind of say okay, yes let's adopt
 3 all these. Then the question becomes to those of you
 4 from New York City in the room.
 5 Are you at the same time going to
 6 adopt all those changes in the unified protocols
 7 today, because I would think that would essentially
 8 mean one and the other.
 9 **MR. ISAACS:** It's Doug Isaacs from New
 10 York City. Can you hear me now?
 11 **CHAIR MARSHALL:** Yes.
 12 **MR. ISAACS:** Right now we're
 13 reviewing, doing a comparison between our regional
 14 protocols to B.L.S. and the state. We still want to
 15 reserve the ability to have our regional protocols
 16 understanding that ... based medicine -- based
 17 medicine how we operationalize that medicine.
 18 We feel we want to have that ability
 19 to do for our region just like every other region
 20 should have that. So right now we're going through
 21 the process. We're going to keep it as similar
 22 possible to the collaborative protocols and the
 23 B.L.S. protocols. We make all efforts, but we still
 24 want that ability to do what we feel is operationally
 25 better for our region.

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 2 **MR. HUDSON:** Don Hudson. So I would
 3 ask what makes something this, the "New York State
 4 B.L.S. protocols?" Is it the patch on the cover? Is
 5 there some other regulatory or statutory process that
 6 does that? And is the true opportunity here to make
 7 one set of protocols while also allowing regional
 8 sovereignty as New York City has in its -- probably
 9 should have because of their uniqueness.
 10 **MR. GREENBERG:** So technically there's
 11 one set of B.L.S. protocols, and there is regional
 12 A.L.S. protocols. Through collaboration and, I
 13 think, you know, design and the right thing we, you
 14 know, the collaborative protocols took the B.L.S.
 15 protocols.
 16 For starters did a lot of work to make
 17 the B.L.S. protocols look like the collaborative
 18 protocols so that people are used to a certain
 19 layout, a certain format, a certain look. So whether
 20 you're an A.L.S. or B.L.S. provider, you're always
 21 looking at that style, but there is still the B.L.S.
 22 protocols.
 23 They are the state -- you know, they
 24 are the state standard for -- set by this council for
 25 what B.L.S. providers will do. Now we're at, you

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 2 know, a little bit of a unique situation to where
 3 with the bulk of the state on collaborative and the
 4 largest metropolitan area on unified.
 5 Question is, if the B.L.S. protocols
 6 are changed due to collaborative and unified have to
 7 change and adopt to whatever this council decides is
 8 the care that will be defined for B.L.S, because the
 9 B.L.S. protocols are a state thing. It's not a
 10 regional thing, it's a state thing.
 11 So if we follow Dr. Dailey right now
 12 and adopt all the changes that seem to be off, yes,
 13 that will solve geographically the largest parts is
 14 the -- the largest amount in state. But call volume
 15 wise, unified protocols would also have to be changed
 16 today to adopt to those same changes.
 17 **MR. HUDSON:** Hasn't there always been
 18 slight differences between New York City's B.L.S.
 19 protocols and state B.L.S. protocols?
 20 **MR. GREENBERG:** I believe there's been
 21 some slight changes in the past, but the minimum
 22 standard was always set by the state.
 23 **MR. HUDSON:** So then I would postulate
 24 that the opportunity here is to use the current, what
 25 we call collaborative as the floor, B.L.S. protocols

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 2 for the state allowing a region to go above them as
 3 we've done in the past with other things.
 4 **CHAIR MARSHALL:** So maybe -- if my
 5 memory serves, so many, many years ago when we
 6 adopted the statewide B.L.S. protocols, we said that
 7 was the only B.L.S. protocols from the state were the
 8 only B.L.S. protocols everywhere. And that there
 9 were no regional differences in B.L.S. protocols.
 10 New York City many, many years ago, I
 11 think I was with the fire department at that time, we
 12 adopted the statewide B.L.S. protocols as our New
 13 York City regional protocols. But over time, that
 14 has changed, right. As the medicine has changed,
 15 we've changed the protocols. So I think that like
 16 several around the table that we should continue to
 17 change protocols as the medicine changes and keep
 18 current.
 19 So I -- but that's just a little
 20 history. But I -- I do think we should make some of
 21 the changes that are here. That's just my opinion,
 22 but --.
 23 **CHAIR MARSHALL:** Anybody else?
 24 **MR. ISAACS:** What would -- Mr. Hudson
 25 said is correct. There is some variations using this

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 2 data as a base, but we do have a variation in terms
 3 of our New York City protocols that we've worked on
 4 over the years. So we try to keep it as similar to
 5 the collaborative and also the state B.L.S.
 6 protocols. But we do have some variations based on
 7 our needs regionally.
 8 **CHAIR MARSHALL:** So there is a -- yes,
 9 yes, Dr. Olsson.
 10 **MR. OLSSON:** Olsson. If the
 11 collaborative protocols have shown us anything, it's
 12 shown us how important having one set of protocols
 13 and one document is. Unless I'm missing something,
 14 when I look through this document that's submitted,
 15 missing information discrepancies, et cetera, I don't
 16 see a heck of a lot of anything that's medical.
 17 It's all just making it say the same
 18 thing. And so if the collaborative protocols B.L.S.
 19 mimic or ape or are the same as the state B.L.S.
 20 protocols, that's what we should be shooting for.
 21 And E.M.T.s, our E.M.T.s, we're not talking drastic
 22 drug changes, defibrillation, all that stuff. So the
 23 basics should be the basics. Thank you.
 24 **CHAIR MARSHALL:** Thank you, Dr.
 25 Olsson. So -- so there's been a motion and a second

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 2 and whatever the outcome is I would recommend that we
 3 put -- somebody -- yes, can you please stand and
 4 state for your name?
 5 **MR. BLOCKER:** Hi, I'm Steven Blocker.
 6 Just real real quick --.
 7 **CHAIR MARSHALL:** Come up.
 8 **MR. GREENBERG:** It's not for ... thank
 9 you.
 10 **CHAIR MARSHALL:** Yeah.
 11 **MR. BLOCKER:** Hi, Steven Blocker ...
 12 Sorry, it's not about the City versus State, it's
 13 just a question. Little more ... than that. If we
 14 are -- are we saying we are eliminating the B.L.S.
 15 protocol documents and now all B.L.S. providers will
 16 follow around the state except for New York City?
 17 That all B.L.S. providers will follow
 18 the B.L.S. section of the collaborative document? Or
 19 are we updating the B.L.S. document to mirror the
 20 collaborative document, but keeping both documents.
 21 And for -- for us, that's an operational question. I
 22 would ask because the table of contents is particular
 23 between B.L.S. and collaborative is different.
 24 And the B.L.S. documents table of
 25 context is much more simplified. For example,

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 2 cardiac arrest. Right under B.L.S. it simply says,
 3 cardiac arrest. Under the collaborative it says,
 4 cardiac arrest adult general approach, pediatric
 5 general approach. And then, you know, ... and on and
 6 on from there.
 7 So -- just so we know what we're going
 8 to implement when you guys make the decisions.
 9 Please let us know. Thank you.
 10 **MR. GREENBERG:** So from my
 11 understanding and feel free to chime up, particularly
 12 you Jeremy, you look like you have a thought. It
 13 could just be the sweater. The -- you know, in this
 14 particular case I think this motion if -- and Mr.
 15 Chair correct me if I'm wrong, would be to update the
 16 B.L.S. protocols based on the differences.
 17 And then I think going forward and Dr.
 18 Olsson and things like that, that might be a bigger
 19 discussion on the long term. But I think in this
 20 particular case were related to the medicine. And
 21 today's discussion, it would be an update of the
 22 B.L.S. protocols to match the collaborative protocol
 23 B.L.S. changes.
 24 So I'll pause there and then we can
 25 have the second half of it after.

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 2 **MR. OLSSON:** Olsson. Is there
 3 anything in the statutes that says that there has to
 4 be a statewide B.L.S. protocol?
 5 **MR. GREENBERG:** There is. And I'm
 6 happy to -- I don't have it today, and I think --
 7 like I said for a longer discussion I think that
 8 would be something that I would entertain and maybe
 9 prep -- have a committee between -- not a committee,
 10 Webex, a working group between now and next meeting.
 11 Bring it back at the next meeting
 12 because I -- I think -- you know, I think these are -
 13 - and you brought it up, they're not really that big
 14 on the clinical side. They're -- you know, some
 15 minor changes. But I do know that our training
 16 centers and I appreciate our training centers on
 17 bringing it up on, what do we train to, what do we
 18 send them to.
 19 And I think that should be a very
 20 clear answer. We should never have a provider out
 21 there who doesn't know what protocol set to look at.
 22 We should never have a -- you know, a provider out
 23 there that turns and well, you know, this protocol
 24 set says to do this, but this one says that and
 25 they're both at my level of care what do I follow.

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 2 We as a group need to make sure that -
 3 - that answer is so easy to answer regardless of
 4 where you are in the state or anything. And -- and
 5 the answer, and that's not about having necessarily
 6 one set of protocols even in New York City. The
 7 answer should be clear for an E.M.T. this is where
 8 you look, for a paramedic this is where you look.
 9 And it might be different by region
 10 because we do have that regional differences, but the
 11 answer of them knowing where to go should be simple.
 12 And so -- you know, I -- I agree Mr. Chair, related
 13 to these changes. And by the way thank you, Steve,
 14 to you and your team, you can stay just in case.
 15 You know, but for identifying these
 16 and bringing it forward and -- and doing the work I
 17 truly appreciate that. But -- you know, in this
 18 particular case I think there's two things. I think
 19 the changes I support but I also just want to
 20 recognize.
 21 We go and make these changes in the
 22 B.L.S. protocols there is a minimum standard that's
 23 changed that New York City is going to have to look
 24 and identify what changes need to change in the
 25 unified protocol. Maybe not a big deal, but just

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 2 recognizing this needs to happen, and then how do we
 3 handle it going forward.
 4 **MR. WINSLOW:** Yeah, Jason Winslow from
 5 Suffolk. So as everyone knows, we've been moving
 6 towards the collaborative for the last several years.
 7 And this question came up and we asked the providers
 8 by survey and B.L.S. providers in our region
 9 overwhelmingly at least through the survey document
 10 that they would prefer to be on one set of protocols
 11 with our A.L.S. providers and to be in the
 12 collaborative.
 13 So it makes sense to me that we would
 14 be doing the entire system a favor here to put them
 15 all in one set of protocols because many a time an
 16 E.M.S. provider is transferring care. It starts as a
 17 B.L.S. call, turns into an A.L.S. call, et cetera and
 18 it makes good sense that there would be one set of
 19 protocols. I recommend that the New York State
 20 B.L.S. protocols be the collaborative.
 21 **MR. GREENBERG:** That sounds like a
 22 much bigger discussion. But -- and you know, I think
 23 there's a question or two. And maybe Mr. Chair, I
 24 guess my recommendation first would be to finish
 25 maybe this motion related to just the changes and to

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 2 -- to updating the document.
 3 It sounds like there's a pretty
 4 consistent message around this table that everybody
 5 agrees with that component. So if that is the case,
 6 maybe we want to finish that and then continue on the
 7 discussion of what that future might look like.
 8 **CHAIR MARSHALL:** Thank you. Any
 9 further comments? If none, there's a motion on the
 10 table to adopt the recommended changes. All those in
 11 favor say, Aye.
 12 **ALL:** Aye.
 13 **CHAIR MARSHALL:** Opposed, abstain.
 14 Carries. So what I'd like to do is I'd like to put
 15 together a working group and have a couple of
 16 meetings between now and the next meeting to address
 17 this issue about B.L.S. and -- and just for
 18 historical reference, I've been coming here for
 19 twenty-five years and we're almost there. We're
 20 almost there to one set of statewide protocols.
 21 So thank you very much for all your
 22 hard work over the years. Dr. Dailey, you had a
 23 finger on the button?
 24 **MR. DAILEY:** No, I was just going to
 25 ask, to make sure that we have either Mr. Greenberg

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 2 or Mr. Dzuria (phonetic spelling) as part of that --
 3 that group, so we can engage the D.O.A. from time to
 4 time as needed to make sure that indeed we're
 5 following both the legislative intent, as well as
 6 existing regulation as we make -- make any changes
 7 and get ourselves there.

8 **MR. GREENBERG:** We will be there as
 9 well as Chris Chen, who is from the Division of Legal
 10 Affairs at the end of the table. He's hiding a
 11 little bit. But -- you know, has joined us. He is
 12 the one who often you'll hear when we refer to we
 13 spoke to D.O.A. or any of those comments it is often
 14 Chris or Jason, another associate from there.

15 So they'll either be on the calls or
 16 be available for any questions that come up with that
 17 as well. You know, the one thing I'll need this
 18 group to also just think about and again, from
 19 feedback and questions I get is often the B.L.S.
 20 providers feel, well, if I go into the collaborative
 21 -- and feedback I get.

22 If I go into collaborative, I'm not
 23 sure, you know, which thing to look at, where to go,
 24 because it goes into a lot more things based on
 25 A.L.S. functions. Even though yes, the first part is

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 2 need to speak because B.L.S. protocols are in
 3 regulation, so that would need a further discussion.
 4 But I think that's the direction we're moving.

5 **MR. HUDSON:** Well, then can I reformat
 6 my motion to table that until the next scheduled
 7 meeting for action, is that proper?

8 **CHAIR MARSHALL:** We can have a -- a
 9 motion to table, yeah till to the next meeting, so
 10 don't table it forever.

11 **MR. HUDSON:** Yes.

12 **CHAIR MARSHALL:** All right.

13 **MR. HUDSON:** Yes.

14 **MR. OLSSON:** Olsson. If this is in
 15 regulation, then doesn't it require legislators or
 16 somebody above us to change it, to take it out of
 17 legislation?

18 **CHAIR MARSHALL:** It might.

19 **MR. GREENBERG:** So I think this is
 20 some of the things that we would want to look at
 21 between now and February which is why -- I think
 22 there's a lot of questions and nuances as we get so
 23 close to being one, but we're not one that would come
 24 up.

25 **MR. OLSSON:** But I think that it boils

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 2 B.L.S. it goes into other things and so I think
 3 that's important too in consideration. And maybe
 4 even -- you know, just thinking -- you know, about if
 5 we were to not have a statewide B.L.S. or something
 6 of that nature, you know, the comfort level of E.M.S.
 7 providers.

8 So might want to -- again, just think
 9 about that, figure out how we might want to get some
 10 feelers on that one and, you know, moving forward.

11 **MR. HUDSON:** Dr. Marshall, Don Hudson
 12 again.

13 **CHAIR MARSHALL:** Yes.

14 **MR. HUDSON:** So just for efficiency
 15 and sanity, we are looking to update a book that the
 16 majority of this body sounds like it wants to shelve
 17 to look like the book we all want to use. Is that
 18 correct? Well, then I'll make the motion to shelve
 19 the current statewide B.L.S. protocols and adopt as
 20 our standard statewide collaborative protocol.

21 **CHAIR MARSHALL:** Okay. There's a
 22 motion on the floor. Is there a second?

23 **MR. DOYNOW:** Second.

24 **CHAIR MARSHALL:** Yeah. So the issue
 25 is that we don't know if we can legally do that. We

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 2 down to the fact that we have one set of B.L.S.
 3 protocols, but two different books. But they're
 4 identical and that's easy. You have the B.L.S.
 5 protocols and they're the same as the collaborative
 6 B.L.S. protocols. It's in a separate book with
 7 different table of contents.

8 And that way if the provider wants to
 9 go to the state B.L.S. protocols that were required
 10 by legislation to have. They can look at those.
 11 They can also look at the collaborative. And they're
 12 going to be identical.

13 **MR. BART:** Which is what we're trying
 14 to eliminate, right? It's -- I -- I don't know, I'm
 15 -- I need clarification. This seems like going full
 16 circle for me. If the intent of the collaborative
 17 was to use this collaborative body to build a set of
 18 protocols and now, we've aligned them to be identical
 19 to the state, the state is the only one required in
 20 regulation.

21 Then why is the question to say that
 22 we're going to retain the collaborative. I guess
 23 somebody can fill me in there. And it seems like
 24 that was the last motion to me, but perhaps --
 25 perhaps, I didn't get that correct. And then the

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 2 elephant in the room was we all agreed that there
 3 should be one set of protocols as to not confuse the
 4 providers.
 5 And we acknowledge that New York City
 6 does something differently.
 7 **MR. DAILEY:** So I think I would just
 8 ask my colleagues having struggled with all of these
 9 various nuances of protocol development over the
 10 course of the last fifteen to twenty years. I would
 11 ask my colleagues to wait, let that committee that
 12 Dr. Marshall was just describing do some work.
 13 Bring back a more concrete concept of
 14 exactly what we need to do from a regulatory
 15 perspective. What's going to be the best answer for
 16 the -- for the providers of the state. And then this
 17 body should really discuss the medicine involved with
 18 that.
 19 So let -- let's figure out what that
 20 structure needs to be with the assistance of our
 21 colleague at the far end of the table over here to
 22 make sure that we're doing it right.
 23 **CHAIR MARSHALL:** Yes.
 24 **MR. GREENBERG:** I -- I would add one
 25 more thing there of as we have that meeting and work

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 2 to get it right, Dr. Rabrich, I would ask you to make
 3 sure that you participate in this as you sit on both
 4 sides of the protocol world. And have such an active
 5 role on both. So I -- I think that would be really
 6 important obviously.
 7 Doug, you know, you as well, but I
 8 think it's important that as we sit there and work on
 9 that determination going forward, we want that
 10 collaboration unified approach to determine, you
 11 know, what that future would look like.
 12 **MR. RABRICH:** Yeah, I'm happy to
 13 participate. Doesn't sound like you were asking
 14 though, but I'm happy to participate.
 15 **MR. GREENBERG:** ...
 16 **MR. RABRICH:** Yeah.
 17 **MR. GREENBERG:** Yeah, it's fine.
 18 **MR. WINSLOW:** Yeah.
 19 **MR. GREENBERG:** All right. Yes.
 20 **MR. WINSLOW:** If I may.
 21 **CHAIR MARSHALL:** Uh-huh.
 22 **MR. WINSLOW:** Yeah, just to comment on
 23 -- on -- on what Dr. Bart was saying. Yes, we
 24 understand that there are some regional differences
 25 and we're moving towards a unique experience here of

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 2 having one set of protocols everywhere except for New
 3 York City. But the process has to move slowly
 4 because it involves so much work in terms of
 5 training, education, credentialing.
 6 I mean, there's a lot that goes into
 7 changing your protocols. I'm going through it now.
 8 I can tell you it is a big move. So we should put
 9 the brakes on, go slow, get an opinion from legal,
 10 look at it in detail. And I'm certainly welcome to
 11 share this with anyone offline but it is a mountain
 12 of work.
 13 **CHAIR MARSHALL:** Thank you. Any other
 14 comments? I -- and we're not going to solve this
 15 right today, but we'll definitely put together a
 16 group. I have a few names already on the list that
 17 have been ... so --
 18 **MALE SPEAKER:** Yeah.
 19 **CHAIR MARSHALL:** Yes. All right,
 20 okay.
 21 **MR. WINSLOW:** Can I join too?
 22 **CHAIR MARSHALL:** Yeah. Okay. Thank
 23 you very much. Moving along, all business protocol
 24 approval update process. So there was a document
 25 that was distributed in Boardable New York statewide

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 2 SEMAC protocol development process which went through
 3 or goes through definitions, community input process.
 4 I think this was originally proposed
 5 by Dr. Cushman many, many years ago. So thank you.
 6 **MR. GREENBERG:** Feels like many years
 7 ago. I think it was just prior to COVID though, but
 8 I -- I believe there was some discussion.
 9 **MR. WINSLOW:** To many that's been
 10 years ago.
 11 **CHAIR MARSHALL:** ... go ahead.
 12 **MR. GREENBERG:** I -- I believe there
 13 was some discussion from Dr. Cushman the last time
 14 about the complexities and maybe bringing it back to
 15 the draft table and simplify.
 16 **MR. CUSHMAN:** Yeah, so -- if -- if I
 17 recall at least in the -- in the Boardable discussion
 18 prior to the last meeting as -- as often typical that
 19 my first draft probably made it far more complicated
 20 than it needed to be.
 21 The revision that I had placed within
 22 the discussion in Boardable prior to the last meeting
 23 was a -- if I recall, much more slimmed down version
 24 that recognizes the responsibility of Med Standards
 25 for doing its job in terms of reviewing feedback and

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 2 comment regarding those protocols.
 3 And the group formerly known as the
 4 collaborative protocol working group was essentially
 5 moot because we're essentially there already. So I
 6 think my understanding from the last meeting was it
 7 seemed like there was general consensus that that
 8 seemed to work.
 9 And I think some of it was coming back
 10 to the bureau in terms of what are the time frames
 11 and are those attainable so that when if -- if we
 12 agree on a process by which protocols are updated on
 13 an annual basis and forwarded for approval at a
 14 certain time, can they be implemented, for example,
 15 in the beginning of '23. So that's -- that's where I
 16 knew it.
 17 **CHAIR MARSHALL:** Thank you.
 18 **MR. CUSHMAN:** Welcome.
 19 **MR. GREENBERG:** So I -- I will say, I
 20 apologize if that was tasked directly to me. And I -
 21 - I'm okay with it if it -- it was. I thought that
 22 document was still in draft and discussion amongst
 23 the group and others based on what you had put up in
 24 Boardable. I'm happy to take a look, you know, and
 25 kind of move that forward or have a discussion on

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 2 realistic time frames or stuff like that, so.
 3 **MR. CUSHMAN:** All right. I just want
 4 it done. I -- I really don't care, if -- if it's my
 5 bad, your bad, who's bad. We got to slap the table
 6 understand what our responsibilities as a body are
 7 for making recommendations to protocols. Understand
 8 what the turnaround time from the bureau, D.O.A. and
 9 so forth is.
 10 Making sure that -- that is equally
 11 aligned with our educators T&E and so forth. So that
 12 if we do make changes that are deemed significant
 13 that we can make sure our providers are educated on
 14 them prior to them going live and then being held
 15 responsible for what is included therein.
 16 **CHAIR MARSHALL:** So I would ask Ryan
 17 and his team to come back the next meeting with
 18 finished document. And we can talk about time frames
 19 but --.
 20 **MR. GREENBERG:** Sure. And Dr.
 21 Cushman, if we can maybe set up a call for the week
 22 of the 19th of this month. Anyone else who you feel
 23 should be on it as well?
 24 **MR. CUSHMAN:** You're all welcome.
 25 That includes the gallery around the table because

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 2 truly the input that we have gotten from my educator
 3 colleagues has been critical as part of this
 4 discussion. So I guess, reach out to Ryan or myself.
 5 We'll get together the week of the 19th and get this
 6 done.
 7 **CHAIR MARSHALL:** Great, thanks. Okay.
 8 Next, we put in a data request -- requested some data
 9 on pediatric patients. I don't know that we have
 10 that for now. But looking at number of patients
 11 three years and younger treated by E.M.S. Percent of
 12 patients three years and younger who did not have
 13 weight documented or the percent that did have weight
 14 documented.
 15 And the number of patients three years
 16 and younger that received any medication and what
 17 were the top five medications that they received. So
 18 if we could, you know, get that information at some
 19 point, that would be great. If there's anybody --
 20 any other data that people would like to request,
 21 please let us know, so that we can ask the department
 22 to do that.
 23 So that's old business. New business,
 24 length based pediatric resuscitation tape and
 25 conflict with the protocols. And I have to admit

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 2 that I did not look and see what the conflicts were.
 3 So I don't know -- I don't know. But that came up as
 4 a request for discussion. So I don't know if
 5 anybody's aware of any conflicts in -- between the
 6 protocols.
 7 **MR. CUSHMAN:** That's I -- I think I
 8 asked for that discussion. So let me place this into
 9 the context of a case. It's two thirty in the
 10 morning. A A.L.S. first response agency arrives on
 11 scene of a four and a half year old seizure patient.
 12 The transporting paramedic unit arrives on scene.
 13 They pull out their length based resuscitation tape.
 14 Thank God.
 15 They read said tape -- said tape.
 16 They utilized the dosage associated with midazolam on
 17 said tape. They administer that midazolam, care
 18 continues. They return back to ... start doing their
 19 documentation. And then I get the call at five
 20 thirty, shit doc, we gave twice the dose that's
 21 includes in the protocols.
 22 Because our protocols for pediatric
 23 seizures is point one milligrams per kilo. To my
 24 knowledge and research, every length based
 25 resuscitation tape that's out there is point two

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 2 milligrams per kilo. Which arguably the science and
 3 the literature would suggest that point two is the
 4 better dose.
 5 But here we had a crew do exactly what
 6 I would want them to do, which I do not do math
 7 terribly well at two o'clock in the afternoon.
 8 Forget about two thirty in the morning. They used
 9 their length based resuscitation tape and had what
 10 they considered was an error, when in fact they used
 11 the tool that we expected.
 12 And therein lies the conflict. The
 13 conflict is that a commercially based length based
 14 resuscitation tape conflicts with our protocols. So
 15 if we expect our providers to use those, then that's
 16 where it is. I went back and then looked at all of
 17 our med dosages and it appears that is actually the
 18 only conflict for medications that we routinely
 19 administer within the New York State Formulary.
 20 So there's two ways to look at this,
 21 right. Number one, if we want folks to use a length
 22 based resuscitation tape, which one would argue is
 23 the best standard for that. Then our protocols
 24 should align with the commonly used dosages.
 25 If there are deviations from that,

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 2 used otherwise known as the Broselow tape for those
 3 of you who are unfamiliar with it which I'm sure
 4 includes no one in this room.
 5 So we'll put that on the agenda for
 6 the next E.M.S.C. meeting which will be happening
 7 soon. Thank you.
 8 **CHAIR MARSHALL:** All right. Thank
 9 you, Dr. Cooper. I think that's a good idea for
 10 E.M.S.C. to come back with that.
 11 **MALE SPEAKER:** Thank you.
 12 **MR. GREENBERG:** I'll also just ... I
 13 do think and -- and the bureau would agree that's an
 14 important update to have, especially as we look at,
 15 you know, the medicine and the Broselow tapes
 16 changing and maybe it's Handtevy or fill in the blank
 17 of what you use.
 18 If this group agrees with the medicine
 19 of the use of those devices and there are slight
 20 variations in a protocol, be it not intentional be it
 21 -- you know, something change medicine, advance
 22 faster than we advance the protocol fill in the
 23 blank. It's important for the state and the bureau
 24 as well to have that additional assistance, not
 25 assistance, clarification of agreement of -- of this

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 2 then we should probably articulate somewhere in the
 3 protocols that if you're using that you should use
 4 the link based resuscitation tape as the expectation
 5 because otherwise that provider could be held to a
 6 standard to which we never really intended them to
 7 which really stinks.
 8 So after I talked that crew off the
 9 ledge, I think they're okay. But this is truly a
 10 system problem. This had nothing to do with these
 11 providers. They did exactly what I would hope all
 12 the docs around this table would want them to do.
 13 **CHAIR MARSHALL:** Thank you. Dr.
 14 Cooper?
 15 **MR. COOPER:** Thank you, Dr. Marshall.
 16 And Dr. Cushman, thank you for bringing this issue to
 17 the table. On behalf of the E.M.S.C. Committee, we
 18 would be happy to review this issue and bring it back
 19 to the next SEMAC meeting. I think your analysis of
 20 the -- of the situation is entirely correct.
 21 I personally agree with it one hundred
 22 percent. But I -- I do think it would benefit from
 23 some additional eyes just to be sure that there are
 24 no other discrepancies between our protocols and the
 25 length based resuscitation tape that is most commonly

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 2 group.
 3 So that if we have to look into an
 4 incident or someone else in a different environment
 5 looks at something. That they are looking at
 6 something that aligns and that they're looking at
 7 something that understands that, you know, the -- the
 8 medicine and the best medicine was followed.
 9 And so thank you for that one. And I
 10 -- I do -- I think that's important to -- to not stay
 11 specific to one specific thing, but you know,
 12 especially on those pediatrics and the different
 13 devices and options now that, you know, can be used
 14 to deliver solid medicine.
 15 **MR. PHILLIPY:** Dr. Marshall?
 16 **CHAIR MARSHALL:** Yes.
 17 **MR. PHILLIPY:** Good morning, Mark
 18 Phillipy. I bring up a really great point there
 19 unintentionally Director Greenberg in that one of the
 20 struggles that many agencies have, including my own,
 21 is that we have many versions of that tape. We try
 22 not to. We try to sort some out as we can, but that
 23 is also a concern.
 24 And I'm fairly confident the dosage of
 25 midazolam probably hasn't changed in a number of

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 2 years for that. But if I have a 2017 version of the
 3 Broselow tape instead of a 2020 version, that also
 4 leads to some -- some level of concern. So I think
 5 this is well placed.
 6 **CHAIR MARSHALL:** Thank you. Yeah,
 7 good point.
 8 **MR. WALTERS:** Dr. Marshall.
 9 **CHAIR MARSHALL:** Yes.
 10 **MR. WALTERS:** Dr. Walters, if I may.
 11 So we also had a similar issue, I think to Dr.
 12 Cushman in our area. And one of the things we found
 13 out is one of the -- there's obviously different
 14 brands out there. One of the commercially available
 15 tapes also has a wheel and I won't mention any
 16 company names here.
 17 But the wheel, because of space
 18 limitations actually used the point two ... does for
 19 intranasal or I.M. but didn't make that I guess
 20 explicitly clear as opposed to the I.V. dose of point
 21 one. And that caused some confusion too. And so
 22 that may be something that even with we can't just
 23 look at the tapes, we also have to look at the wheels
 24 or other devices or apps or things that are out there
 25 as we're doing this.

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 2 And I -- I -- this might grow in and
 3 morph into a larger discussion, but if we find
 4 discrepancies between the different brands or
 5 commercially available products, do we have to list
 6 specific ones that we would support or endorse that
 7 are consistent with our protocols. And maybe that's
 8 something we look at.
 9 **MR. ISAACS:** Yeah, for -- if there are
 10 differences -- I mean, a lot of research -- evidence
 11 based research right in regions or I guess the state
 12 into developing pediatric protocols. Why don't we
 13 use these other devices to estimate the weight and
 14 just follow the protocols since they should be up to
 15 date, evidence based driven and so on as opposed to
 16 looking at these different devices.
 17 Look at differences between these
 18 devices and your protocols.
 19 **MR. GREENBERG:** So I'll speak as a
 20 paramedic in the field. You know, I think my concern
 21 with that one would be pediatric patients I think for
 22 everyone. I think I haven't met many providers
 23 probably except for Dr. Cooper who -- you know, when
 24 we have that really sick pediatric patient that
 25 you're like ourselves or -- oh crap, okay.

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 2 You know, what's going on? How do I
 3 do this? And I think the -- the least amount of
 4 looking around resourcing and flipping back and forth
 5 between something is critical. And so I think if it
 6 -- if I have a device and if this group, you know,
 7 agrees with those devices that are out there.
 8 And now I've used that device to
 9 determine the weight. I've used that device to
 10 determine, you know, the medicine, the equipment I'm
 11 going to use and things like that. I would much
 12 rather stick with that same device for the medicine
 13 dosages as well opposed to, okay they're this weight
 14 and now I'm going to go and look in a separate place
 15 for dosing or things like that. That is just the
 16 opinion of one.
 17 **MR. WINSLOW:** And the other way to
 18 look at it is we could just use some of our state
 19 funds to create a length based tape in accordance
 20 with our protocols and have the state provide them to
 21 the regions. I mean, I do --.
 22 **MR. GREENBERG:** Do you know how long
 23 it takes me to update protocols?
 24 **CHAIR MARSHALL:** So I -- I -- I think
 25 some of these are good -- good ideas. And we'll

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 2 allow E.M.S.C. to -- to do their job and come back
 3 with an appropriate recommendation. I think
 4 considering all the comments that have been made.
 5 Okay. Anything else on the length based tape? No,
 6 okay. So the next -- if you have some.
 7 **MR. GREENBERG:** Dr. Cushman, is there
 8 anything that you want to talk about just in your
 9 area on length based tapes and some things that are
 10 coming up maybe?
 11 **MR. CUSHMAN:** Sure. Through great
 12 partnership with the bureau and Amy and -- and the
 13 whole team. ... region is going to be launching a
 14 pilot using the Handtevy App because, again, one
 15 would argue that even a length based resuscitation
 16 tape is not the best tool. It is utilizing a tool
 17 that does the calculation for you.
 18 So that you are volumetrically dosing
 19 your medication not having to do math of a mg per
 20 kg, then milligrams per milliliter then administering
 21 again whether it's two o'clock in the morning or two
 22 o'clock in the afternoon.
 23 So that's -- that pilot will hopefully
 24 be a -- a kicking off first quarter of next year and
 25 I think we're going to hopefully learn some things,

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 2 as well as how that can be implemented widely and
 3 adjacent to ... point looking at -- in the end, all
 4 you need to know is the color. And -- and so a -- a
 5 color tape then is utilizing an app which can be
 6 updated with whatever is appropriate.
 7 And again, this happens to be
 8 Handtevy, but there are some others out there is --
 9 is likely the best way to enable our providers to
 10 appropriately dose medications in -- in the pre-
 11 hospital environment, so more to come on that. And
 12 as we move forward with that, certainly we'll be
 13 sharing that experience with everybody around the
 14 table.
 15 **MR. GREENBERG:** And I think it's an
 16 important one to highlight, I mean, this group is,
 17 you know, we talk about research, we talk about, you
 18 know -- you know, evidence-based practices. And so
 19 this is an excellent opportunity, an excellent
 20 partnership with E.M.S. for children and Amy
 21 Eisenhower and championing that one and having some
 22 funds.
 23 And Dr. Cooper, you know, from the
 24 E.M.S. for Children, federal program, to -- to do an
 25 initiative like this. And to see kind of what those

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 2 results are. And to -- to -- I just want to say
 3 thank you to Jeremy and your team for taking on some
 4 of that lift and roll out and, you know, seeing what
 5 it is and analyzing, you know, things from there.
 6 So you know, whether it be that,
 7 whether it be the ... program, you know, I think
 8 there's really exciting stuff that's coming up in New
 9 York City E.M.S. And I think there's even more that
 10 can come. I think there's some opioid stuff that
 11 we'd love to look at. And, you know, focus on that
 12 as we know that there's a crisis around the state.
 13 But these specific initiatives really
 14 are what, you know, help us move forward, but also
 15 help us highlight and help us, you know, as I go to -
 16 - you know, the commissioner's office and say, you
 17 know, what's going on? And be able to highlight, you
 18 know, hey, look, here's some of the things that we're
 19 doing and here's some of the, you know, the
 20 components that are happening and so you know, these
 21 programs are -- are wonderful things that the bureau
 22 can do to support it.
 23 We want to and yes, I think we should
 24 talk more about opioids in -- in the next look at
 25 things.

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 2 **CHAIR MARSHALL:** What was the name of
 3 that app?
 4 **MR. CUSHMAN:** Sorry, it's the Handtevy
 5 product. H-A-N-D-T-E-V-Y.
 6 **CHAIR MARSHALL:** Thank you.
 7 **MR. LYNCH:** And Dr. Cushman, you're
 8 looking at pediatric dosing on that app?
 9 **MR. CUSHMAN:** Everything. So those of
 10 you that are familiar with that, you can set it so it
 11 includes pediatric dosing, I -- I use it as ...
 12 medical agency. So we have adult dosing in there
 13 which again allows for ideal body weight or weight-
 14 based dosing for a seventy-five kilo adult, hundred
 15 kilo adult, hundred and twenty-five kilo adult
 16 depending on -- on what it is.
 17 The -- the challenge that our little
 18 tiny region has, which I'm quite confident most of
 19 your regions will have, is that in many cases our
 20 agencies may carry different concentrations of drugs
 21 which creates error within an app that is again,
 22 utilizing a drug concentration to determine your
 23 volumetric determination.
 24 And so part of our process and
 25 partnership with -- with Amy in the bureau is

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 2 figuring out what are the processes, what are the
 3 builds associated with that, so we can try to reduce
 4 that error to acceptable levels across a diverse
 5 system. And making sure that agencies aren't when
 6 they're changing out a drug concentration because of
 7 shortages or supply issues.
 8 We have again, processes in place so
 9 that if Jason goes from fifty mg per M.L. of ketamine
 10 to a hundred mg per M.L. of ketamine we don't issues
 11 at his agency versus my agency at that point in time,
 12 so that if -- if it all works, we'll at least have a
 13 template for everybody else to use.
 14 It's easy to do at a singular agency
 15 relatively. The -- the challenges when you're
 16 dealing with dozens of agencies with different drugs
 17 that -- that's where it becomes a little bit more
 18 complicated. So that's what we're working through.
 19 **CHAIR MARSHALL:** Yeah, we have --
 20 state your name for the record.
 21 **MS. SINGLETON:** Debbie Singleton. We
 22 have used Handtevy for four years. It's very painful
 23 setting it up, but once you get past there, you have
 24 to go through every age and confirm what the dosage
 25 is. It goes up to thirteen years and then it has the

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 2 adult as well. But along with using the Handtevy,
 3 there's a whole program that you attend.
 4 And ... Handtevy had great success in
 5 Florida with saves on pediatrics because when you
 6 walk in the door on a cardiac arrest, you have your
 7 first four Epis all drawn up and they show you how to
 8 -- you know, how to make things more effective based
 9 on the age. It's a -- it's an amazing app.
 10 We've had no issues. It's just
 11 painful setting it up. But once you get past that,
 12 everybody loves it.
 13 **CHAIR MARSHALL:** Great. Thank you.
 14 Doctor?
 15 **MR. KUGLER:** Thank you. Dr. Kugler
 16 here. Just a quick question. I believe the state
 17 already has a medication slash protocol app that
 18 they've supported and endorsed and pushed out. And
 19 on that app, there's the ability to take a weight and
 20 put it in and you could use the protocol and it'll
 21 calculate the appropriate drug dose based on the
 22 protocol without purchasing any other applications or
 23 devices or systems.
 24 So perhaps we can continue using our
 25 outdated Broselow tapes just for the weight estimate.

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 2 Put that weight into this app that's already
 3 supported by the state, which has our current
 4 protocol on it, and do the pediatric drug
 5 calculations. So it's been brought to my attention
 6 that this part of the app does require a
 7 subscription.
 8 So maybe the state could open up for
 9 the pediatric dosing for the providers that part of
 10 the app. And then this way agencies aren't obliged
 11 to purchase other products -- other commercial
 12 products, have other systems. And this way, when I
 13 come in with my A.L.S. first response agency to your
 14 agency and you Handtevy and I have the state ... app.
 15 You know, I don't know how to use your
 16 Handtevy device, but I know how to use mine. It'll -
 17 - it just foster more symmetry among the providers
 18 and make things I think a little bit easier. Thank
 19 you.
 20 **CHAIR MARSHALL:** Thank you. Okay.
 21 Any other comments? Can't wait to see what the
 22 E.M.S.C. comes back with. That would be great.
 23 **MR. GREENBERG:** Okay. The only other
 24 comment I'd have on that one is, you know, Dr.
 25 Kugler, I -- you bring up an interesting point as

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 2 well. And -- and, you know, maybe as we're looking
 3 in Dr. Cushman, I'm not sure which particular
 4 components you'll be looking at from your study using
 5 Handtevy.
 6 But if there is similar things that
 7 could be looked at and maybe looking in Dr. Kugler in
 8 your region. I -- I believe your call volume matches
 9 somewhat similar. And, you know, use of the Mover
 10 app (phonetic spelling) ... and really, you know,
 11 engaging those providers in order to have a similar
 12 kind of clinical research and clinical look at the
 13 Mover app or things from that point, from that
 14 medication dosing and -- and ease of use and the
 15 feedback of the providers as well.
 16 Yes, you brought up an idea and yes, I
 17 would like to know if you have ...
 18 **MR. KUGLER:** Look at all the data, but
 19 I --.
 20 **MR. GREENBERG:** Maybe with Dr.
 21 Winslow.
 22 **CHAIR MARSHALL:** Thank you. Dr. Bart?
 23 **MR. BART:** Thank you. Re-circling
 24 just back to the dosage here, it sounds like we all
 25 agree that use of the -- the tapes is acceptable

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 2 practice. However -- and asking E.M.S.C. to -- to
 3 review this, I think what we're asking is to review
 4 the appropriate dosage and to make sure that we're
 5 still in line with the discrepancy we've discovered
 6 between the protocol and the tapes.
 7 I guess from a medical standards
 8 perspective, I'd like to hear around the room here.
 9 Are we that far off? If this is a -- if we're at
 10 point one migs per kilo is our acceptable dose in
 11 protocol and the -- the tapes are saying point two.
 12 If we're that far off on our dose range, we've
 13 uncovered something that sounds like it's fairly
 14 critical that we should solve now.
 15 **MR. GREENBERG:** From my understanding,
 16 I don't think that the dosing or the tapes are that
 17 off. I think it's a situation of if they were
 18 slightly off or if there was a minor change that it's
 19 not set in stone in the protocol, so that
 20 documentation wise and things of that nature.
 21 You know, if something went in a
 22 different direction and the state had to look into
 23 something that there was a, you know, ability and
 24 appropriateness that the provider used an appropriate
 25 dose based on either the protocol that they followed

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 2 or the -- you know, an approved weight based
 3 pediatric dose measuring device.
 4 **CHAIR MARSHALL:** Yeah. Dr. Cooper?
 5 **MR. BART:** It just seems germane in
 6 the conversation that if we're saying that it's
 7 doubling, such as Dr. Cushman brought up his example
 8 here, that the discrepancy of five versus ten
 9 milligrams of midazolam is not a documentation error.
 10 You know, that is potentially a patient error.
 11 I just want to make sure that we're
 12 still comfortable at our point one migs per kilo as
 13 we've discussed and implemented. And that we're not
 14 the ones that are wrong and potentially the tapes are
 15 right.
 16 **MR. GREENBERG:** In that particular
 17 case, I would think that maybe this group or subset
 18 of this group would want to take a look at those
 19 tapes, you know, maybe the -- the -- a couple of the
 20 tapes as well as the protocols and see, are there
 21 really any differences or many differences or so on
 22 and so forth just to ensure that we do align.
 23 **MR. BART:** I -- I think Mr. Greenberg
 24 what -- what we're really saying is E.M.S.C., please
 25 help us. Take -- take a look at the tapes, make sure

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 2 indeed this is the only drug dosage that's different.
 3 The advantage that we have in this case is -- and I
 4 think the motion that I would make here would be
 5 very, very different if our protocol was double the
 6 dose that was on the tape, right?
 7 But that dose that's on the tape is
 8 double what we are doing. One of the rules that I
 9 follow in medicine is you can always put in more but
 10 you can't take it out, right. So we may end up
 11 inadvertently asking a child, you know, giving a
 12 child two doses of medication, if indeed the point
 13 two is the one that E.M.S.C. comes back as.
 14 And we'd be better off with that point
 15 two, but let's -- let them do their work and bring
 16 that information back to us the next meeting.
 17 **CHAIR MARSHALL:** Thank you. Yeah, Dr.
 18 Cooper?
 19 **MR. COOPER:** Yeah, at the risk of
 20 stating the obvious, I -- I think every emergency
 21 practitioner sitting around this table and
 22 physicians, nurses, et cetera who deal with children
 23 understand that midazolam as well as most other ...
 24 and many other drugs as well, are administered, you
 25 know, in a range of and the commonly cited range in

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 2 pediatrics is at point one to point two, right.
 3 So I mean, neither dose is entirely
 4 correct, neither dose is entirely wrong, right. It's
 5 a range. And you know, we tend to shy away from
 6 ranges in our protocols because we want explicit
 7 direction for our providers. But you know, I think
 8 that this is an issue that we can easily deal with in
 9 discussion.
 10 I think some of the larger issues that
 11 have been raised also need some degree of -- of
 12 vetting and we'll at least take a stab at looking at
 13 some of those as well. But as Dr. Dailey points out,
 14 the immediate and Dr. Cushman points out the
 15 immediate issue is to resolve the discrepancy between
 16 the point one and the point two and the protocols in
 17 the tape.
 18 But we'll -- thank you for -- again
 19 Jeremy and Michael for bringing this up and ensuring
 20 that we get this done in a timely manner. And of
 21 course, Don and Will as well.
 22 **CHAIR MARSHALL:** Thank you. So why
 23 don't we stick with pediatrics since we're on
 24 pediatrics. Another item for discussion came up.
 25 I'm just trying to pull it up. Pediatric CPAP and

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 2 pediatric high flow nasal cannula for the respiratory
 3 surge. Let me just see. We got where -- who --
 4 where did that come from?
 5 **CHAIR MARSHALL:** The pediatric CPAP.
 6 Dr. Dailey.
 7 **MR. CUSHMAN:** I can do my best to
 8 elucidate that and, Amy, if you want to add anything
 9 additional. Amy had reached out to -- to me, lucky
 10 me. I still love you, Amy. Regarding a question
 11 from Upstate regarding high-flow nasal cannula, CPAP
 12 and BiPAP in pediatric patients and whether it is
 13 allowable within protocol, given our current search
 14 00:00:38 search.
 15 Okay. And I -- I had shared -- we got
 16 that information, the specific citation and so forth
 17 on I think Monday night. So I sent it out sorry in
 18 Boardable Monday night in the -- in the discussion
 19 group.
 20 My read of it is as follows. Number
 21 one, this very much prompted me relooking at all of
 22 our protocols and going I think we need to relook at
 23 some of our protocols. Particularly as it relates to
 24 pediatric respiratory distress and some of our
 25 developing respiratory therapy techniques that may --

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 2 may have value in them.
 3 But again, I would -- I would defer a
 4 fair amount of that to -- to E.M.S.C. From a high-
 5 flow nasal cannula perspective Upstate had cited some
 6 recent literature and -- and reviews. I think the
 7 take home point is that although it does decrease
 8 respiratory rate and objective measures of dyspnea,
 9 it doesn't change meaningful outcomes.
 10 Meaning intubation rates, I.C.U.
 11 admissions, length of stays, things that at least I
 12 care a lot about. The other challenge obviously is
 13 logistically doing high-flow nasal cannula in even
 14 adult is almost impossible unless you have a liquid
 15 oxygen tank or a tractor trailer of oxygen that you -
 16 - you carry behind the ambulance to go from point A
 17 to point B.
 18 Add into that the logistical and
 19 practicality of warming and humidifying oxygen to be
 20 able to administer in high-flow nasal cannula at
 21 ranges that most of our regulators currently can't
 22 even fathom to manage and you can't titrate it as us
 23 clinicians know. I mean, oftentimes we're only doing
 24 a fifty percent FiO, but at liter flows of thirty,
 25 2
 forty, fifty liters per minute within -- within that

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 2 it -- it's not titratable.
 3 So although conceptually, adding this
 4 high-flow nasal cannula to the toolbox of E.M.S.
 5 providers, is likely within their scope since it is a
 6 nasal cannula, but it's not really a nasal cannula,
 7 it's a bigger nasal cannula, is probably within the
 8 scope of E.M.T.s and paramedics.
 9 My concern on the issue of high-flow
 10 nasal cannula is that I fear that many providers
 11 would look at high-flow nasal cannula and say great,
 12 I'm going to put a nasal cannula on -- on Dr. Rabrich
 13 here and you know put it a flush rate and he'll do
 14 better. And the reality is, is that, no, actually
 15 he'll probably do worse.
 16 I probably will not do what I should
 17 be doing, which is to support his respiratory effort
 18 utilizing other good techniques, i.e. B.V.M. so on
 19 and so forth. And so in -- in the absence of
 20 evidence that high-flow nasal cannula when it really
 21 is high-flow nasal cannula does not improve
 22 significantly outcomes that at least Jeremy cares
 23 about the risk outweighs the benefit from -- from
 24 that -- from those particular circumstances.
 25 Should we get to a point where we have

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 2 high-flow nasal cannula that can be run in the back
 3 of a truck, amen. It would be great for some of our
 4 adults. Maybe even some of our pediatrics. CPAP
 5 kind of follows in that same vein. CPAP in kids, I
 6 realized our protocols technically allow CPAP in
 7 "older pediatrics."
 8 Let's not get into the conversation
 9 about what age someone becomes an adult. It's a huge
 10 range. I think most of us would agree that if we're
 11 using CPAP in a child, they often need some level of
 12 sedation and/or anxiolysis which also tends to scare
 13 the crap out of me even when I'm doing it.
 14 Forget about me teaching a paramedic
 15 how to do that and -- and so forth. So that was --
 16 that was my read. I'm not the interpreter of the
 17 protocols. I'm just a guy. And so I offered to
 18 bring it to this group to get some general thoughts
 19 and consensus so that, you know, perhaps we can take
 20 it back to both Upstate and/or E.M.S.C and/or
 21 whomever else to look at some of these emerging
 22 technologies and figure out.
 23 Do they have a place in the
 24 prehospital setting this week, perhaps in the future,
 25 what have you? Sorry for the long rant, but that

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 2 hopefully provides the context.
 3 **CHAIR MARSHALL:** No, thank you. That
 4 was great context. Dr. Cooper?
 5 **MR. COOPER:** I think Dr. Cushman has
 6 raised a number of key issues regarding this request.
 7 This is already on our agenda for -- for discussion
 8 at the next meeting of E.M.S.C. Let me just, you
 9 know, from a -- from a very simple practical
 10 standpoint, you know, use of -- you know, high-flow
 11 nasal cannula, CPAP, BiPAP, in the pediatric age
 12 ranges, not only would require a good deal of
 13 protocol review, and so on, and -- and education and
 14 -- and so forth.
 15 But, you know, it also entails a whole
 16 bunch of additional equipment that our folks would
 17 have to carry, and -- and so on. So I, you know,
 18 well, off the top of my head, my senses were not
 19 quite there yet. But as Dr. Cushman points out, we
 20 may be there at some point in the future. But this
 21 is certainly something worthy of discussion.
 22 And as I said, is already on our
 23 agenda for the next meeting. Thank you.
 24 **CHAIR MARSHALL:** Thank you. Thank you
 25 both. Yes.

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 2 **MR. SANDBERG:** Doug Sandburg, Upstate.
 3 So just real quick. This request came about as we
 4 were developing some outreach education and looking
 5 at options, more from an inter facility transfer
 6 standpoint, than the 911 response time. What we're
 7 finding is our patients are traveling greater
 8 distances and are sicker.
 9 And we're struggling to get patients
 10 to tertiary care facilities safely. So looking at
 11 alternatives that are out there for that critical
 12 care transport or specialty care transport paramedic,
 13 that brought the impetus of the CPAP discussion,
 14 high-flow nasal cannula.
 15 Those agencies that are invested in
 16 that and conducting those transports obviously, they
 17 need to invest in their providers and the equipment
 18 to do that safely and effectively. But the fact of
 19 the matter is, we're in a crisis and we're
 20 transporting patients well beyond traditional
 21 distances.
 22 And we need to make sure that we're
 23 preparing those E.M.S. providers which are those 911
 24 providers in the community that are answering the
 25 call. So that's the impetus of the education and --

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 2 and why we're looking for that guidance.
 3 **CHAIR MARSHALL:** Thank you.
 4 **MR. GREENBERG:** I think it's a very
 5 timely discussion. I think it's an important one,
 6 especially as, you know, on a regular basis both the
 7 S.O.C., so the Search Operation Center is getting
 8 calls for longer and longer distances for longer and
 9 longer transports and, you know, in that, that
 10 becomes problematic.
 11 As well, as, you know, even simple
 12 things of, you know, a call that I had last week with
 13 -- you know, a provider who's trying to get the
 14 patient to where they need to be. The patient
 15 couldn't be flown, paramedic wasn't, you know, in
 16 that situation wasn't an option.
 17 And they literally were talking about,
 18 well, can I -- can I relay ambulances in order to
 19 have enough oxygen. In order to get them, you know,
 20 to the right place. And you know, even just in
 21 talking to Dr. Dailey, you know, the places that
 22 Albany Med is getting referrals from these days is
 23 not where the places that were getting referrals from
 24 five years ago.
 25 And you know, as that adopts as that -

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 2 - as that changes in where referrals and pathways and
 3 -- and, you know, essentially, you know, the
 4 hospitals who can handle the more complex patients
 5 are handling more and more and the community centers
 6 are sending more and more.
 7 That puts more of an onus on our
 8 E.M.S. system, on our agency medical directors in
 9 ways that aren't covered under our protocols because
 10 it's critical care transport, its non-emergency. But
 11 it brings up, you know, the point that Doug brings up
 12 is, you know, having those providers feel comfortable
 13 with that training.
 14 Having the providers feel comfortable,
 15 you know, being out there and -- and -- and doing
 16 those things. And you know, I think this is
 17 something absolutely that this group should -- should
 18 bring up and address. Not just the nasal -- you
 19 know, high-flow nasal that's important.
 20 But also how well we're going to
 21 address when a paramedic is now asked to do you know,
 22 a two, three, four hour transport of a truly critical
 23 patient, because they can't be flown or they can't,
 24 you know, get there in any other way or there's no
 25 beds available in the region. And I think this group

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 2 has, you know, a lot of opportunity to -- to help in
 3 that and to offer their expertise.
 4 **CHAIR MARSHALL:** Thank you. Any other
 5 comments? Yes. State your name, please.
 6 **MR. CALL:** Jeff Call from Upstate New
 7 York. I am the provider that called Ryan. In the
 8 height of our seventy-two-inch snowstorm two weeks
 9 ago, I was asked by Samaritan how will we transport
 10 these eight pediatric patients that are on high-flow
 11 nasal to Albany Med in Westchester if we can't get an
 12 aircraft which, of course, you can imagine that's
 13 seven tanks of oxygen, seven tanks of air five --
 14 literally five different ambulance companies.
 15 We're going to make it happen. But
 16 fortunately, the kids did well on the treatment
 17 within the hospital. But with this becoming a new
 18 treatment in the hospital, I mean, just leave out the
 19 part about can we do it in E.M.S. as it becomes more
 20 and more common in adult and pediatric care in the
 21 hospitals.
 22 The hospitals can't maintain that
 23 treatment. And I can tell you from Upstate New York
 24 on a daily basis we're taking patients to
 25 Westchester. So that's -- that's a lot of oxygen and

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 2 a lot of air. And in the words of Bob Riley, I can't
 3 -- I can make you a truck to carry the amount of air
 4 and oxygen you need.
 5 But your -- your paramedic and nurse
 6 will have to be thirty-three pounds. Because the
 7 vehicle will not have any weight left for anyone but
 8 the child. So you know, logistically, it is
 9 something we have to address because more and more
 10 smaller hospitals are using this treatment because it
 11 is effective.
 12 And we're trying to keep these kids
 13 from becoming intubated and -- and that's the result,
 14 if we can't get them out of there on that, you know,
 15 so that's the question. Is there -- is there a
 16 medium to it because if they start the high-flow
 17 nasal at the hospital which is right, putting them we
 18 did it.
 19 We took one down to Dr. Dailey and by
 20 the time we got to Albany Med on CPAP or BiPAP
 21 whatever we did for that child. He was in
 22 significantly worse shape than when we left Samaritan
 23 and -- and we -- we dealt with it, the child did
 24 fine, but it's -- it's going to be more and more as
 25 that treatment becomes more common.

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 2 And so we in the E.M.S. have to figure
 3 out how to move it, because there isn't a helicopter
 4 available every day. I will tell you U.V.M. does
 5 have one unit. I believe that either has liquid or
 6 generated air and oxygen that -- that -- that Michael
 7 was willing to send down to us. Dr. Bombard actually
 8 arranged.
 9 We could get that vehicle to move
 10 these kids because we were getting a lot of snow just
 11 in Watertown. It wasn't anywhere else. But we had
 12 to get out of that snow with his child. And so -- so
 13 this is -- this is real. And it's scary when it's --
 14 when they call and say we have eight kids on this.
 15 And by the way, we don't have a
 16 pediatric I.C.U. Pediatric I.C.U. at Upstate is
 17 beyond full. You know, we called them and they are
 18 packed. And so we're going to see Dr. Dailey with
 19 these kids in -- in Westchester if they can't take
 20 them. So it's real. And we're just looking for some
 21 help on how to -- how to treat them, how to guide
 22 them.
 23 **MR. DAILEY:** You should actually
 24 clarify because it means something very --
 25 **MR. CALL:** Upstate Medical Center,

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 2 Syracuse PICU, which normally would take those, and
 3 to be completely honest with you, as much as
 4 Vapotherm Corporation says their unit can't go in.
 5 And I can tell you we can get a Vapotherm unit from
 6 Watertown to Syracuse to safely and legally, but
 7 that's it. Syracuse is dry roads.
 8 It's the tap seventy-seven minutes is
 9 my maximum amount of time with this child so.
 10 **MR. GREENBERG:** And Jeff, can you just
 11 clarify who you're actually with because it sounded
 12 like you're with Upstate Medical?
 13 **MR. CALL:** Yes, I'm from Upstate, New
 14 York, Watertown, New York. And North. Upstate
 15 Medical would be our closest PICU, but that's when I
 16 say Upstate New York, I'm saying --.
 17 **MR. GREENBERG:** And your agency and
 18 affiliate -- and association too because I think
 19 that's relevant in a number of calls that you get.
 20 **MR. CALL:** Guilfoyle Ambulance Service
 21 in Watertown, New York is my agency that would be
 22 transporting these children.
 23 **MR. GREENBERG:** So I'll also add that
 24 he's a little bit modest. He's also the current
 25 either Chair or President of U.N.Y.A.N. which

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 2 represents the commercials, which is the ones who are
 3 in many situations right now being asked to -- you
 4 know, perform these transports and longer, and that
 5 we're getting, you know, increasing challenges in
 6 doing that, in some cases, because of the distance,
 7 the amount of time, getting the patients back when
 8 they need to come back.
 9 So just many conversations with Jeff
 10 and I appreciate it. Thank you very much for -- you
 11 know, the feedback from -- from what is happening out
 12 in the field and -- and how some of those
 13 complications are happening across the state.
 14 **CHAIR MARSHALL:** Thank you. Great
 15 discussion. All right. Any other discussion on
 16 pediatrics?
 17 **DR. DAILEY:** I -- I think the only
 18 other thing I have to add is that, you know, the
 19 folks from the Bureau that are staffing the ...
 20 center, that are helping folks like Jeff ... are
 21 incredibly important. You know, number of years ago
 22 I was in Albany Med, and I had a provider bring a
 23 patient into me that had been transferred from a
 24 great distance away for profound respiratory
 25 distress.

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 2 Went in and checked the patient. He
 3 actually looked pretty good. ... breathing he was
 4 doing fine. And the paramedic turned around to me.
 5 He said, what do I do with this? And in his hand, he
 6 had ten vials of midazolam. I said, where'd that
 7 come from?
 8 He said, well, I when I left the
 9 community hospital the doctor said, hey, take this.
 10 And if you need to intubate the patient on the way,
 11 give him all of it, and then intubate him. We need
 12 to be really careful because some of our community
 13 hospitals aren't going to have doctors that we
 14 interact with on a regular basis.
 15 We need to make sure that we give our
 16 providers the tools and the contacts in order to
 17 discuss with E.M.S. physicians and E.M.S. leadership,
 18 how to safely do their job. Because for these
 19 providers and community hospitals, they got a patient
 20 they need to get out the door because they're worried
 21 they're going to die.
 22 They're really desperate to get that
 23 patient out the door. And once the door closes
 24 behind that patient, the door is closed behind that
 25 patient, regardless of what ... says, right? So we

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 2 **CHAIR MARSHALL:** Yeah, yeah, yeah,
 3 okay.
 4 **MR. GREENBERG:** You're good.
 5 **CHAIR MARSHALL:** Sugar rush. So --
 6 but thanks for bringing that up. The last item for
 7 discussion was related to an article that was sent
 8 out. Article came out in November, Defibrillation
 9 Strategies for Refractory V-Fib. And the article
 10 actually showed they had a four hundred five patients
 11 and actually showed -- looking at three different
 12 methods of defibrillation.
 13 One is double sequential
 14 defibrillation, which is taking two defibrillators
 15 and shocking the patient, one after the other. And
 16 then Vector Change Defibrillation where you move the
 17 pads from one area to the other. And then the last
 18 one was standard defibrillation.
 19 And the article actually showed that
 20 there was improved -- improved survival in patients
 21 who had double sequential defibrillation and had a
 22 better neurological outcome. So I think -- I mean, I
 23 see some logistical issues in the pre-hospital
 24 setting using double sequential.
 25 But certainly, there may be some other

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 2 need to make sure that we remain the resource for
 3 those providers to keep them safe in their job.
 4 So that they don't end up with that
 5 moral quandary that puts them in an extraordinarily
 6 difficult position coming back to work the next day.
 7 **MR. GREENBERG:** I would add to that,
 8 as these patients move longer distances, also making
 9 sure that when they get to someplace that they have a
 10 place to go and that is not in one geographic area.
 11 We're hearing this problem across the state where
 12 patients are, you know, going to a hospital and when
 13 they get to a hospital, there is still a wait time
 14 for them to either get matched or go through
 15 something else.
 16 And again, that continues to tax the
 17 E.M.S. system as well. I know from a different
 18 discussion on ... and things like that, that I think
 19 Dr. (unintelligible) will talk about later.
 20 **CHAIR MARSHALL:** Thank you. I think
 21 it's really important as Dr. Dailey said that we
 22 provide resources for these providers because handing
 23 pre-hospital provider a handful of midazolam vials is
 24 just beyond the pale.
 25 **MR. GREENBERG:** Just open your hands.

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 2 options that we can look at Vector Change for
 3 example, might be something because that also showed
 4 improvement to hospital discharge for refractory V-
 5 fib. So it was very interesting article, so thank
 6 you for sending that. Dr. Dailey, I see your finger
 7 over the button.
 8 **MR. DAILEY:** No, I was just going to
 9 say I think this is -- this is important because we
 10 did have double sequential defibrillation in -- in
 11 our protocols as an option. We then removed it. And
 12 these trials actually use double sequential
 13 defibrillation. But you can't actually separate the
 14 fact that double sequential defibrillation is just
 15 Vector Change.
 16 Right, it's -- it's really the same
 17 thing, but then with another defibrillator to confuse
 18 things. So I think in our education in particular
 19 pushing forward the idea that after three shocks,
 20 changing that Vector for your next shock, is going to
 21 be extremely good medicine for our providers to do.
 22 It doesn't require protocol change.
 23 Requires educational change at the level of the
 24 regions and the agencies and hopefully will leave us
 25 with more citizens in the state of New York.

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 2 **CHAIR MARSHALL:** Great. So should
 3 just go to T.N.E.? Okay.
 4 **MR. CUSHMAN:** Sir, I would just -- I
 5 think what -- what Dr. Dailey said was important,
 6 because it's the New England Journal Article so of
 7 course the most important analysis they didn't do,
 8 right, which is comparing dual sequential with vector
 9 change. They -- they -- they compared both with
 10 standard.
 11 You know, to me, the real question is,
 12 is there non inferiority between Vector change and
 13 dual sequential. And I don't know that because of
 14 the methods that they used. And so when -- when I
 15 shared this with some of my providers, they said,
 16 great. This scrap again, you -- you add it to our
 17 protocols, and you take it away, then you're going to
 18 add it back.
 19 And -- and what I've -- what I've at
 20 least promised them is we're not going to do it yet.
 21 But at the same time, you know, we don't speak to
 22 Vector change and specifically anteroposterior pad
 23 placements as often as we should. Particularly for
 24 pacing and cardioversion with at least within the --
 25 the -- the cardiac literature is pretty standard.

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 2 And at least my own personal anecdotal
 3 experiences is that my both pacing and cardioversion
 4 is far less painful and far more successful when we
 5 are -- when we are placing pads antero/posteriorly
 6 rather than in our traditional sternal apex
 7 positioning.
 8 So again, I -- I think our -- our
 9 educators are -- are very well knowledgeable of these
 10 different approaches. I -- I think there is some
 11 nuance in all of this. But the take home message
 12 should be more of what my colleague from -- from the
 13 eastern half of the state just mentioned.
 14 Which is we -- we have to know in this
 15 population that those in refractory V.F. really may -
 16 - may get better with Vector change. But those that
 17 are truly in refractory V.F. need extracorporeal life
 18 support. Because you're -- they -- they will be in
 19 persistent V.F. until you reperfuse them, and then
 20 you can get them out.
 21 So point being is that we don't want
 22 crews at least with systems that have extracorporeal
 23 life support capabilities to sit on scene changing
 24 pad placement for half an hour when really what we
 25 need to do is reestablished flow and open up the ...

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 2 vessels so that we can actually defibrillate them
 3 after we get reperfusion.
 4 **CHAIR MARSHALL:** Thank you. Any other
 5 -- any other thoughts on the article? Yes. No.
 6 Turn your mic on.
 7 **MR. KUGLER:** It was -- it was
 8 something in addition to that. I thought --
 9 **CHAIR MARSHALL:** Okay.
 10 **MR. KUGLER:** -- we were done with the
 11 article.
 12 **CHAIR MARSHALL:** No, go ahead.
 13 **MR. KUGLER:** Okay.
 14 **CHAIR MARSHALL:** Go ahead.
 15 **MR. KUGLER:** All right. Thank you.
 16 So just briefly, just a point of information or point
 17 of order or wherever, however it's taken, I'm not
 18 really sure I need Dr. Langsam. With the past many
 19 years, we've complained about getting the agendas,
 20 the documents for review in a timely fashion.
 21 And at times, we had such important
 22 documents to review that we've received within
 23 twenty-four hours that they were just tabled at this
 24 meeting and nothing could be acted upon, because it
 25 wasn't enough time for this body to review the

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 2 information. And yet again, today or should -- I
 3 should say yesterday, we received the agendas for the
 4 meetings and the documents to review for this
 5 meeting.
 6 Had there been something substantive
 7 that required actionable movement, I don't think this
 8 body could have done it because we didn't have the
 9 documents in a -- in a reasonable time. Is there any
 10 way, once again, to plead with the State to please
 11 get these the items to us at least within more than
 12 twenty-four hours before the State meeting where we
 13 have to actually act on them.
 14 **CHAIR MARSHALL:** Thank you.
 15 **MR. GREENBERG:** Sure. I -- I
 16 appreciate the feedback. And I was asked the same
 17 thing back of when we ask everybody to have their
 18 agendas in a month ahead of time that they're
 19 actually submitted a month -- month ahead of time.
 20 And it's -- it's a two-way street and we know that we
 21 have, you know, our issues and our delays.
 22 The other thing and it really hasn't
 23 been used at all lately is that, you know,
 24 committees, including SEMAC or sub committees of
 25 SEMAC, are welcome to have, you know, a WebEx, a

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 2 quick WebEx, a briefing. You know, we have an
 3 executive call the week before this one. Where we go
 4 over, you know, kind of different things and so on
 5 and so forth.
 6 If you're working on a document, if
 7 you're -- you know, in a group or anything like that,
 8 that can happen in between, that can show up and so
 9 you can have a discussion. So when you come here and
 10 the documents are there and they're available for
 11 everybody in public, you've seen them, you've
 12 discussed them and everything else.
 13 But that's on the committee and the
 14 working groups to -- you know, have those discussions
 15 prior to. And obviously, now, there's also, you
 16 know, Boardable, which allows for those discussions
 17 to occur, you know, in -- in a different format too.
 18 So you know, that's why we're, we continue to add,
 19 you know, different platforms, different options, you
 20 know, to -- to avoid that.
 21 The -- you know, the process for
 22 approval and getting it out and ... layers that's
 23 always going to be a timely process will be my guess
 24 because it's not unique to us. Please don't feel
 25 like it's not just the bureau or just this, you know,

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 2 As soon as it's approved, don't wait, just send it
 3 out on mass. Send that out. Put it on Boardable.
 4 **MR. GREENBERG:** It -- it goes as a
 5 packet. Everything goes up. But then --
 6 **MR. KUGLER:** Makes no sense.
 7 **MR. GREENBERG:** If -- if something's
 8 available. Make it available to everybody as soon as
 9 it's approved to be available. And then add it to
 10 the pot -- add it to a folder saying, this is for our
 11 next meeting. Please review and then let everybody
 12 know when the next thing is added in.
 13 And then when the agenda is done. You
 14 could put that in too. But I don't -- I think
 15 throwing everything in all at the last minute for
 16 everybody to review sometimes can be -- there could
 17 be a lot of information. And it's not fair for the
 18 members of the committee's to have to review that
 19 information in a very short period of time and it's
 20 not conducive to good business. Thank you.
 21 **CHAIR MARSHALL:** All right. Thank
 22 you, everybody. If there is no other discussion or
 23 new business, we'll entertain a motion to adjourn.
 24 **MR. PHILLIPY:** Dr. Marshall?
 25 **CHAIR MARSHALL:** Yes. Yes.

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 2 it's across the board for anything that we do.
 3 But -- but it's definitely
 4 collaboration of a timely manner for -- for
 5 everybody. And unfortunately, let's say Med
 6 Standards and Dr. Marshall is, you know, perfect in
 7 getting in every time. It takes every chair getting
 8 it in on time before we can push it off, and so that
 9 that's the challenge because it has to go as one
 10 packet.
 11 So -- I mean, the other option would
 12 be is, you know, if the chair of -- you know, the
 13 SEMSCO says, hey, if you don't have in here, their
 14 meeting doesn't get held or it doesn't have an agenda
 15 or fill in the blank. And -- and we can go that
 16 route, but then notoriously what happens a weeks
 17 later, hey, can we please or can we stop that? Or
 18 can we put this in?
 19 And -- and I'm just, you know, being
 20 honest of what occurs in those layers. And I'm open
 21 to ideas, suggestions, feedback, anything to help.
 22 **MR. KUGLER:** Just a question or a
 23 favor then is as the documents because I'm not asking
 24 for the particular agendas then per se. But as a
 25 document comes up and gets approved for distribution.

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 2 **MR. PHILLIPY:** Good morning.
 3 **CHAIR MARSHALL:** Good morning.
 4 **MR. PHILLIPY:** I --- I don't want to
 5 hold everyone up. So I just would like to throw that
 6 out to this committee for consideration between now
 7 and the February meeting. As we face the rising
 8 specter of a potential Ebola Virus Disease, ... New
 9 York State. Yes. Dr. Cooper, you're right. Oh god,
 10 we're -- we're -- we're back to 2014. I feel like a
 11 hamster is back on the wheel again.
 12 I -- I make a plea on behalf of my --
 13 my constituents and other providers that we are
 14 getting a paucity of guidance on E.M.S. response to
 15 this potential. In particular I've seen a lot of
 16 guidance for hospitals and facilities, but not a ton
 17 on -- on what we should be doing.
 18 And in particular, I'm looking at
 19 physical decontamination things that we've learned
 20 from COVID. What have we learned since 2014 with
 21 regard to E.V.D. and -- and the handling of that in
 22 transport. I want to thank Dr. Cushman for offering
 23 some thoughts at a meeting that was held yesterday in
 24 Monroe County.
 25 Very, very pointed, and thank you

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 2 doctor for that. But insofar as statewide guidance
 3 for other agencies as we have these statewide
 4 meetings whether it's here, at SEMAC or somewhere.
 5 We -- we desperately need some guidance to make sure
 6 that we're following best practices and lessons
 7 learned from COVID. Thank you.
 8 **CHAIR MARSHALL:** Thank you. All
 9 right. Any other comments?
 10 **MR. GREENBERG:** I would just back that
 11 as well. You know, as we work on advice and -- and
 12 guidance to put out for Ebola and for other things,
 13 sometimes the guidance that we get and that, you
 14 know, we have the opportunity to put out isn't very
 15 E.M.S. centric.
 16 It's not -- you know, it's a different
 17 -- you know, it comes with the best of intentions,
 18 but also, you know, comes in a more complex way than
 19 probably most E.M.S. providers would absorb, maybe
 20 the medical director and the agency leadership
 21 absolutely.
 22 But the providers and so I think there
 23 is an opportunity here and I know we spoke about it
 24 in the past and I think, again, everybody's busy
 25 schedules you spoke about those, you know, creating

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 2 protocols that can turn on and off based on a
 3 regional issue coming up or happening. And I hope
 4 Ebola doesn't end up being anything that we, you
 5 know, need to but we need to be prepared for that.
 6 And so this is the prime example of
 7 when maybe we should turn on a protocol or turn off a
 8 protocol or design a protocol that, you know, t
 9 handle something like this and I think just sparked
 10 Doug's interest.
 11 **MR. ISAACS:** And I'll just --
 12 **MR. GREENBERG:** Dr. Isaacs.
 13 **MR. ISAACS:** -- I was just agreeing
 14 with your comments and more than happy to help out
 15 with that.
 16 **CHAIR MARSHALL:** Okay. All right. If
 17 there is no other business, I would just like to
 18 mention that we will be holding our Med Standards
 19 Conference call before the next meeting, so we can
 20 discuss some of the items that came up today and some
 21 formal recommendation so stay tune for that.
 22 Hearing no other business, we'll
 23 entertain the motion to adjourn. Okay.
 24 Thank you very much everybody.
 25 See you in an hour.

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 2 (The meeting adjourned at 10:05 a.m.)
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 2 STATE OF NEW YORK
 3 I, DANIELLE CHRISTIAN, do hereby certify that the
 4 foregoing was reported by me, in the cause, at the time
 5 and place, as stated in the caption hereto, at Page 1
 6 hereof; that the foregoing typewritten transcription
 7 consisting of pages 1 through 79, is a true record of all
 8 proceedings had at the hearing.
 9
 10 IN WITNESS WHEREOF, I have hereunto subscribed
 11 my name, this the 22nd day of December, 2022.
 12
 13 DANIELLE CHRISTIAN, Reporter
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