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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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APPEARANCES:

ARTHUR COOPER
BRIAN WALTERS
DANIEL OLSSON
DAVID KUGLER
DEBBIE SINGLETON
DONALD DOYNOW
DONALD HUDSON
DOUG SANDBERG
DOUGLAS ISAACS
JASON WINSLOW
JEFF CALL
JEFFREY RABRICH
JEREMY CUSHMAN
JOSEPH BART
JOSHUA LYNCH
MARK PHILLIPY
MATTHEW TALBOT
MICHAEL DAILEY
MICKEY FORNESS
RYAN GREENBERG
STEVEN BLOCKER
THERESA ALLEN
VALARIE OZGA

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(The meeting commenced at 8:35 a.m.)

CHAIR MARSHALL: So a little housekeeping before we begin. I would just request that as you make comments please state your name first, so that we can record your comments accurately and attribute them to the right person. And then when you're done speaking, you can say thank you or I'm done or something or like that, so that we can move on to the next.

And with that we'll call the meeting to order. And we're going to record attendance or -- yeah.

MS. ALLEN: Dr. Bart?

MR. BART: I know how to use this. I'm here. Here we go.

CHAIR MARSHALL: There it is. Good Morning.

MS. ALLEN: Dr. Cushman?

MR. CUSHMAN: Good morning.

MS. ALLEN: Dr. Dailey?

MR. DAILEY: Good morning.

MS. ALLEN: Dr. Detraglia (phonetic spelling)? Dr. Doynow?

MR. DOYNOW: Here.

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MS. ALLEN: Michelle Forness?

MS. FORNESS: Here.

MS. ALLEN: Don Hudson?

MR. HUDSON: The medical show the doctor how to use the mic. Yes, Don Hudson present.

MS. ALLEN: Dr. Kugler?

MR. KUGLER: Present.

MS. ALLEN: Jared Cudson (phonetic spelling)? Dr. Langsam? Joseph Lynch?

MR. LYNCH: Josh Lynch here.

MS. ALLEN: Oh, my gosh.

MR. LYNCH: Joseph's a good name. But ...

MS. ALLEN: Okay. Lewis Marshall -- Dr. Marshall?

CHAIR MARSHALL: Yeah.

MS. ALLEN: Dr. Murphy? Dr. Olsson?

MR. OLSSON: Here, Olsson.

MS. ALLEN: Dr. Rabrich?

MR. RABRICH: Here.

MS. ALLEN: Dr. Talbot?

MR. TALBOT: Here.

MS. ALLEN: Dr. Walters.

MR. WALTERS: I'm here.

MS. ALLEN: Dr. Winslow?

MR. WINSLOW: Present.

MS. ALLEN: Dr. Isaacs?

MR. ISAACS: Here.

MS. ALLEN: Dr. Cooper?

MR. COOPER: Here.

MS. ALLEN: Roll call complete.

CHAIR MARSHALL: Thank you. All right. So moving right along. So the first protocol for review and action is New York City Protocol. Addition of tetracaine to the eye injury protocol in the collaborative protocols, eye injury protocols, on page one fifty-four, the collaborative. And it is already there.

And in the New York City Protocols, tetracaine is in the burn protocol. So we're just adding it to the eye injury protocol. Any comments, recommendations? Seeing none. All those in favor?

MR. DAILEY: Aye.

CHAIR MARSHALL: All right. Opposed, abstain, unanimous, thank you. The next item is a little more tricky, I think. And this has to do with aligning the state B.L.S. protocols with the collaborative and the collaborative B.L.S. protocols.

So we put together the state B.L.S. protocols many years ago. And the latest version was effective this past February.

But there are some differences between the collaborative pediatric protocols and the state B.L.S. protocol. So everybody should have received a document which outlines the differences and the discrepancies. If anybody has any particular comments, I mean, going through all the discrepancies, I think based upon the age of the state B.L.S. protocols and the more current collaborative B.L.S. protocols that we should adopt.

We should adopt what's in the collaborative protocols for the state B.L.S. protocols. But we can talk about any specific area if anybody has any comments or questions about any of the specific differences.

MR. DAILEY: So I'm happy to clarify some of that.

CHAIR MARSHALL: Yes.

MR. DAILEY: There never was any intention that we would continue to move along and update two sets of protocols with the State B.L.S. protocols, but then follow along with collaborative

protocols, collaborative protocols make change. As a reminder, the collaborative protocols are put together by a volunteer group of -- of folks. And we're doing our best to maintain the one set.

I still would love to see the regions come together and actually fund a system that would allow this to work on a compensated manner for some of the people that were at least doing the -- the secretarial work in order to bring it all together. But really the collaborative protocols will be the marker that we need to continue to advance.

So I agree with your thoughts, advance ...

CHAIR MARSHALL: Thank you. Don't forget to say your name before you speak. Anybody else, comments, recommendations?

MR. CUSHMAN: Cushman.

CHAIR MARSHALL: Yes.

MR. CUSHMAN: Cushman, move it. Move to approve.

CHAIR MARSHALL: Okay.

MR. GREENBERG: Second.

CHAIR MARSHALL: Okay.

MR. GREENBERG: So --.

CHAIR MARSHALL: Yes.

MR. GREENBERG: Can I make one comment in there?

CHAIR MARSHALL: You can make as many comments as you like.

MR. GREENBERG: Careful about that. So -- and -- and I've had a conversation with some of you and this brings up, you know, some of the discussions that Mike has brought up. And -- and trying to figure out the best way to move forward. First, I'll answer Mike's question about compensation and some of the things I -- I do -- help secretarial support kind of component not for you.

But support in that component. You know, one of the initiatives that we are trying to figure out how to move forward is to have, you know, something similar to a program agency for the state council. Hopefully that would be for, you know, things like this in the secretarial support and initiatives.

Not just with this particular committee but now pretty active other committees which is exciting to see. The issue that comes up, and I would love to hear some discussion from this

group, is -- you know, we have the B.L.S. state protocol which is, you know, that's out there. And we talk about aligning them with the collaborative protocols which -- not against.

But then the question becomes what happens with the other areas that aren't on collaborative protocols. And how do they align? How do they move? Whether that be New York City, whether that be at the moment Suffolk County, although Suffolk's moving to the collaborative and setting, you know, that standard for what B.L.S. will be doing.

One of the biggest -- not biggest, one of the more comments that we've seen recently is, you know, the questions from training center. Well, what protocols are the B.L.S. providers supposed to follow? Are they supposed to use the collaborative protocol set and find the B.L.S. protocol that they're supposed to follow. Or are they supposed to use the B.L.S. protocol set?

And this should be a quick, you know, answer of oh it's exactly this. But yet, I think if we were to go around this room, we probably would have a series of different answers. So -- you know,

as we sit here and kind of say okay, yes let's adopt all these. Then the question becomes to those of you from New York City in the room.

Are you at the same time going to adopt all those changes in the unified protocols today, because I would think that would essentially mean one and the other.

MR. ISAACS: It's Doug Isaacs from New York City. Can you hear me now?

CHAIR MARSHALL: Yes.

MR. ISAACS: Right now we're reviewing, doing a comparison between our regional protocols to B.L.S. and the state. We still want to reserve the ability to have our regional protocols understanding that ... based medicine -- based medicine how we operationalize that medicine.

We feel we want to have that ability to do for our region just like every other region should have that. So right now we're going through the process. We're going to keep it as similar possible to the collaborative protocols and the B.L.S. protocols. We make all efforts, but we still want that ability to do what we feel is operationally better for our region.

MR. HUDSON: Don Hudson. So I would ask what makes something this, the "New York State B.L.S. protocols?" Is it the patch on the cover? Is there some other regulatory or statutory process that does that? And is the true opportunity here to make one set of protocols while also allowing regional sovereignty as New York City has in its -- probably should have because of their uniqueness.

MR. GREENBERG: So technically there's one set of B.L.S. protocols, and there is regional A.L.S. protocols. Through collaboration and, I think, you know, design and the right thing we, you know, the collaborative protocols took the B.L.S. protocols.

For starters did a lot of work to make the B.L.S. protocols look like the collaborative protocols so that people are used to a certain layout, a certain format, a certain look. So whether you're an A.L.S. or B.L.S. provider, you're always looking at that style, but there is still the B.L.S. protocols.

They are the state -- you know, they are the state standard for -- set by this council for what B.L.S. providers will do. Now we're at, you

know, a little bit of a unique situation to where with the bulk of the state on collaborative and the largest metropolitan area on unified.

Question is, if the B.L.S. protocols are changed due to collaborative and unified have to change and adopt to whatever this council decides is the care that will be defined for B.L.S, because the B.L.S. protocols are a state thing. It's not a regional thing, it's a state thing.

So if we follow Dr. Dailey right now and adopt all the changes that seem to be off, yes, that will solve geographically the largest parts is the -- the largest amount in state. But call volume wise, unified protocols would also have to be changed today to adopt to those same changes.

MR. HUDSON: Hasn't there always been slight differences between New York City's B.L.S. protocols and state B.L.S. protocols?

MR. GREENBERG: I believe there's been some slight changes in the past, but the minimum standard was always set by the state.

MR. HUDSON: So then I would postulate that the opportunity here is to use the current, what we call collaborative as the floor, B.L.S. protocols

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for the state allowing a region to go above them as we've done in the past with other things.

CHAIR MARSHALL: So maybe -- if my memory serves, so many, many years ago when we adopted the statewide B.L.S. protocols, we said that was the only B.L.S. protocols from the state were the only B.L.S. protocols everywhere. And that there were no regional differences in B.L.S. protocols.

New York City many, many years ago, I think I was with the fire department at that time, we adopted the statewide B.L.S. protocols as our New York City regional protocols. But over time, that has changed, right. As the medicine has changed, we've changed the protocols. So I think that like several around the table that we should continue to change protocols as the medicine changes and keep current.

So I -- but that's just a little history. But I -- I do think we should make some of the changes that are here. That's just my opinion, but --.

CHAIR MARSHALL: Anybody else?

MR. ISAACS: What would -- Mr. Hudson said is correct. There is some variations using this

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data as a base, but we do have a variation in terms of our New York City protocols that we've worked on over the years. So we try to keep it as similar to the collaborative and also the state B.L.S. protocols. But we do have some variations based on our needs regionally.

CHAIR MARSHALL: So there is a -- yes, yes, Dr. Olsson.

MR. OLSSON: Olsson. If the collaborative protocols have shown us anything, it's shown us how important having one set of protocols and one document is. Unless I'm missing something, when I look through this document that's submitted, missing information discrepancies, et cetera, I don't see a heck of a lot of anything that's medical.

It's all just making it say the same thing. And so if the collaborative protocols B.L.S. mimic or ape or are the same as the state B.L.S. protocols, that's what we should be shooting for. And E.M.T.s, our E.M.T.s, we're not talking drastic drug changes, defibrillation, all that stuff. So the basics should be the basics. Thank you.

CHAIR MARSHALL: Thank you, Dr. Olsson. So -- so there's been a motion and a second

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and whatever the outcome is I would recommend that we put -- somebody -- yes, can you please stand and state for your name?

MR. BLOCKER: Hi, I'm Steven Blocker. Just real real quick --.

CHAIR MARSHALL: Come up.

MR. GREENBERG: It's not for ... thank you.

CHAIR MARSHALL: Yeah.

MR. BLOCKER: Hi, Steven Blocker ... Sorry, it's not about the City versus State, it's just a question. Little more ... than that. If we are -- are we saying we are eliminating the B.L.S. protocol documents and now all B.L.S. providers will follow around the state except for New York City?

That all B.L.S. providers will follow the B.L.S. section of the collaborative document? Or are we updating the B.L.S. document to mirror the collaborative document, but keeping both documents. And for -- for us, that's an operational question. I would ask because the table of contents is particular between B.L.S. and collaborative is different.

And the B.L.S. documents table of context is much more simplified. For example,

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cardiac arrest. Right under B.L.S. it simply says, cardiac arrest. Under the collaborative it says, cardiac arrest adult general approach, pediatric general approach. And then, you know, ... and on and on from there.

So -- just so we know what we're going to implement when you guys make the decisions. Please let us know. Thank you.

MR. GREENBERG: So from my understanding and feel free to chime up, particularly you Jeremy, you look like you have a thought. It could just be the sweater. The -- you know, in this particular case I think this motion if -- and Mr. Chair correct me if I'm wrong, would be to update the B.L.S. protocols based on the differences.

And then I think going forward and Dr. Olsson and things like that, that might be a bigger discussion on the long term. But I think in this particular case were related to the medicine. And today's discussion, it would be an update of the B.L.S. protocols to match the collaborative protocol B.L.S. changes.

So I'll pause there and then we can have the second half of it after.

MR. OLSSON: Olsson. Is there anything in the statutes that says that there has to be a statewide B.L.S. protocol?

MR. GREENBERG: There is. And I'm happy to -- I don't have it today, and I think -- like I said for a longer discussion I think that would be something that I would entertain and maybe prep -- have a committee between -- not a committee, Webex, a working group between now and next meeting.

Bring it back at the next meeting because I -- I think -- you know, I think these are -- and you brought it up, they're not really that big on the clinical side. They're -- you know, some minor changes. But I do know that our training centers and I appreciate our training centers on bringing it up on, what do we train to, what do we send them to.

And I think that should be a very clear answer. We should never have a provider out there who doesn't know what protocol set to look at. We should never have a -- you know, a provider out there that turns and well, you know, this protocol set says to do this, but this one says that and they're both at my level of care what do I follow.

We as a group need to make sure that -- that answer is so easy to answer regardless of where you are in the state or anything. And -- and the answer, and that's not about having necessarily one set of protocols even in New York City. The answer should be clear for an E.M.T. this is where you look, for a paramedic this is where you look.

And it might be different by region because we do have that regional differences, but the answer of them knowing where to go should be simple. And so -- you know, I -- I agree Mr. Chair, related to these changes. And by the way thank you, Steve, to you and your team, you can stay just in case.

You know, but for identifying these and bringing it forward and -- and doing the work I truly appreciate that. But -- you know, in this particular case I think there's two things. I think the changes I support but I also just want to recognize.

We go and make these changes in the B.L.S. protocols there is a minimum standard that's changed that New York City is going to have to look and identify what changes need to change in the unified protocol. Maybe not a big deal, but just

recognizing this needs to happen, and then how do we handle it going forward.

MR. WINSLOW: Yeah, Jason Winslow from Suffolk. So as everyone knows, we've been moving towards the collaborative for the last several years. And this question came up and we asked the providers by survey and B.L.S. providers in our region overwhelmingly at least through the survey document that they would prefer to be on one set of protocols with our A.L.S. providers and to be in the collaborative.

So it makes sense to me that we would be doing the entire system a favor here to put them all in one set of protocols because many a time an E.M.S. provider is transferring care. It starts as a B.L.S. call, turns into an A.L.S. call, et cetera and it makes good sense that there would be one set of protocols. I recommend that the New York State B.L.S. protocols be the collaborative.

MR. GREENBERG: That sounds like a much bigger discussion. But -- and you know, I think there's a question or two. And maybe Mr. Chair, I guess my recommendation first would be to finish maybe this motion related to just the changes and to

-- to updating the document.

It sounds like there's a pretty consistent message around this table that everybody agrees with that component. So if that is the case, maybe we want to finish that and then continue on the discussion of what that future might look like.

CHAIR MARSHALL: Thank you. Any further comments? If none, there's a motion on the table to adopt the recommended changes. All those in favor say, Aye.

ALL: Aye.

CHAIR MARSHALL: Opposed, abstain. Carries. So what I'd like to do is I'd like to put together a working group and have a couple of meetings between now and the next meeting to address this issue about B.L.S. and -- and just for historical reference, I've been coming here for twenty-five years and we're almost there. We're almost there to one set of statewide protocols.

So thank you very much for all your hard work over the years. Dr. Dailey, you had a finger on the button?

MR. DAILEY: No, I was just going to ask, to make sure that we have either Mr. Greenberg

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

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

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

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

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

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

MR. HUDSON: Dr. Marshall, Don Hudson again.

CHAIR MARSHALL: Yes.

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

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

MR. DOYNOW: Second.

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

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

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

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

MR. HUDSON: Yes.

CHAIR MARSHALL: All right.

MR. HUDSON: Yes.

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

CHAIR MARSHALL: It might.

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

MR. OLSSON: But I think that it boils

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

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

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

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

elephant in the room was we all agreed that there should be one set of protocols as to not confuse the providers.

And we acknowledge that New York City does something differently.

MR. DAILEY: So I think I would just ask my colleagues having struggled with all of these various nuances of protocol development over the course of the last fifteen to twenty years. I would ask my colleagues to wait, let that committee that Dr. Marshall was just describing do some work.

Bring back a more concrete concept of exactly what we need to do from a regulatory perspective. What's going to be the best answer for the -- for the providers of the state. And then this body should really discuss the medicine involved with that.

So let -- let's figure out what that structure needs to be with the assistance of our colleague at the far end of the table over here to make sure that we're doing it right.

CHAIR MARSHALL: Yes.

MR. GREENBERG: I -- I would add one more thing there of as we have that meeting and work

to get it right, Dr. Rabrich, I would ask you to make sure that you participate in this as you sit on both sides of the protocol world. And have such an active role on both. So I -- I think that would be really important obviously.

Doug, you know, you as well, but I think it's important that as we sit there and work on that determination going forward, we want that collaboration unified approach to determine, you know, what that future would look like.

MR. RABRICH: Yeah, I'm happy to participate. Doesn't sound like you were asking though, but I'm happy to participate.

MR. GREENBERG: ...

MR. RABRICH: Yeah.

MR. GREENBERG: Yeah, it's fine.

MR. WINSLOW: Yeah.

MR. GREENBERG: All right. Yes.

MR. WINSLOW: If I may.

CHAIR MARSHALL: Uh-huh.

MR. WINSLOW: Yeah, just to comment on -- on -- on what Dr. Bart was saying. Yes, we understand that there are some regional differences and we're moving towards a unique experience here of

having one set of protocols everywhere except for New York City. But the process has to move slowly because it involves so much work in terms of training, education, credentialing.

I mean, there's a lot that goes into changing your protocols. I'm going through it now. I can tell you it is a big move. So we should put the brakes on, go slow, get an opinion from legal, look at it in detail. And I'm certainly welcome to share this with anyone offline but it is a mountain of work.

CHAIR MARSHALL: Thank you. Any other comments? I -- and we're not going to solve this right today, but we'll definitely put together a group. I have a few names already on the list that have been ... so --

MALE SPEAKER: Yeah.

CHAIR MARSHALL: Yes. All right, okay.

MR. WINSLOW: Can I join too?

CHAIR MARSHALL: Yeah. Okay. Thank you very much. Moving along, all business protocol approval update process. So there was a document that was distributed in Boardable New York statewide

SEMAC protocol development process which went through or goes through definitions, community input process.

I think this was originally proposed by Dr. Cushman many, many years ago. So thank you.

MR. GREENBERG: Feels like many years ago. I think it was just prior to COVID though, but I -- I believe there was some discussion.

MR. WINSLOW: To many that's been years ago.

CHAIR MARSHALL: ... go ahead.

MR. GREENBERG: I -- I believe there was some discussion from Dr. Cushman the last time about the complexities and maybe bringing it back to the draft table and simplify.

MR. CUSHMAN: Yeah, so -- if -- if I recall at least in the -- in the Boardable discussion prior to the last meeting as -- as often typical that my first draft probably made it far more complicated than it needed to be.

The revision that I had placed within the discussion in Boardable prior to the last meeting was a -- if I recall, much more slimmed down version that recognizes the responsibility of Med Standards for doing its job in terms of reviewing feedback and

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comment regarding those protocols.

And the group formerly known as the collaborative protocol working group was essentially moot because we're essentially there already. So I think my understanding from the last meeting was it seemed like there was general consensus that that seemed to work.

And I think some of it was coming back to the bureau in terms of what are the time frames and are those attainable so that when if -- if we agree on a process by which protocols are updated on an annual basis and forwarded for approval at a certain time, can they be implemented, for example, in the beginning of '23. So that's -- that's where I knew it.

CHAIR MARSHALL: Thank you.

MR. CUSHMAN: Welcome.

MR. GREENBERG: So I -- I will say, I apologize if that was tasked directly to me. And I -- I'm okay with it if it -- it was. I thought that document was still in draft and discussion amongst the group and others based on what you had put up in Boardable. I'm happy to take a look, you know, and kind of move that forward or have a discussion on

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realistic time frames or stuff like that, so.

MR. CUSHMAN: All right. I just want it done. I -- I really don't care, if -- if it's my bad, your bad, who's bad. We got to slap the table understand what our responsibilities as a body are for making recommendations to protocols. Understand what the turnaround time from the bureau, D.O.A. and so forth is.

Making sure that -- that is equally aligned with our educators T&E and so forth. So that if we do make changes that are deemed significant that we can make sure our providers are educated on them prior to them going live and then being held responsible for what is included therein.

CHAIR MARSHALL: So I would ask Ryan and his team to come back the next meeting with finished document. And we can talk about time frames but --.

MR. GREENBERG: Sure. And Dr. Cushman, if we can maybe set up a call for the week of the 19th of this month. Anyone else who you feel should be on it as well?

MR. CUSHMAN: You're all welcome. That includes the gallery around the table because

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truly the input that we have gotten from my educator colleagues has been critical as part of this discussion. So I guess, reach out to Ryan or myself. We'll get together the week of the 19th and get this done.

CHAIR MARSHALL: Great, thanks. Okay. Next, we put in a data request -- requested some data on pediatric patients. I don't know that we have that for now. But looking at number of patients three years and younger treated by E.M.S. Percent of patients three years and younger who did not have weight documented or the percent that did have weight documented.

And the number of patients three years and younger that received any medication and what were the top five medications that they received. So if we could, you know, get that information at some point, that would be great. If there's anybody -- any other data that people would like to request, please let us know, so that we can ask the department to do that.

So that's old business. New business, length based pediatric resuscitation tape and conflict with the protocols. And I have to admit

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that I did not look and see what the conflicts were. So I don't know -- I don't know. But that came up as a request for discussion. So I don't know if anybody's aware of any conflicts in -- between the protocols.

MR. CUSHMAN: That's I -- I think I asked for that discussion. So let me place this into the context of a case. It's two thirty in the morning. A A.L.S. first response agency arrives on scene of a four and a half year old seizure patient. The transporting paramedic unit arrives on scene. They pull out their length based resuscitation tape. Thank God.

They read said tape -- said tape. They utilized the dosage associated with midazolam on said tape. They administer that midazolam, care continues. They return back to ... start doing their documentation. And then I get the call at five thirty, shit doc, we gave twice the dose that's includes in the protocols.

Because our protocols for pediatric seizures is point one milligrams per kilo. To my knowledge and research, every length based resuscitation tape that's out there is point two

milligrams per kilo. Which arguably the science and the literature would suggest that point two is the better dose.

But here we had a crew do exactly what I would want them to do, which I do not do math terribly well at two o'clock in the afternoon. Forget about two thirty in the morning. They used their length based resuscitation tape and had what they considered was an error, when in fact they used the tool that we expected.

And therein lies the conflict. The conflict is that a commercially based length based resuscitation tape conflicts with our protocols. So if we expect our providers to use those, then that's where it is. I went back and then looked at all of our med dosages and it appears that is actually the only conflict for medications that we routinely administer within the New York State Formulary.

So there's two ways to look at this, right. Number one, if we want folks to use a length based resuscitation tape, which one would argue is the best standard for that. Then our protocols should align with the commonly used dosages.

If there are deviations from that,

then we should probably articulate somewhere in the protocols that if you're using that you should use the link based resuscitation tape as the expectation because otherwise that provider could be held to a standard to which we never really intended them to which really stinks.

So after I talked that crew off the ledge, I think they're okay. But this is truly a system problem. This had nothing to do with these providers. They did exactly what I would hope all the docs around this table would want them to do.

CHAIR MARSHALL: Thank you. Dr. Cooper?

MR. COOPER: Thank you, Dr. Marshall. And Dr. Cushman, thank you for bringing this issue to the table. On behalf of the E.M.S.C. Committee, we would be happy to review this issue and bring it back to the next SEMAC meeting. I think your analysis of the -- of the situation is entirely correct.

I personally agree with it one hundred percent. But I -- I do think it would benefit from some additional eyes just to be sure that there are no other discrepancies between our protocols and the length based resuscitation tape that is most commonly

used otherwise known as the Broselow tape for those of you who are unfamiliar with it which I'm sure includes no one in this room.

So we'll put that on the agenda for the next E.M.S.C. meeting which will be happening soon. Thank you.

CHAIR MARSHALL: All right. Thank you, Dr. Cooper. I think that's a good idea for E.M.S.C. to come back with that.

MALE SPEAKER: Thank you.

MR. GREENBERG: I'll also just ... I do think and -- and the bureau would agree that's an important update to have, especially as we look at, you know, the medicine and the Broselow tapes changing and maybe it's Handtevy or fill in the blank of what you use.

If this group agrees with the medicine of the use of those devices and there are slight variations in a protocol, be it not intentional be it -- you know, something change medicine, advance faster than we advance the protocol fill in the blank. It's important for the state and the bureau as well to have that additional assistance, not assistance, clarification of agreement of -- of this

group.

So that if we have to look into an incident or someone else in a different environment looks at something. That they are looking at something that aligns and that they're looking at something that understands that, you know, the -- the medicine and the best medicine was followed.

And so thank you for that one. And I -- I do -- I think that's important to -- to not stay specific to one specific thing, but you know, especially on those pediatrics and the different devices and options now that, you know, can be used to deliver solid medicine.

MR. PHILLIPY: Dr. Marshall?

CHAIR MARSHALL: Yes.

MR. PHILLIPY: Good morning, Mark Phillipy. I bring up a really great point there unintentionally Director Greenberg in that one of the struggles that many agencies have, including my own, is that we have many versions of that tape. We try not to. We try to sort some out as we can, but that is also a concern.

And I'm fairly confident the dosage of midazolam probably hasn't changed in a number of

years for that. But if I have a 2017 version of the Broselow tape instead of a 2020 version, that also leads to some -- some level of concern. So I think this is well placed.

CHAIR MARSHALL: Thank you. Yeah, good point.

MR. WALTERS: Dr. Marshall.

CHAIR MARSHALL: Yes.

MR. WALTERS: Dr. Walters, if I may. So we also had a similar issue, I think to Dr. Cushman in our area. And one of the things we found out is one of the -- there's obviously different brands out there. One of the commercially available tapes also has a wheel and I won't mention any company names here.

But the wheel, because of space limitations actually used the point two ... does for intranasal or I.M. but didn't make that I guess explicitly clear as opposed to the I.V. dose of point one. And that caused some confusion too. And so that may be something that even with we can't just look at the tapes, we also have to look at the wheels or other devices or apps or things that are out there as we're doing this.

And I -- I -- this might grow in and morph into a larger discussion, but if we find discrepancies between the different brands or commercially available products, do we have to list specific ones that we would support or endorse that are consistent with our protocols. And maybe that's something we look at.

MR. ISAACS: Yeah, for -- if there are differences -- I mean, a lot of research -- evidence based research right in regions or I guess the state into developing pediatric protocols. Why don't we use these other devices to estimate the weight and just follow the protocols since they should be up to date, evidence based driven and so on as opposed to looking at these different devices.

Look at differences between these devices and your protocols.

MR. GREENBERG: So I'll speak as a paramedic in the field. You know, I think my concern with that one would be pediatric patients I think for everyone. I think I haven't met many providers probably except for Dr. Cooper who -- you know, when we have that really sick pediatric patient that you're like ourselves or -- oh crap, okay.

You know, what's going on? How do I do this? And I think the -- the least amount of looking around resourcing and flipping back and forth between something is critical. And so I think if it -- if I have a device and if this group, you know, agrees with those devices that are out there.

And now I've used that device to determine the weight. I've used that device to determine, you know, the medicine, the equipment I'm going to use and things like that. I would much rather stick with that same device for the medicine dosages as well opposed to, okay they're this weight and now I'm going to go and look in a separate place for dosing or things like that. That is just the opinion of one.

MR. WINSLOW: And the other way to look at it is we could just use some of our state funds to create a length based tape in accordance with our protocols and have the state provide them to the regions. I mean, I do --.

MR. GREENBERG: Do you know how long it takes me to update protocols?

CHAIR MARSHALL: So I -- I -- I think some of these are good -- good ideas. And we'll

allow E.M.S.C. to -- to do their job and come back with an appropriate recommendation. I think considering all the comments that have been made. Okay. Anything else on the length based tape? No, okay. So the next -- if you have some.

MR. GREENBERG: Dr. Cushman, is there anything that you want to talk about just in your area on length based tapes and some things that are coming up maybe?

MR. CUSHMAN: Sure. Through great partnership with the bureau and Amy and -- and the whole team. ... region is going to be launching a pilot using the Handtevy App because, again, one would argue that even a length based resuscitation tape is not the best tool. It is utilizing a tool that does the calculation for you.

So that you are volumetrically dosing your medication not having to do math of a mig per kg, then milligrams per milliliter then administering again whether it's two o'clock in the morning or two o'clock in the afternoon.

So that's -- that pilot will hopefully be a -- a kicking off first quarter of next year and I think we're going to hopefully learn some things,

as well as how that can be implemented widely and adjacent to ... point looking at -- in the end, all you need to know is the color. And -- and so a -- a color tape then is utilizing an app which can be updated with whatever is appropriate.

And again, this happens to be Handtevy, but there are some others out there is -- is likely the best way to enable our providers to appropriately dose medications in -- in the pre-hospital environment, so more to come on that. And as we move forward with that, certainly we'll be sharing that experience with everybody around the table.

MR. GREENBERG: And I think it's an important one to highlight, I mean, this group is, you know, we talk about research, we talk about, you know -- you know, evidence-based practices. And so this is an excellent opportunity, an excellent partnership with E.M.S. for children and Amy Eisenhower and championing that one and having some funds.

And Dr. Cooper, you know, from the E.M.S. for Children, federal program, to -- to do an initiative like this. And to see kind of what those

results are. And to -- to -- I just want to say thank you to Jeremy and your team for taking on some of that lift and roll out and, you know, seeing what it is and analyzing, you know, things from there.

So you know, whether it be that, whether it be the ... program, you know, I think there's really exciting stuff that's coming up in New York City E.M.S. And I think there's even more that can come. I think there's some opioid stuff that we'd love to look at. And, you know, focus on that as we know that there's a crisis around the state.

But these specific initiatives really are what, you know, help us move forward, but also help us highlight and help us, you know, as I go to -- you know, the commissioner's office and say, you know, what's going on? And be able to highlight, you know, hey, look, here's some of the things that we're doing and here's some of the, you know, the components that are happening and so you know, these programs are -- are wonderful things that the bureau can do to support it.

We want to and yes, I think we should talk more about opioids in -- in the next look at things.

CHAIR MARSHALL: What was the name of that app?

MR. CUSHMAN: Sorry, it's the Handtevy product. H-A-N-D-T-E-V-Y.

CHAIR MARSHALL: Thank you.

MR. LYNCH: And Dr. Cushman, you're looking at pediatric dosing on that app?

MR. CUSHMAN: Everything. So those of you that are familiar with that, you can set it so it includes pediatric dosing, I -- I use it as ... medical agency. So we have adult dosing in there which again allows for ideal body weight or weight-based dosing for a seventy-five kilo adult, hundred kilo adult, hundred and twenty-five kilo adult depending on -- on what it is.

The -- the challenge that our little tiny region has, which I'm quite confident most of your regions will have, is that in many cases our agencies may carry different concentrations of drugs which creates error within an app that is again, utilizing a drug concentration to determine your volumetric determination.

And so part of our process and partnership with -- with Amy in the bureau is

figuring out what are the processes, what are the builds associated with that, so we can try to reduce that error to acceptable levels across a diverse system. And making sure that agencies aren't when they're changing out a drug concentration because of shortages or supply issues.

We have again, processes in place so that if Jason goes from fifty mg per M.L. of ketamine to a hundred mg per M.L. of ketamine we don't issues at his agency versus my agency at that point in time, so that if -- if it all works, we'll at least have a template for everybody else to use.

It's easy to do at a singular agency relatively. The -- the challenges when you're dealing with dozens of agencies with different drugs that -- that's where it becomes a little bit more complicated. So that's what we're working through.

CHAIR MARSHALL: Yeah, we have -- state your name for the record.

MS. SINGLETON: Debbie Singleton. We have used Handtevy for four years. It's very painful setting it up, but once you get past there, you have to go through every age and confirm what the dosage is. It goes up to thirteen years and then it has the

adult as well. But along with using the Handtevy, there's a whole program that you attend.

And ... Handtevy had great success in Florida with saves on pediatrics because when you walk in the door on a cardiac arrest, you have your first four Epis all drawn up and they show you how to -- you know, how to make things more effective based on the age. It's a -- it's an amazing app.

We've had no issues. It's just painful setting it up. But once you get past that, everybody loves it.

CHAIR MARSHALL: Great. Thank you. Doctor?

MR. KUGLER: Thank you. Dr. Kugler here. Just a quick question. I believe the state already has a medication slash protocol app that they've supported and endorsed and pushed out. And on that app, there's the ability to take a weight and put it in and you could use the protocol and it'll calculate the appropriate drug dose based on the protocol without purchasing any other applications or devices or systems.

So perhaps we can continue using our outdated Broselow tapes just for the weight estimate.

Put that weight into this app that's already supported by the state, which has our current protocol on it, and do the pediatric drug calculations. So it's been brought to my attention that this part of the app does require a subscription.

So maybe the state could open up for the pediatric dosing for the providers that part of the app. And then this way agencies aren't obliged to purchase other products -- other commercial products, have other systems. And this way, when I come in with my A.L.S. first response agency to your agency and you Handtevy and I have the state ... app.

You know, I don't know how to use your Handtevy device, but I know how to use mine. It'll -- it just foster more symmetry among the providers and make things I think a little bit easier. Thank you.

CHAIR MARSHALL: Thank you. Okay. Any other comments? Can't wait to see what the E.M.S.C. comes back with. That would be great.

MR. GREENBERG: Okay. The only other comment I'd have on that one is, you know, Dr. Kugler, I -- you bring up an interesting point as

well. And -- and, you know, maybe as we're looking in Dr. Cushman, I'm not sure which particular components you'll be looking at from your study using Handtevy.

But if there is similar things that could be looked at and maybe looking in Dr. Kugler in your region. I -- I believe your call volume matches somewhat similar. And, you know, use of the Mover app (phonetic spelling) ... and really, you know, engaging those providers in order to have a similar kind of clinical research and clinical look at the Mover app or things from that point, from that medication dosing and -- and ease of use and the feedback of the providers as well.

Yes, you brought up an idea and yes, I would like to know if you have ...

MR. KUGLER: Look at all the data, but I --.

MR. GREENBERG: Maybe with Dr. Winslow.

CHAIR MARSHALL: Thank you. Dr. Bart?

MR. BART: Thank you. Re-circling just back to the dosage here, it sounds like we all agree that use of the -- the tapes is acceptable

practice. However -- and asking E.M.S.C. to -- to review this, I think what we're asking is to review the appropriate dosage and to make sure that we're still in line with the discrepancy we've discovered between the protocol and the tapes.

I guess from a medical standards perspective, I'd like to hear around the room here. Are we that far off? If this is a -- if we're at point one migs per kilo is our acceptable dose in protocol and the -- the tapes are saying point two. If we're that far off on our dose range, we've uncovered something that sounds like it's fairly critical that we should solve now.

MR. GREENBERG: From my understanding, I don't think that the dosing or the tapes are that off. I think it's a situation of if they were slightly off or if there was a minor change that it's not set in stone in the protocol, so that documentation wise and things of that nature.

You know, if something went in a different direction and the state had to look into something that there was a, you know, ability and appropriateness that the provider used an appropriate dose based on either the protocol that they followed

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or the -- you know, an approved weight based pediatric dose measuring device.

CHAIR MARSHALL: Yeah. Dr. Cooper?

MR. BART: It just seems germane in the conversation that if we're saying that it's doubling, such as Dr. Cushman brought up his example here, that the discrepancy of five versus ten milligrams of midazolam is not a documentation error. You know, that is potentially a patient error.

I just want to make sure that we're still comfortable at our point one migs per kilo as we've discussed and implemented. And that we're not the ones that are wrong and potentially the tapes are right.

MR. GREENBERG: In that particular case, I would think that maybe this group or subset of this group would want to take a look at those tapes, you know, maybe the -- the -- a couple of the tapes as well as the protocols and see, are there really any differences or many differences or so on and so forth just to ensure that we do align.

MR. BART: I -- I think Mr. Greenberg what -- what we're really saying is E.M.S.C., please help us. Take -- take a look at the tapes, make sure

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indeed this is the only drug dosage that's different. The advantage that we have in this case is -- and I think the motion that I would make here would be very, very different if our protocol was double the dose that was on the tape, right?

But that dose that's on the tape is double what we are doing. One of the rules that I follow in medicine is you can always put in more but you can't take it out, right. So we may end up inadvertently asking a child, you know, giving a child two doses of medication, if indeed the point two is the one that E.M.S.C. comes back as.

And we'd be better off with that point two, but let's -- let them do their work and bring that information back to us the next meeting.

CHAIR MARSHALL: Thank you. Yeah, Dr. Cooper?

MR. COOPER: Yeah, at the risk of stating the obvious, I -- I think every emergency practitioner sitting around this table and physicians, nurses, et cetera who deal with children understand that midazolam as well as most other ... and many other drugs as well, are administered, you know, in a range of and the commonly cited range in

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pediatrics is at point one to point two, right.

So I mean, neither dose is entirely correct, neither dose is entirely wrong, right. It's a range. And you know, we tend to shy away from ranges in our protocols because we want explicit direction for our providers. But you know, I think that this is an issue that we can easily deal with in discussion.

I think some of the larger issues that have been raised also need some degree of -- of vetting and we'll at least take a stab at looking at some of those as well. But as Dr. Dailey points out, the immediate and Dr. Cushman points out the immediate issue is to resolve the discrepancy between the point one and the point two and the protocols in the tape.

But we'll -- thank you for -- again Jeremy and Michael for bringing this up and ensuring that we get this done in a timely manner. And of course, Don and Will as well.

CHAIR MARSHALL: Thank you. So why don't we stick with pediatrics since we're on pediatrics. Another item for discussion came up. I'm just trying to pull it up. Pediatric CPAP and

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pediatric high flow nasal cannula for the respiratory surge. Let me just see. We got where -- who -- where did that come from?

CHAIR MARSHALL: The pediatric CPAP. Dr. Dailey.

MR. CUSHMAN: I can do my best to elucidate that and, Amy, if you want to add anything additional. Amy had reached out to -- to me, lucky me. I still love you, Amy. Regarding a question from Upstate regarding high-flow nasal cannula, CPAP and BiPAP in pediatric patients and whether it is allowable within protocol, given our current search 00:00:38 search.

Okay. And I -- I had shared -- we got that information, the specific citation and so forth on I think Monday night. So I sent it out sorry in Boardable Monday night in the -- in the discussion group.

My read of it is as follows. Number one, this very much prompted me relooking at all of our protocols and going I think we need to relook at some of our protocols. Particularly as it relates to pediatric respiratory distress and some of our developing respiratory therapy techniques that may --

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may have value in them.

But again, I would -- I would defer a fair amount of that to -- to E.M.S.C. From a high-flow nasal cannula perspective Upstate had cited some recent literature and -- and reviews. I think the take home point is that although it does decrease respiratory rate and objective measures of dyspnea, it doesn't change meaningful outcomes.

Meaning intubation rates, I.C.U. admissions, length of stays, things that at least I care a lot about. The other challenge obviously is logistically doing high-flow nasal cannula in even adult is almost impossible unless you have a liquid oxygen tank or a tractor trailer of oxygen that you -- you carry behind the ambulance to go from point A to point B.

Add into that the logistical and practicality of warming and humidifying oxygen to be able to administer in high-flow nasal cannula at ranges that most of our regulators currently can't even fathom to manage and you can't titrate it as us clinicians know. I mean, oftentimes we're only doing a fifty percent FiO, but at liter flows of thirty,

forty, fifty liters per minute within -- within that

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it -- it's not titratable.

So although conceptually, adding this high-flow nasal cannula to the toolbox of E.M.S. providers, is likely within their scope since it is a nasal cannula, but it's not really a nasal cannula, it's a bigger nasal cannula, is probably within the scope of E.M.T.s and paramedics.

My concern on the issue of high-flow nasal cannula is that I fear that many providers would look at high-flow nasal cannula and say great, I'm going to put a nasal cannula on -- on Dr. Rabrich here and you know put it a flush rate and he'll do better. And the reality is, is that, no, actually he'll probably do worse.

I probably will not do what I should be doing, which is to support his respiratory effort utilizing other good techniques, i.e. B.V.M. so on and so forth. And so in -- in the absence of evidence that high-flow nasal cannula when it really is high-flow nasal cannula does not improve significantly outcomes that at least Jeremy cares about the risk outweighs the benefit from -- from that -- from those particular circumstances.

Should we get to a point where we have

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high-flow nasal cannula that can be run in the back of a truck, amen. It would be great for some of our adults. Maybe even some of our pediatrics. CPAP kind of follows in that same vein. CPAP in kids, I realized our protocols technically allow CPAP in "older pediatrics."

Let's not get into the conversation about what age someone becomes an adult. It's a huge range. I think most of us would agree that if we're using CPAP in a child, they often need some level of sedation and/or anxiolysis which also tends to scare the crap out of me even when I'm doing it.

Forget about me teaching a paramedic how to do that and -- and so forth. So that was -- that was my read. I'm not the interpreter of the protocols. I'm just a guy. And so I offered to bring it to this group to get some general thoughts and consensus so that, you know, perhaps we can take it back to both Upstate and/or E.M.S.C and/or whomever else to look at some of these emerging technologies and figure out.

Do they have a place in the prehospital setting this week, perhaps in the future, what have you? Sorry for the long rant, but that

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hopefully provides the context.

CHAIR MARSHALL: No, thank you. That was great context. Dr. Cooper?

MR. COOPER: I think Dr. Cushman has raised a number of key issues regarding this request. This is already on our agenda for -- for discussion at the next meeting of E.M.S.C. Let me just, you know, from a -- from a very simple practical standpoint, you know, use of -- you know, high-flow nasal cannula, CPAP, BiPAP, in the pediatric age ranges, not only would require a good deal of protocol review, and so on, and -- and education and -- and so forth.

But, you know, it also entails a whole bunch of additional equipment that our folks would have to carry, and -- and so on. So I, you know, well, off the top of my head, my senses were not quite there yet. But as Dr. Cushman points out, we may be there at some point in the future. But this is certainly something worthy of discussion.

And as I said, is already on our agenda for the next meeting. Thank you.

CHAIR MARSHALL: Thank you. Thank you both. Yes.

MR. SANDBERG: Doug Sandburg, Upstate. So just real quick. This request came about as we were developing some outreach education and looking at options, more from an inter facility transfer standpoint, than the 911 response time. What we're finding is our patients are traveling greater distances and are sicker.

And we're struggling to get patients to tertiary care facilities safely. So looking at alternatives that are out there for that critical care transport or specialty care transport paramedic, that brought the impetus of the CPAP discussion, high-flow nasal cannula.

Those agencies that are invested in that and conducting those transports obviously, they need to invest in their providers and the equipment to do that safely and effectively. But the fact of the matter is, we're in a crisis and we're transporting patients well beyond traditional distances.

And we need to make sure that we're preparing those E.M.S. providers which are those 911 providers in the community that are answering the call. So that's the impetus of the education and --

and why we're looking for that guidance.

CHAIR MARSHALL: Thank you.

MR. GREENBERG: I think it's a very timely discussion. I think it's an important one, especially as, you know, on a regular basis both the S.O.C., so the Search Operation Center is getting calls for longer and longer distances for longer and longer transports and, you know, in that, that becomes problematic.

As well, as, you know, even simple things of, you know, a call that I had last week with -- you know, a provider who's trying to get the patient to where they need to be. The patient couldn't be flown, paramedic wasn't, you know, in that situation wasn't an option.

And they literally were talking about, well, can I -- can I relay ambulances in order to have enough oxygen. In order to get them, you know, to the right place. And you know, even just in talking to Dr. Dailey, you know, the places that Albany Med is getting referrals from these days is not where the places that were getting referrals from five years ago.

And you know, as that adopts as that -

- as that changes in where referrals and pathways and -- and, you know, essentially, you know, the hospitals who can handle the more complex patients are handling more and more and the community centers are sending more and more.

That puts more of an onus on our E.M.S. system, on our agency medical directors in ways that aren't covered under our protocols because it's critical care transport, its non-emergency. But it brings up, you know, the point that Doug brings up is, you know, having those providers feel comfortable with that training.

Having the providers feel comfortable, you know, being out there and -- and -- and doing those things. And you know, I think this is something absolutely that this group should -- should bring up and address. Not just the nasal -- you know, high-flow nasal that's important.

But also how well we're going to address when a paramedic is now asked to do you know, a two, three, four hour transport of a truly critical patient, because they can't be flown or they can't, you know, get there in any other way or there's no beds available in the region. And I think this group

has, you know, a lot of opportunity to -- to help in that and to offer their expertise.

CHAIR MARSHALL: Thank you. Any other comments? Yes. State your name, please.

MR. CALL: Jeff Call from Upstate New York. I am the provider that called Ryan. In the height of our seventy-two-inch snowstorm two weeks ago, I was asked by Samaritan how will we transport these eight pediatric patients that are on high-flow nasal to Albany Med in Westchester if we can't get an aircraft which, of course, you can imagine that's seven tanks of oxygen, seven tanks of air five -- literally five different ambulance companies.

We're going to make it happen. But fortunately, the kids did well on the treatment within the hospital. But with this becoming a new treatment in the hospital, I mean, just leave out the part about can we do it in E.M.S. as it becomes more and more common in adult and pediatric care in the hospitals.

The hospitals can't maintain that treatment. And I can tell you from Upstate New York on a daily basis we're taking patients to Westchester. So that's -- that's a lot of oxygen and

a lot of air. And in the words of Bob Riley, I can't -- I can make you a truck to carry the amount of air and oxygen you need.

But your -- your paramedic and nurse will have to be thirty-three pounds. Because the vehicle will not have any weight left for anyone but the child. So you know, logistically, it is something we have to address because more and more smaller hospitals are using this treatment because it is effective.

And we're trying to keep these kids from becoming intubated and -- and that's the result, if we can't get them out of there on that, you know, so that's the question. Is there -- is there a medium to it because if they start the high-flow nasal at the hospital which is right, putting them we did it.

We took one down to Dr. Dailey and by the time we got to Albany Med on CPAP or BiPAP whatever we did for that child. He was in significantly worse shape than when we left Samaritan and -- and we -- we dealt with it, the child did fine, but it's -- it's going to be more and more as that treatment becomes more common.

And so we in the E.M.S. have to figure out how to move it, because there isn't a helicopter available every day. I will tell you U.V.M. does have one unit. I believe that either has liquid or generated air and oxygen that -- that -- that Michael was willing to send down to us. Dr. Bombard actually arranged.

We could get that vehicle to move these kids because we were getting a lot of snow just in Watertown. It wasn't anywhere else. But we had to get out of that snow with his child. And so -- so this is -- this is real. And it's scary when it's -- when they call and say we have eight kids on this.

And by the way, we don't have a pediatric I.C.U. Pediatric I.C.U. at Upstate is beyond full. You know, we called them and they are packed. And so we're going to see Dr. Dailey with these kids in -- in Westchester if they can't take them. So it's real. And we're just looking for some help on how to -- how to treat them, how to guide them.

MR. DAILEY: You should actually clarify because it means something very --.

MR. CALL: Upstate Medical Center,

Syracuse PICU, which normally would take those, and to be completely honest with you, as much as Vapotherm Corporation says their unit can't go in. And I can tell you we can get a Vapotherm unit from Watertown to Syracuse to safely and legally, but that's it. Syracuse is dry roads.

It's the tap seventy-seven minutes is my maximum amount of time with this child so.

MR. GREENBERG: And Jeff, can you just clarify who you're actually with because it sounded like you're with Upstate Medical?

MR. CALL: Yes, I'm from Upstate, New York, Watertown, New York. And North. Upstate Medical would be our closest PICU, but that's when I say Upstate New York, I'm saying --.

MR. GREENBERG: And your agency and affiliate -- and association too because I think that's relevant in a number of calls that you get.

MR. CALL: Guilfoyle Ambulance Service in Watertown, New York is my agency that would be transporting these children.

MR. GREENBERG: So I'll also add that he's a little bit modest. He's also the current either Chair or President of U.N.Y.A.N. which

represents the commercials, which is the ones who are in many situations right now being asked to -- you know, perform these transports and longer, and that we're getting, you know, increasing challenges in doing that, in some cases, because of the distance, the amount of time, getting the patients back when they need to come back.

So just many conversations with Jeff and I appreciate it. Thank you very much for -- you know, the feedback from -- from what is happening out in the field and -- and how some of those complications are happening across the state.

CHAIR MARSHALL: Thank you. Great discussion. All right. Any other discussion on pediatrics?

DR. DAILEY: I -- I think the only other thing I have to add is that, you know, the folks from the Bureau that are staffing the ... center, that are helping folks like Jeff ... are incredibly important. You know, number of years ago I was in Albany Med, and I had a provider bring a patient into me that had been transferred from a great distance away for profound respiratory distress.

Went in and checked the patient. He actually looked pretty good. ... breathing he was doing fine. And the paramedic turned around to me. He said, what do I do with this? And in his hand, he had ten vials of midazolam. I said, where'd that come from?

He said, well, I when I left the community hospital the doctor said, hey, take this. And if you need to intubate the patient on the way, give him all of it, and then intubate him. We need to be really careful because some of our community hospitals aren't going to have doctors that we interact with on a regular basis.

We need to make sure that we give our providers the tools and the contacts in order to discuss with E.M.S. physicians and E.M.S. leadership, how to safely do their job. Because for these providers and community hospitals, they got a patient they need to get out the door because they're worried they're going to die.

They're really desperate to get that patient out the door. And once the door closes behind that patient, the door is closed behind that patient, regardless of what ... says, right? So we

need to make sure that we remain the resource for those providers to keep them safe in their job.

So that they don't end up with that moral quandary that puts them in an extraordinarily difficult position coming back to work the next day.

MR. GREENBERG: I would add to that, as these patients move longer distances, also making sure that when they get to someplace that they have a place to go and that is not in one geographic area. We're hearing this problem across the state where patients are, you know, going to a hospital and when they get to a hospital, there is still a wait time for them to either get matched or go through something else.

And again, that continues to tax the E.M.S. system as well. I know from a different discussion on ... and things like that, that I think Dr. (unintelligible) will talk about later.

CHAIR MARSHALL: Thank you. I think it's really important as Dr. Dailey said that we provide resources for these providers because handing pre-hospital provider a handful of midazolam vials is just beyond the pale.

MR. GREENBERG: Just open your hands.

CHAIR MARSHALL: Yeah, yeah, yeah, okay.

MR. GREENBERG: You're good.

CHAIR MARSHALL: Sugar rush. So -- but thanks for bringing that up. The last item for discussion was related to an article that was sent out. Article came out in November, Defibrillation Strategies for Refractory V-Fib. And the article actually showed they had a four hundred five patients and actually showed -- looking at three different methods of defibrillation.

One is double sequential defibrillation, which is taking two defibrillators and shocking the patient, one after the other. And then Vector Change Defibrillation where you move the pads from one area to the other. And then the last one was standard defibrillation.

And the article actually showed that there was improved -- improved survival in patients who had double sequential defibrillation and had a better neurological outcome. So I think -- I mean, I see some logistical issues in the pre-hospital setting using double sequential.

But certainly, there may be some other

options that we can look at Vector Change for example, might be something because that also showed improvement to hospital discharge for refractory V-fib. So it was very interesting article, so thank you for sending that. Dr. Dailey, I see your finger over the button.

MR. DAILEY: No, I was just going to say I think this is -- this is important because we did have double sequential defibrillation in -- in our protocols as an option. We then removed it. And these trials actually use double sequential defibrillation. But you can't actually separate the fact that double sequential defibrillation is just Vector Change.

Right, it's -- it's really the same thing, but then with another defibrillator to confuse things. So I think in our education in particular pushing forward the idea that after three shocks, changing that Vector for your next shock, is going to be extremely good medicine for our providers to do.

It doesn't require protocol change. Requires educational change at the level of the regions and the agencies and hopefully will leave us with more citizens in the state of New York.

CHAIR MARSHALL: Great. So should just go to T.N.E.? Okay.

MR. CUSHMAN: Sir, I would just -- I think what -- what Dr. Dailey said was important, because it's the New England Journal Article so of course the most important analysis they didn't do, right, which is comparing dual sequential with vector change. They -- they -- they compared both with standard.

You know, to me, the real question is, is there non inferiority between Vector change and dual sequential. And I don't know that because of the methods that they used. And so when -- when I shared this with some of my providers, they said, great. This scrap again, you -- you add it to our protocols, and you take it away, then you're going to add it back.

And -- and what I've -- what I've at least promised them is we're not going to do it yet. But at the same time, you know, we don't speak to Vector change and specifically anteroposterior pad placements as often as we should. Particularly for pacing and cardioversion with at least within the -- the -- the cardiac literature is pretty standard.

And at least my own personal anecdotal experiences is that my both pacing and cardioversion is far less painful and far more successful when we are -- when we are placing pads antero/posteriorly rather than in our traditional sternal apex positioning.

So again, I -- I think our -- our educators are -- are very well knowledgeable of these different approaches. I -- I think there is some nuance in all of this. But the take home message should be more of what my colleague from -- from the eastern half of the state just mentioned.

Which is we -- we have to know in this population that those in refractory V.F. really may -- may get better with Vector change. But those that are truly in refractory V.F. need extracorporeal life support. Because you're -- they -- they will be in persistent V.F. until you reperfuse them, and then you can get them out.

So point being is that we don't want crews at least with systems that have extracorporeal life support capabilities to sit on scene changing pad placement for half an hour when really what we need to do is reestablished flow and open up the ...

vessels so that we can actually defibrillate them after we get reperfusion.

CHAIR MARSHALL: Thank you. Any other -- any other thoughts on the article? Yes. No. Turn your mic on.

MR. KUGLER: It was -- it was something in addition to that. I thought --

CHAIR MARSHALL: Okay.

MR. KUGLER: -- we were done with the article.

CHAIR MARSHALL: No, go ahead.

MR. KUGLER: Okay.

CHAIR MARSHALL: Go ahead.

MR. KUGLER: All right. Thank you. So just briefly, just a point of information or point of order or wherever, however it's taken, I'm not really sure I need Dr. Langsam. With the past many years, we've complained about getting the agendas, the documents for review in a timely fashion.

And at times, we had such important documents to review that we've received within twenty-four hours that they were just tabled at this meeting and nothing could be acted upon, because it wasn't enough time for this body to review the

information. And yet again, today or should -- I should say yesterday, we received the agendas for the meetings and the documents to review for this meeting.

Had there been something substantive that required actionable movement, I don't think this body could have done it because we didn't have the documents in a -- in a reasonable time. Is there any way, once again, to plead with the State to please get these the items to us at least within more than twenty-four hours before the State meeting where we have to actually act on them.

CHAIR MARSHALL: Thank you.

MR. GREENBERG: Sure. I -- I appreciate the feedback. And I was asked the same thing back of when we ask everybody to have their agendas in a month ahead of time that they're actually submitted a month -- month ahead of time. And it's -- it's a two-way street and we know that we have, you know, our issues and our delays.

The other thing and it really hasn't been used at all lately is that, you know, committees, including SEMAC or sub committees of SEMAC, are welcome to have, you know, a WebEx, a

quick WebEx, a briefing. You know, we have an executive call the week before this one. Where we go over, you know, kind of different things and so on and so forth.

If you're working on a document, if you're -- you know, in a group or anything like that, that can happen in between, that can show up and so you can have a discussion. So when you come here and the documents are there and they're available for everybody in public, you've seen them, you've discussed them and everything else.

But that's on the committee and the working groups to -- you know, have those discussions prior to. And obviously, now, there's also, you know, Boardable, which allows for those discussions to occur, you know, in -- in a different format too. So you know, that's why we're, we continue to add, you know, different platforms, different options, you know, to -- to avoid that.

The -- you know, the process for approval and getting it out and ... layers that's always going to be a timely process will be my guess because it's not unique to us. Please don't feel like it's not just the bureau or just this, you know,

it's across the board for anything that we do.

But -- but it's definitely collaboration of a timely manner for -- for everybody. And unfortunately, let's say Med Standards and Dr. Marshall is, you know, perfect in getting in every time. It takes every chair getting it in on time before we can push it off, and so that that's the challenge because it has to go as one packet.

So -- I mean, the other option would be is, you know, if the chair of -- you know, the SEMSCO says, hey, if you don't have in here, their meeting doesn't get held or it doesn't have an agenda or fill in the blank. And -- and we can go that route, but then notoriously what happens a weeks later, hey, can we please or can we stop that? Or can we put this in?

And -- and I'm just, you know, being honest of what occurs in those layers. And I'm open to ideas, suggestions, feedback, anything to help.

MR. KUGLER: Just a question or a favor then is as the documents because I'm not asking for the particular agendas then per se. But as a document comes up and gets approved for distribution.

As soon as it's approved, don't wait, just send it out on mass. Send that out. Put it on Boardable.

MR. GREENBERG: It -- it goes as a packet. Everything goes up. But then --.

MR. KUGLER: Makes no sense.

MR. GREENBERG: If -- if something's available. Make it available to everybody as soon as it's approved to be available. And then add it to the pot -- add it to a folder saying, this is for our next meeting. Please review and then let everybody know when the next thing is added in.

And then when the agenda is done. You could put that in too. But I don't -- I think throwing everything in all at the last minute for everybody to review sometimes can be -- there could be a lot of information. And it's not fair for the members of the committee's to have to review that information in a very short period of time and it's not conducive to good business. Thank you.

CHAIR MARSHALL: All right. Thank you, everybody. If there is no other discussion or new business, we'll entertain a motion to adjourn.

MR. PHILLIPY: Dr. Marshall?

CHAIR MARSHALL: Yes. Yes.

MR. PHILLIPY: Good morning.

CHAIR MARSHALL: Good morning.

MR. PHILLIPY: I --- I don't want to hold everyone up. So I just would like to throw that out to this committee for consideration between now and the February meeting. As we face the rising specter of a potential Ebola Virus Disease, ... New York State. Yes. Dr. Cooper, you're right. Oh god, we're -- we're -- we're back to 2014. I feel like a hamster is back on the wheel again.

I -- I make a plea on behalf of my -- my constituents and other providers that we are getting a paucity of guidance on E.M.S. response to this potential. In particular I've seen a lot of guidance for hospitals and facilities, but not a ton on -- on what we should be doing.

And in particular, I'm looking at physical decontamination things that we've learned from COVID. What have we learned since 2014 with regard to E.V.D. and -- and the handling of that in transport. I want to thank Dr. Cushman for offering some thoughts at a meeting that was held yesterday in Monroe County.

Very, very pointed, and thank you

doctor for that. But insofar as statewide guidance for other agencies as we have these statewide meetings whether it's here, at SEMAC or somewhere. We -- we desperately need some guidance to make sure that we're following best practices and lessons learned from COVID. Thank you.

CHAIR MARSHALL: Thank you. All right. Any other comments?

MR. GREENBERG: I would just back that as well. You know, as we work on advice and -- and guidance to put out for Ebola and for other things, sometimes the guidance that we get and that, you know, we have the opportunity to put out isn't very E.M.S. centric.

It's not -- you know, it's a different -- you know, it comes with the best of intentions, but also, you know, comes in a more complex way than probably most E.M.S. providers would absorb, maybe the medical director and the agency leadership absolutely.

But the providers and so I think there is an opportunity here and I know we spoke about it in the past and I think, again, everybody's busy schedules you spoke about those, you know, creating

protocols that can turn on and off based on a regional issue coming up or happening. And I hope Ebola doesn't end up being anything that we, you know, need to but we need to be prepared for that.

And so this is the prime example of when maybe we should turn on a protocol or turn off a protocol or design a protocol that, you know, t handle something like this and I think just sparked Doug's interest.

MR. ISAACS: And I'll just --

MR. GREENBERG: Dr. Isaacs.

MR. ISAACS: -- I was just agreeing with your comments and more than happy to help out with that.

CHAIR MARSHALL: Okay. All right. If there is no other business, I would just like to mention that we will be holding our Med Standards Conference call before the next meeting, so we can discuss some of the items that came up today and some formal recommendation so stay tune for that.

Hearing no other business, we'll entertain the motion to adjourn. Okay.

Thank you very much everybody.

See you in an hour.

(The meeting adjourned at 10:05 a.m.)

STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription consisting of pages 1 through 79, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 22nd day of December, 2022.

DANIELLE CHRISTIAN, Reporter

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