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NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS

DATE: May 8, 2024

TIME: 8:09 a.m. to 9:01 a.m.

CHAIR: JEFFREY RABRICH

LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

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APPEARANCES:
AL KIM
ART COOPER
BRIAN CLEMENCY
BRIAN WALTERS
CHIEF MAGER
DANIEL OLSSON
DAVID KUGLER
DAVID VIOLANTE
DON DOYNOW
DONALD DUVALL
DONALD HUDSON
DOUGLAS ISAACS
JARED KUTZIN
JASON WINSLOW
JEREMY CUSHMAN
JOE BART
JOSHUA LYNCH
MICHAEL DAILEY
MICHELE FORENESS
MIKE MCEVOY
PAMELA MURPHY
RYAN GREENBERG
THERESA ALLEN
TIFFANY BOMBARD
YEDIDYAH LANGSAM

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(The meeting commenced at 8:09 am.)

CHAIR RABRICH: We're just going to give it a few minutes. All right, good morning. We're going to get started. I'd like to call the meeting to order of the Protocol Med Standards Subcommittee. If we could record the attendance. Do we have? It's going around, very good.

Okay. So we have a couple items of old business. I think Mr. Violante, you're going to give us a report on the update on the i-gel project. Do we have new data?

MR. VIOLANTE: We do, as soon as my computer boots up.

CHAIR RABRICH: Okay. You're -- what --?

MR. VIOLANTE: Give me one second.

CHAIR RABRICH: While he's doing that, does anyone have any other old business to discuss?

MR. VIOLANTE: Well, if we had a Mac.

CHAIR RABRICH: Yeah, that's true. I mean, that's not a Mac, is it?

MR. COMMITTEE MEMBER: Yes.

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that. Okay. So we have at this point received a total of around two hundred and fifty-six i-gels confirmed on the New York State website when we get the report from them on Mondays. And of those two hundred and fifty-six, what we do is we calculate the data down and come up with numbers that -- that we had sent out previously.

And so these are the median numbers that I'm going to report out on this. We also have about fifty-three reports that are on Drupal. So when an agency does an i-gel, they will also send us this Drupal that says we've done one, here's the run number, here's the date and time, et cetera, so expect to see that.

And we have about fifty-three of those that are not in the State report as of yet. And what we've been doing over time since our last meeting is trying to assess why those folks haven't gotten that data from their agency Drupal report into the State report. And we've been working with the data informatics team about that and the agencies with that.

those things not coming across. Some of it is related to reports not meeting the Schematron at the regional or the State level. Some of them are related to not the right codes that are being transmitted and so it doesn't make the State report and such.

And so in each of those instances, we're continuing to work on bringing that number down and fixing those issues. And the last time we had nearly eighty Drupals that didn't make the State report, so we've -- we've cut that almost in half as to the data that's coming in.

So the usual dispatch -- or sorry, median dispatch to outpatient time is about eight minutes. Outpatient to i-gel about six minutes. The i-gel size most used, not surprisingly, is the number four. We have great end-tidal CO2 values after use.

About hundred and seventy-eight of these have been confirmed, meaning that someone else double checked the i-gel placement and the rest have not. And in those cases, it's because it was an arrest that was terminated in the field and so there

And so out of those cases, we have two hundred and forty-one that are considered successful, fifteen that were not. And we have the Q.I. process to look into why those other ones were not successful. The responses, eighty-eight were improved, a hundred and sixty-seven unchanged. In two hundred and thirty-seven of the cases, there were no adverse events.

In other ones, there were some things like vomiting or it wasn't recorded. In terms of ROSC, we had a number of different ROSC scenarios. In ten, it was sustained for twenty minutes. Forty-eight, yes, prior to arrival at the E.D. Eight, yes, arrival at the E.D. And the other ones were no.

In terms of outcomes, we have fifty-two expired in the E.D., ninety-two expired in the field, twenty-two ROSC in the field, fifty-two expired in the E.D., thirty-one ongoing resuscitation, and twenty-five ROSC in the E.D. In a lot of these cases, the reason it was discontinued was because it was a medical control order and that relates to some of the ones that were done in the

that it was at the time where they moved the patient over.

In terms of age, weight, and gender, median age is sixty-nine, median weight is eighty-six. And sorry, gents, but males outweigh females two to one in the number of uses, hundred and sixty-nine to eighty-seven. In terms of the regions, they've done a great job with this. The highest region is central New York using this, Hudson Valley, Monroe, Livingston, New York, Susquehanna follow after that.

These reports will go out quarterly to the agencies and out to the program agencies and to the regional area reps. And that's about where we are with it. We're continuing to look at the process. We're continuing to see the next way forward in terms of what happens in trying to make this in the national scope of practice.

And unless there's any other questions, that's the end of -- of my report.

CHAIR RABRICH: Thank you for the report. Are there any questions or comments on the

MR. DAILEY: What's the end point?

MR. VIOLANTE: So that's a great question. And I think that the end point is when we've received enough data to make the needle move at the national level, one of the things that we're really hoping to do is not take this away from folks that are doing it right now because there really appears to be great success.

And we also have said many times that we really don't want to move away from the national scope of practice model as well. And so that ends up being the next thing that we would really like to do. And it seems like as of the last change with the folks creating the national scope, they were really on the edge of making this something in the E.M.T. curriculum or not.

And so we're really looking to present this data in addition to other national data to try and move that.

CHAIR RABRICH: Any other comments or questions? Well, we thank you for the ongoing tremendous work and effort you're doing. And Dr.

MR. DAILEY: I guess I would just caution us as a State in terms of trying to turn an aircraft carrier and then provide change to our patients. You know, yes, we've decided the national scope of practice model is going to be what we are going to work towards.

I think that is serving us quite well. I do think that this is something that has a significant number of other opportunities that we're seeing out there. You're demonstrating that it works quite well in New York.

As we did with Naloxone, as we did with injectable epinephrine, I don't think that we should wait until we can change what's happening on a national level, particularly since that's basically a bunch of smart folks sitting around a table, just like what we've got in here, who ultimately change that. But every number of years rather than -- than any more frequently.

I think you're demonstrating you've got something that you've brought to a population of our providers specific to some areas of the State

whether or not that's something that we should advance regardless of whether or not it's in the national scope of practice model.

CHAIR RABRICH: Right. And one doesn't preclude the other. We can do that and still work towards the national scope of practice models.

MR. VIOLANTE: I concur. I think that's great. And I'm also happy to provide this data to -- to this group on any basis as you would like or see fit.

CHAIR RABRICH: Thank you. All right. If there's no other old business, we'll move on to new business. So the first item is the New York City protocol, which is an updated protocol for the rescue task force medical protocol. You should all have this in your packet.

Most -- most of the changes to this protocol are a bunch of wordsmithing and clarification. So just for clarification, this protocol is only used by rescue task force providers in a warm zone. It's a -- it's a restricted protocol in that regard. There's been some updates to it.

do you want to -- I know you were involved in the creation of this protocol. Do you want to talk about it or?

MR. ISAACS: Sure. Just to add on to what you said, these are only people who received specialized training at FDNY with appropriate gear.

And it's just making some mi -- minor revisions to the existing protocol in terms of updating the equipment as well as being aligned with recommendations by the T.C.C. guidelines, such as the use of M.P.A. and recovery position.

And the other big change was the extended care, wherein patients can't be rapidly extricated from the warm zone and providing some of that care until it's safe to do so.

CHAIR RABRICH: Thanks. So really the only new part of this is the extended care, which requires physician involvement. And you'll see in that protocol there's a section under physician, which is really just kind of advisory to the physicians. Obviously not a protocol for physicians to use.

It's just to provide some transparency and --

CHAIR RABRICH: Right.

MR. ISAACS: -- the comprehensive care being provided.

CHAIR RABRICH: Is there any discussion on this protocol, comments? Yes?

MR. OLSSON: Dan Olsson. I just have a question on page -- excuse me, page five, item two. The -- the area deleted and what's supposed to be in there is just not clear to my reading. So if that's how it's supposed to look, that's fine. But I just have trouble understanding it.

CHAIR RABRICH: This is the line about writing the triage category on the forehead of the patient?

MR. OLSSON: That's the line. And if you take out the red.

MR. ISAACS: Sorry, page five. No, the red is the edited changes. They're adding. It's not removing. I'm sorry. What -- what -- I don't understand your question about the red category or I'm not --

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right?

MR. ISAACS: No. Red is the --

CHAIR RABRICH: No, that is the --

MR. ISAACS: -- revisions.

CHAIR RABRICH: It's just -- it's just changed. The red just shows that that was changed --

MR. ISAACS: Yes, it just changed not to be removed.

CHAIR RABRICH: -- and was deleted off to the right.

MR. OLSSON: Okay. Thank you.

CHAIR RABRICH: Any other questions or comments? Dr. Winslow, looks like you're about to say something.

MR. WINSLOW: Motion to approve.

CHAIR RABRICH: So we have a motion to approve. Is there a second?

MR. OLSSON: I'll second.

CHAIR RABRICH: Second. All those in favor? Any opposed? Okay, motion carries. Thank you. Next, we have some discussion items. We'll skip the first one since Dr. Dailey just walked out

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So we wanted to have a discussion about clinical data, its availability, its usage, and basically to help us in guiding us in answering clinical questions, right? So you know, whether that's, you know, how -- what's our first best success rate in the State? What's our, you know, you know, door to E.K.G. time?

You know, all the -- the performance metrics that we're looking to capture as well as some of the great work that's been going on with some of the pilot projects like the i-gel and getting good data around that.

We seem to have an issue for a number of reasons, whether it's, you know, standardizing the way we input data into a P.C.R. to be able to get that data, looking at the data, analyzing it. So we want to have a discussion with the idea being to create a data integrity TAG that could kind of look at best practices in how to accurately capture data across the State and then use that data in the best possible way to answer what we really want to know, which are, you know, how are our outcomes?

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State? And as well as answering research questions around some of our pilot projects. So I just wanted to open that up to discussion about data and then, you know, the ultimate goal being to put together a TAG on this. So I'll open it up for discussion.

Yeah, it's not designed to duplicate or take over efforts of other groups that are working on data. It's really more just to ensure the integrity of data and basically best practices in data so that we're getting what the information we need to apply it clinically. So -- .

MR. WALTERS: Dr. Rabrich?

CHAIR RABRICH: Yes.

MR. WALTERS: So I would agree. I think one of the issues that was brought up at the last meeting with the i-gel project was some of the data not coming in or how we're collecting it, which was, I think, concerning to a bunch of us. So if we're documenting all these things, we want to make sure we have access to it.

If we're running reports, we're getting the right data. And I think as some of my

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Q.A., Q.I. metrics and how to implement them, and we look at their impressions list, for example, there's a lot of variability, even just amongst my agencies, what their -- what impression list they're using.

It may not be NEMSIS. It may not be the New York State Data Dictionary list of impressions. And so if we're all -- if we're not requiring a certain list to pick from, that data and those impressions or, you know, the diagnoses, if you will, I know the impressions, not diagnoses, but when we start to pull data based on those, we're not getting the right data or if we're not all charting the same way or documenting the same way.

And what I find is not only is it people not understanding what their E.M.R. does or how to use it, but we haven't really taught our providers how we want things documented. We're not all doing it the same way, even in the same agency.

And so I think that these are some of the issues that are critically important for us if we want to have good data, if it's meaningful, and if we can make medical decisions and quality standard of

CHAIR RABRICH: Thank you. I see you're making a case to be chair of this TAG, but --.

MR. WALTERS: I am definitely not making that case, but -- but I do have a new SEMAC unvetted member who might be interested.

CHAIR RABRICH: Okay.

MR. COMMITTEE MEMBER: It's okay to vote.

CHAIR RABRICH: It's okay. You can -- you can be on a TAG and not be able to vote. Any -- any other comments on -- on this -- on data? No?

MR. DUVALL: It seems to me from the various agencies that I have experience with, there is a huge variability of pick lists, if you will, that probably have a fairly significant impact on -- on data collection.

Not only patient impressions, but the discussion I had yesterday down to the use of lights and sirens and how that tends to be documented in -- in terms of what NEMSIS requires, what New York State requires, and -- and even so what individual regions and individual agencies require.

our charting system and compare it against disposition fields in various other agencies that I've worked with, and even patient disposition or patient outcome fields are extremely variable. And I was told that part of that was because of a tradeoff in a move to electronic charting where a region attempted to standardize those codes but still allowed agencies to utilize their own codes.

And at some point, if you want good, relevant, pertinent data, I -- I think some of these pick lists need to be drilled down and standardized so that providers in the field don't wind up in a position where I need to put something in a box to make this chart lock and make it advance.

And I found out that it doesn't really matter what I put in the box, so if I want to get my chart locked and go home, the data is probably not going to be correct. And that's an honest answer from a field provider.

I -- I did a chart a couple weeks ago on a pediatric patient with roughly a half a block transport time and spent over an hour trying to

a number in the respiratory rate box.

Now, by rapid pediatric assessment, breathing, respiratory rate, work of breathing was normal, color was good, I could document that, but I could not honestly put a number in that box. And -- but I couldn't not put a number in the box and advance the chart.

We really need to look at standardizing a lot of these pick lists, even across different charting platforms, and standardize them with an eye on what it is that we're trying to find. There are way too many data points that way too many entities are trying to collect that either are similar or, in some cases, non-issues that maybe we should just do away with in the interest of easier, more efficient charting.

CHAIR RABRICH: Thank you.

MR. VIOLANTE: Mr. Chair?

CHAIR RABRICH: Yes.

MR. VIOLANTE: So I can answer some of those things. There is a lot of variability of -- of data, although it all does come down to the NEMSIS

and since there's, I think it's nineteen different vendors perhaps that are out there.

Some of them must meet NEMSIS requirements and do have additional other capabilities into some of those pick lists as well that some of the agencies can modify in some way, but a number of them they can't. We're hoping that the move to NEMSIS three point five will make a lot of that easier in terms of pick lists and destinations especially, dispositions, et cetera, to make some of that documentation quite a bit easier as well.

To answer the question down here at the agency, the agency absolutely has great data of their own that they can look at, understand, chew up and figure out and move forward with.

Where some of the problems come into is when that data then gets transmitted up to the regional or the State level because that's where some of the variability comes in in terms of how things are identified from one vendor to another and how things actually move.

So that's where some of the problems

been working on as well to try and make those a little bit more streamlined and accurate and make the data more relevant to where it needs to go in a timeframe that's really appropriate for physicians to be able to look at and be able to use.

So hopefully the move to three point five will make some of that easier, but yes, you're right, we really do need to make sure that all of the vendors are using the same language and the same data is going to the same fields and it's appropriate, it's right, it's not variable and it's not so much that it's so onerous for providers that they can't document what really needs to be done or for physicians to get that and understand what had been done as well.

CHAIR RABRICH: Thanks. And I think that's some of the issues, right, that hopefully this tech will be able to address is the best practices around each of those steps, right, from the -- the end user inputting data correctly and having standard pick lists to, you know, what are the issues when that then goes to the regional or State level and

to extract that data to answer a clinical question. So I think those are kind of the goals that we're -- we're looking to --

MR. DAILEY: Jeff?

CHAIR RABRICH: -- accomplish. Yes, Dr. Dailey.

MR. DAILEY: So I -- I apologize for -- for jumping in. But you know, the one thing that you can't miss in taking care of patients' part, right?

CHAIR RABRICH: Right.

MR. DAILEY: So at the end of the day, the first reason that we document, right, isn't for billing. It's not for NEMSIS. It's not for the department, right, but it's to document the care that we have provided as Chapter 1 of a patient experience, right --

CHAIR RABRICH: Yeah.

MR. DAILEY: -- moving forward through a continuum of health care. Unless we make sure that the things that we accept as products here in New York, right, will ultimately serve to

hospitals as well, that's all lost.

There is a group that's working towards this. We haven't met in a while. We had one initial meeting. We've had some very robust email conversations. That needs to continue moving forward. It's endorsed by the STAC, has significant participation across the department, and that really needs to be the focus here.

How can the data both serve the people that want data, right, but more importantly and most importantly serve the people that are taking care of the patients themselves?

CHAIR RABRICH: Absolutely, yes. And that should definitely be a part of this as well, right? Because I think we -- we all struggle on the hospital side with trying to find those reports, get those reports, being able to get the information about what happened pre-hospitally, so absolutely.

And you know, just like hospital E.M.R.s, I'm not sure these systems are designed with that primarily in mind, right, there's all these other reasons that charting is created the way it is.

thing to remember, too, is that E.M.S., regardless of the independence of our small agencies, right, E.M.S. is a part of a healthcare continuum, and when there's a significant amount of work that's been done within that healthcare continuum to create pathways for data to flow, we need to change and we really need to moderate the policies that we have promulgated from the department that then ultimately allow agencies to willy-nilly make decisions and change their -- their data management systems.

I have one local county which was entirely on one data platform until an agency randomly decided we want to have a new data management platform, didn't consult with their medical director and just went and did it. That has to stop. We have to have policies that don't allow that.

I don't care what policy everybody uses within any one county, but it needs to be one so that way we have data that's all in the same language with the same data standards so we can then have a better understanding of what's happening, rather than

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dilutes the information that we're absorbing.

CHAIR RABRICH: Thank you.

MR. DUVALL: I wrote a fair share of paper charts in the early days, and I remember -- I remember the very beginning of the migration to electronic charting. And at that point, a charting platform needed State approval before it could actually go live.

Which meant that we -- when we started our electronic charting platform, we submitted duplicate data for thirty days with both electronic charts and paper charts. And the electronic charts were measured against the State's data format. And it required approval from the Department of Health before we could go live.

I would submit that some place we've gotten soft. We -- there are tons of vendors out there, and between vendors and agencies, I think Dr. Dailey is right. They've -- the train has just kind of run away.

And somewhere along the way we maybe need to go back and suggest to vendors that if you

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things that we expect and the things that we require as a State. How you do it is up to you. But how it comes out from your platform needs our approval or -- or you're not going to sell your software here.

CHAIR RABRICH: Thank you. Did you want to comment on anything?

MR. GREENBERG: So sorry, just dealing with an issue in the hallway at the same time. But -- so part of the problem, too, is you know, yes, they have to meet certain requirements to come in. But anybody who meets those requirements essentially would be permitted in.

The only other option for something of this nature to limit essentially the number of P.C.R. vendors or anything like that would be to have a regulatory set or to look into a regulatory set that would further align it and then set, hey, you, you know, have to meet additional standards or you have to be approved through this process or anything else.

But right now, I think we're actually down. I think we're from twenty-one down to seventeen or sixteen. So we're doing better. But

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as well. You know, it would flow better and work better for us if it was less as well.

If that is a pathway that this group feels that we should go down, it is something we can look at. And it's not even -- it's things we've spoken about before, so this isn't anything new.

But, you know, bandwidth of everything else, you'll hear me talk about it later, there's five different regulatory sets that we're looking at.

But it might be the right time to look at this as well because as the technology is advancing and we're moving to three point five and we know what the problems are and some of the data coming in, maybe it's the right time to evaluate if this needs a stronger set.

But then the problem comes the flip side where the agency in turn says, well, the department or the SEMSCO or the REMSCO or fill in the blank, whoever, are trying to dictate what I do and how I do it. And then they get up, Al Kim is shaking his head vigorously on the other side, you know, becomes on the other side.

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this room today, there's probably a lot of opinions at the table behind this table. Step up and say something, you know, because if this is a direction to go from a Bureau point of view, we can look into it. We just need to know direction that this group and SEMSCO would want to go.

CHAIR RABRICH: Yeah, I think everyone is very eloquently making the case for a TAG and why a TAG would be good to look at all these -- these issues and create some recommendations about how we should proceed. But other comments?

MS. BOMBARD: If you're looking for voices, Ryan, there -- there's one here. That's fine. Absolutely, I think this is in all of our best interest and first and foremost in our patient's best interest to not have this documentation lost, right?

Our E.M.S. providers are generating actually better and better documentation. I get to read it about patients I've never seen because I do my agency's Q.A., right? But the physicians actually taking care of those patients never read it. It's difficult, if not impossible, to find.

anywhere for a couple of hours. And by then, nobody cares, right? We've received oral report. We've already taken care of the patient. They've been dispositioned, et cetera, et cetera. And all of that excellent work is lost. And that's a problem, right?

It's a problem for our patient's safety. So absolutely we want the Bureau to be involved in this and absolutely we want to fix it.

CHAIR RABRICH: All right. Thank you. So yes, so there will be -- behind me.

MR. KIM: Jeff?

CHAIR RABRICH: Yes, go ahead.

MR. KIM: I'll speak loud. Come up.

CHAIR RABRICH: Come on up.

MR. GREENBERG: Al when you come up, make sure to say your full name first up front.

MR. KIM: Okay, I'll speak to David. Hi, Al Kim. I just wanted to echo Dr. Dailey's comment about the disconnect between hospitals, you know, E.M.R.s and the pre-hospital cares. I mean, it's something that Ryan and I have spoken about in the past of how many E.D.s are making an issue of not

drop-off.

And that's just a piece of it. I've seen multiple regions struggling with this very, very topic about, you know, small agencies to large ones using multitudes of platforms. And the fact that there has not been a regulatory component in regulating this, I think, is, you know, we put the -- the horse before the -- the cart before the horse. I think it's an important piece of it.

CHAIR RABRICH: Thank you, Al. All right, so --.

MR. KIM: Yes, to regulatory.

CHAIR RABRICH: Okay. Well, that will be another piece that the TAG can advise on.

MR. GREENBERG: Just want to make sure you got that on the record, right? Okay, good. All right. That was Al Kim, Westchester region.

CHAIR RABRICH: Very good. So I will send out something in the near future to collect interest in people who's interested in serving on the TAG and we will go from there. Yes, sir?

MR. GREENBERG: Just a reminder, so

committee. It can cross over committees and this would probably be one that would be a --

CHAIR RABRICH: Absolutely. We want a broad representation on this.

MR. GREENBERG: Right.

CHAIR RABRICH: Yeah. All right. The next discussion item was opiate antagonists. And -- did he leave the room again?

MR. GREENBERG: He left again. Maybe we should just call him. Let's try and see how long you can get the meeting to go on for.

CHAIR RABRICH: Yeah, well, other new business. Yes, Dr. Isaacs?

MR. ISAACS: Good morning. I'd like to propose a TAG for fetal blood transfusion. So just want to build upon the great work that Dr. Dailey's done with the legislative group, modifying or revising the Public Health Law, 2003-B. Some discussions that Director Greenberg and I have had with the blood resources program with our friends at Wadsworth.

And since we're close to reality of

it's taken quite some time, but we're on the cusp of it, of creating a TAG where we collectively, along with other stakeholders throughout the system, from our friends at the trauma centers, blood centers and so on, working together, creating best practices, sharing training, equipment, you know, for example, how to create a protocol to validate our blood storage, which will require both bed banks.

So it's a lot of work to do that, but by sharing our resources collectively, you know, can all have successful programs. Also looking at some of the research side of it as well.

CHAIR RABRICH: Thanks. Discussion on this, anyone want to add? I think it would be good to have a group to kind of work on developing best practices and administering fetal transfusions, but I know there's been some work on this already. Go ahead, Ryan.

MR. GREENBERG: So I think what Doug -- and I think it's important to -- to just understand the two things. So what Doug is proposing is something for best practices and moving forward in a

TAG.

And the group that's currently wrapping up their project somewhat is the one who worked on the blood regulations --

CHAIR RABRICH: Uh-huh.

MR. GREENBERG: -- which we have had really good progress with. We met at Wadsworth. They gave us some pointers on that one. We're going to go back to that group. So I think what Doug's suggesting would be a separate one, kind of almost a next step.

And I will say we do have blood transfusion in the field now. It's only in the air medical field, but it's getting to the field, it just only if it comes in by the air. So I think there's also that starting point, too, on starting those discussions sooner than later, because that is happening today.

MR. ISAACS: Yes, just want to echo what Director Greenberg said. So again, we're -- we're on the cusp of us working together, it's a lot to take off to kind of really implement a program.

along with it.

So by starting that process now, I think we can work to make sure everyone has a successful program in terms of what limitation are and so on. But it's also a nice opportunity to work with other stakeholders within the system, from, you know, the trauma folks and everyone else, blood centers.

So there's a lot of work to be done, and starting that process now, again, just build upon all the great work that others have made it possible to get to this point, so.

MR. GREENBERG: I think my suggestion, Doug, let me know if it works for you, is to maybe have people, if they're interested, raise their interest between now and September, and then have that further discussion to September on who that group would be.

MR. ISAACS: Yes, so I'll put some type of mission statement or something together, and of course it's open to anyone who wants to participate, and then look for a meeting in the

CHAIR RABRICH: Yes, I think -- I think that would be great. And as we said, to develop kind of as we roll this out, right, what are the logistical challenges and the best practices in -- - in actually executing on, you know, administering the transfusions once the regulations are in place, it's kind of the next step.

MR. GREENBERG: And I think Doug had pointed out yesterday, too, you know, the statute that is in place today that allows air medical to carry blood, carry and administer blood, there is a proposal in the Senate right now to essentially, I don't know, I didn't look at it exactly to see --

CHAIR RABRICH: Yeah.

MR. GREENBERG: -- if they're changing wording or adding wording or whatever it is, and ground or whatever, but --

CHAIR RABRICH: Yes.

MR. GREENBERG: -- it is there.

CHAIR RABRICH: Yes, it amends it to add ground. I believe it's in assembly as well as in committee currently.

A.L.S. --

CHAIR RABRICH: Yeah.

MR. ISAACS: -- specifically that was added to it, taking out Air Medical specifically.

CHAIR RABRICH: Right, so if your emergency is on a morning like this morning and, you know, you can't fly, you can still get the appropriate care. All right, thank you. I don't see Dr. Dailey, but he -- the next discussion item was opioid antagonist that he wanted to speak on the appropriate opioid antagonist to use in the field and continuing to use naloxone and the role of nalmefene, I don't -- is he out there? Does anyone see him?

MS. BOMBARD: We should elect him for something while he's gone.

CHAIR RABRICH: Go ahead.

MS. BOMBARD: I don't have anything in mind.

CHAIR RABRICH: Okay.

MS. BOMBARD: Anyone -- anyone want to talk to --

CHAIR RABRICH: Oh, he is coming now.

CHAIR RABRICH: Dr. Dailey, you keep walking out of the room and I want to discuss the opioid antagonist, so.

MR. DAILEY: You wanted to pick an antagonist?

CHAIR RABRICH: Yes. So now that you're appropriately antagonized, the floor is yours. On the use of the -- the opioid antagonist and which one is appropriate for prehospital use and --.

MR. DAILEY: So nice to -- to walk back into a room when I was relatively unprepared, I apologize. But so we did a -- we did a study with the State police that was published in the M.M.W.R. that looked at the difference between the four milligram and the eight milligram naloxone formulations.

This was done with the Office of Drug User Health and the Office of Program Evaluation and Research at the AIDS Institute. And what we did was we took three of the eleven troops within the State and we substituted the eight milligram for the four milligram there.

of what the formulations were and then allowed them just to practice for a little over a year. In the course of that time, we administered about a hundred doses of the eight milligram, around two hundred and fifty doses of the four milligram.

And found out a couple of things. One is, if you get eight milligram doses of naloxone, you end up with two-and-a-half times more symptoms of withdrawal, including vomiting, which as we all know has the potential to lead to aspiration.

The other thing that I found very fascinating was that we actually went back and looked at all of the fatalities that we were involved with and looked at the body worn camera footage, the A.E.D. reports when they were available, and any other information that was surrounding the case.

And we found that when law enforcement was called to the scene of an overdose, ninety-nine percent of them survived in both arms of that study. So I think that tells us something different, which is I don't think we have a naloxone problem. I think we really need to look at what is appropriate to have

The four milligram naloxone is probably the most appropriate product we have right now. But I would caution that we still have a significant amount of withdrawal with that four milligram formulation. We probably should look to something lower rather than higher, even in this world of synthetic opioids.

But along the way I had -- had a chance to talk to some drug users. And people who use drugs have a slightly different approach to the idea of being reversed. There are some people that I've heard say, well, being woken up, even if it's really -- sorry.

Even if it's a really rude wake up or really miserable wake up, it's still better than dying. If you actually talk to some of the drug users, they will tell you they disagree with that. Would you talk to him for me? Sorry, that's a medical control call at the same time.

One of the drug users commented on a reversal that he had had of an overdose, where he had had a compassionate approach from people that he knew

friends. And they woke him up actually with titrated intramuscular naloxone and rescue breaths.

And he woke up, felt fine, didn't throw up, and everything was okay. The next time he overdosed, he was using with people that he didn't know. And that time, he woke up after getting multiple intranasal naloxones with a firefighter and a cop both looking down at him saying, what did you take? What did you take? What did you take?

And he said the experience was so bad that he then attempted to make that feeling go away by continuing to shoot drugs after signing off against medical advice for the next six hours while he waited for the naloxone to wear off. And then he used alone for the next six months.

I'll point out the single most dangerous thing that any drug user can use -- can do is to use alone, particularly in this world of a completely variable drug supply.

And I would suggest that what we need to do is a compassionate approach to opioid antagonism, is to make sure that we're looking at the

making sure that we are taking their experience into consideration as we formulate our responses.

The only data that exists is the data that we produce through the AIDS Institute and the Department of Health. Nobody else has looked at these cases. We have an ongoing fatality review that is continuing to attempt to gain data, to look at data, but they're having some of the same challenges of data acquisition that David was mentioning before. All right?

But the reality is we believe that if you call 911 on a patient who is viable, they will survive. We don't need longer-acting opioid antagonists. We don't need higher doses of opioid antagonists. We need a compassionate, thoughtful response for public safety to the problem of opioid overdose.

CHAIR RABRICH: Thank you. Any other comments or questions for Dr. Dailey? Don?

MR. DUVALL: I find Dr. Dailey's comments interesting because it mirrors my personal experience working as a paramedic in a sort of rural

the reason I very rarely give Narcan to patients is because on the way to the call I get updates from the 911 center, patient's received four milligrams of Narcan from law enforcement. Patient received their second dose. Patient received their third dose.

We're seeing patients that are getting eight, twelve and sixteen milligrams. I think because law enforcement maybe doesn't see the expected effect where a patient instantaneously wakes up. And Dr. Dailey is right, a lot of these patients are sick.

They're -- they're extremely sick. They're acutely withdrawing. They're vomiting everywhere. They're angry. When I do get the opportunity to give Narcan, I typically will do, you know, maybe that one milligram and then the second milligram.

And I'm okay with bagging a patient for a few minutes until the Narcan takes effect and they -- they begin to wake up. And I -- I can see that it's much better for patients from my perspective. And it's much easier to work with

And I think the big problem is -- and it's great that Narcan is readily available and it's in police cars across the State, but I think in the interest of making it simple, it kind of swung that pendulum way overboard when patients are getting twelve and sixteen milligrams before the ambulance gets on scene.

MR. DAILEY: Just -- just one thing for clarification. As we look at the total number of doses of Naloxone that folks got between the four and the eight milligram, the four milligram, they got about one point seven doses. You'll remember that these are single dose applicators. So you can't actually give a point seven, right? This is an average.

And in the eight milligram, they got about one point seven doses. So exactly the same number, really done more by biomechanics, I think, than ultimate need. The other interesting thing is when we went back and we looked at the people that had received the two milligram and two M.L. you remember the one that we put together --

MR. DAILEY: -- with the mucosal atomizer device? They got one point seven too.

CHAIR RABRICH: Any other comments?

MR. HUDSON: Doc.

CHAIR RABRICH: Yes?

MR. HUDSON: So again, we all look at things from our own perspective. So from -- from an education and then I would suggest to this group medical oversight aspect, I would ask, are we using a comparable number of B.V.M.s to Narcan?

CHAIR RABRICH: Good point.

MR. HUDSON: And if not, perhaps we're skipping a step. And that to me speaks to medical oversight and education of our partner public safety agencies that we gave this miraculous drug to that has saved countless lives without the necessary oversight and guidance of how to properly use it.

And I don't mean just initially, but I mean, you know, debriefing like, you know, I know it was stressful. I know we've all been there, but waterboarding somebody with Narcan is not best practices.

speaks also to, right, like what is the clinical end point they should expect with the Narcan, right? I don't know that we do a great job of making that clear as well.

MR. DAILEY: So I think the idea of -- of encouraging, right, ventilatory support is incredibly important. I think that we know that people will be relatively reticent to use the little face mask things. They will be challenged by using B.V.M.s. But I think both of -- both of those things are incredibly important.

Central in the education that we're providing is the idea that what we're after here is respiration, not conversation. And that when the person's breathing is improving, that's exactly what we were going for, and that's going to continue to improve.

The other thing that's in -- that's -- that we should note, and certainly at this table we know, is that there is no amount of Narcan that will ultimately reverse the effects of xylazine or some of the synthetic and unapproved benzodiazepines that are

I saw one -- more than one tox report where I've had to go and look up all kinds of fancy medications that are approved in other countries or not approved anywhere that happen to be mixed into some of -- some of the drug supply.

And currently there's an ongoing drug checking program that will yield some interesting data that hopefully we'll get here as well that's being done through the department. And I'm really enthusiastic about the opportunities there.

There are also more programs looking at the crossover that many people at this table are providing, which is the crossover between public health and public safety that we really need here, right?

The answer isn't just to support one or just to support the other, but how to interface the two in order to make sure that the safety net that E.M.S., law enforcement, fire provide ultimately can save the people that can't be cared for by their peers or by their family. And to continue to encourage safe consumption by people who choose to

CHAIR RABRICH: Thank you. All right. Anything else? Does anyone have any other new business they want to discuss? Dr. Dailey?

MR. DAILEY: So I know that as a body we are not allowed to -- to lobby. However, most of the folks in here are actually also individuals, so you can keep this in mind. Assembly bill 5789 is currently moving through committee. This is Assemblywoman Warner's bill to allow blood to be administered.

CHAIR RABRICH: Yes. This was discussed I think when you were out of the room. It was mentioned that it is in committee, so.

MR. DAILEY: Good. It's in -- it's in committee. Support it. Thanks. Good. Bye.

CHAIR RABRICH: There you go. Not as this body but as individuals support it.

MR. ISAACS: Yes.

CHAIR RABRICH: Dr. Isaacs?

MR. ISAACS: Dr. Dailey, give you props. Thank you for the leadership on helping push that issue through, so thank you. We did go out of

out, so thank you.

CHAIR RABRICH: All right. Does anyone have anything else? Any other new business? All right. Seeing none, I will entertain a motion to adjourn. Or you can sit here all morning.

MR. DOYNOW: I'll make a motion.

CHAIR RABRICH: Oh, there's a motion. All right. Second? All in favor? Okay, we are adjourned. Thank you very much.

MR. DOYNOW: If you're on E.C., that meeting is in sage ballroom.

(The meeting adjourned 9:01 a.m.)

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I, DANIELLE CHRISTIAN, hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 48, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 28th day of May, 2024.

DANIELLE CHRISTIAN

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