5-25-2021 - Emergency Medical Standards
NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS MEETING

DATE: May 25, 2021 at 8:06 a.m.
CHAIRS: LEWIS MARSHALL
VENUE: WebEx

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APPEARANCES:

PETER RODIE, HOST

PANELISTS
ALEXANDER KACZOR
DAN OLSSON
JACOB DEMAY
JOHN MACMILLAN
LEWIS MARSHALL
STEVEN DZIURA
VALERIE OZGA

YEDIDYAH LANGSAM
DONALD HUDSON

RYAN GREENBERG
JOSEF SCHENKER
BRIAN WALTERS
MATTHEW MAYNARD
TIFFANY BOMBARD
ARTHUR COOPER
MARK PHILIPPY
TERESA HAMILTON
DANIEL CLAYTON
DAVID KUGLER
DON DOYNOW

JACK DAVIDOFF
JEFFREY RABRICH

JEREMY CUSHMAN
JOE BART

MICKEY FORNESS
NIKOLAOS ALEXANDROU

ATTENDEES
BETH MCGOWAN
CAROL BRANDT
CHARLOTTE CRAWFORD
DAVID GRASS
DAVID VIOLANTE
EDWARD MAGER
JARED KUTZIN

MARK DEAKERS
MELISSA LOCKWOOD

MICHAEL COX
MIKE MCEVOY

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(The meeting commenced, 8:06 a.m.)

DR. MARSHALL: Good morning, everyone. Welcome to the Medical Standards Subcommittee meeting of Tuesday, May 25th. We have an agenda with quite a bit of discussion planned for this morning. So we will try to make sure it's -- it's streamlined.

Just a couple on housekeeping. If you're not speaking, please keep yourself on mute so that we don't get any background noise.

So we'll start. We'll call the meeting to order and I'll ask Valerie to record the attendance. I guess since we're recording, the attendance is recorded.

MR. MACMILLAN: Just give us a second, Dr. Marshall. We're logging her on.

DR. MARSHALL: Okay. You're muted, Valerie.

MS. OZGA: There we go. All right. We're early, so.

Okay. I'm going to take roll call.

Dr. Alexandrou?

DR. ALEXANDROU: Present. Good morning.

MS. OZGA: Okay. Just a reminder

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everybody, if you could just announce your names for the stenographer, that would be great.

Joseph Bart?

Jeremy Cushman?

MR. CUSHMAN: Here.

MS. OZGA: Michael Daily? Not here.

Dr. Davidoff?

DR. DAVIDOFF: I'm here.

MS. OZGA: Don DeTraglia?

Dr. Doynow?

DR. DOYNOW: Here.

MS. OZGA: Mickey Forness?

MS. FORNESS: Mickey Forness here.

MS. OZGA: Donald Hudson?

MR. HUDSON: Donald Hudson, present.

MS. OZGA: Dr. David Kugler?

DR. KUGLER: Dr. David Kugler, present.

MS. OZGA: Jared Kutzin?

MR. KUTZIN: Jared Kutzin, present.

MS. OZGA: Dr. Langsom?

DR. LANGSOM: Yedidyah Langsom, present.

MS. OZGA: Dr. Marshall?

DR. MARSHALL: Lewis Marshall present.
MS. OZGA: Dr. Pam Murphy?
Dr. Olsson?
DR. OLSSON: Dan Olsson here.
MS. OZGA: Dr. Rabrich?
DR. RABRICH: Jeff Rabrich here.
MS. OZGA: Dr. Walters?
DR. WALTERS: Walters here.
MS. OZGA: Dr. Young?
Okay. Roll call is complete.
DR. MARSHALL: Thank you, Valerie.
So the first item of business on the agenda is the New York State Unified Protocols, which were sent out to everyone to review. I would like to go over some of the changes because I do not believe you received a -- a redline version. So I will just go through the protocols and tell you what specific things were changed.
So for the most part, most of the changes were formatting to bring us more in line with the collaborative protocols. And there are some other things that were added, which I will get to. So for example, on the nontraumatic cardiac arrest protocol, this was combined, and it removed some of

the subprotocols that we had like for V-fib pulse with V-tach and P.D.A., and combine them into the one nontraumatic cardiac arrest protocol.
Similar for pediatrics with the change of assisted ventilation rate to reflect the current PALS recommendation based on the AHA update. In addition to that one, all other protocols were brought in line with the most recent American Heart Association update.
In the respiratory distress protocol, nitroglycerin I.V. bolus dosing was added. This was based on a -- an article in 2020 in prehospital emergency care on using bolus dosing nitroglycerin. Systolic -- minimal systolic blood pressure for dosing of nitro was changed from one -- changed to one twenty verses from one hundred, which it was previously.
Excited delirium protocol. Medications standing orders and medical control option medications were changed to weight-based dosing to increase patient safety profile.
V-fib, V-tach with a pulse, we added lidocaine as an option.
Under pediatric dysrhythmias, this is

a new protocol, which reflects the uniformity of the adult protocols. And some of it was previously included under septic shock and this should bring us more in line with the collaborative protocols in that -- in that area.
Obstetric emergencies included paramedics that can treat eclampsia with magnesium sulfate under standing orders. This is also available in the collaborative and in New York under the seizure protocol where they can administer magnesium sulfate under standing orders.
Under the adult C.O.P.D., wheezing, both for adult and pediatric patients, we added ipratropium bromide as -- at the E.M.T. level consistent with changes in the national E.M.S. scope of practice, which does allow medical directors to determine which of these medications can be used.
We added dexamethasone to -- under the steroids and dexamethasone is one of the medications that was approved as an alternative medication under our medication protocol or policy from years ago.
Undifferentiated shock protocol, it's a newly added protocol for the general management of patients and shock despite treatment under other

specific protocols. And vasopressin was included here. Vasopressors are norepinephrine, dopamine, push-dose epi, and vasopressin.
Under the stroke protocol, criteria for New York City's LAMS score, exclusion criteria to greater than twenty-four hours from last known well, with a score of greater than or equal to four. Consistent with the current guidelines for thrombectomy for large vessel occlusion.
General pain management, a newly added protocol which organized all analgesic medication options in one protocol to eliminate pain medications and specific protocols.
Under procedural sedation, we removed -- it's a new protocol. We removed a lot of what was under the G.O.P., where a lot of these treatments were -- were available. It's now a separate protocol under procedural sedation.
Pediatric patients requiring sedation will still require online medical control contact.
Under general trauma care, it's a new added protocol. It just brings all the trauma related protocols into one place and removes some redundancy of previous protocols such as chest

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injuries and abdominal injuries. It also includes treatment for open chest wounds and impaled objects.

And those are all the significant changes, as I mentioned. Other changes were formatting changes and some wording changes to bring the unified protocols more in line with the collaborative protocols. Certainly, if -- if Nick has any comments, or if anybody has any questions on any specific protocols or the -- the things that I've mentioned, please feel free to bring it up now.

DR. DAVIDOFF: Jack Davidoff. Just two questions, actually. As I read through them, there were several protocols where it talks about I.V., but doesn't mention I.O. And I think that's probably just something that was left out and you might want to add on as you go through it.

And secondly, you folks added the nitroglycerin I.V. bolus protocol, which we've all been sitting on because of the packaging of the nitroglycerin. Have you gotten around that, or are you just ignoring that?

DR. MARSHALL: We have not gotten around the packaging at this point. I think that that's still something to be worked out. But once

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that's worked out, then that would be available.

DR. DAVIDOFF: So are you carrying an I.V. nitroglycerin? Or maybe I shouldn't ask you at this point. Maybe that's an offline question.

MR. GREENBERG: Hi everyone. Good morning.

DR. MARSHALL: Good morning. Yes, good morning.

MR. GREENBERG: This is Ryan.

DR. MARSHALL: Yes, I hear you, but I don't see you.

MR. GREENBERG: You don't see me yet. I'm not on camera yet. Nobody really wants to see me.

To -- to answer, Jack, both of your questions, actually, we are working on a exemption or essentially a waiver to our executive order to allow for that I.V. nitro to be permitted on an ambulance. However, I will warn everybody, the waiver will only last as long as the executive order is in place because we do not have a waiver process beyond that. So just want to give that update. I know Dr. Dailey has submitted a list of agencies that are looking for that waiver to occur. If there are other agencies

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that are looking for that similar waiver in the near future, if they contact us, we'd be happy to help facilitate that.

And if it is a more global thing and this does seem like something that wants to happen more statewide, we can ask legal if it can be done more statewide. It might have to be per agency just based on some of the verbiage and the way that we're doing it. However, we're happy to look into that because we want to take it as more of a statewide approach.

DR. MARSHALL: Thank you, Ryan. And we can't wait to see you.

DR. OLSSON: I just have a quick question.

DR. MARSHALL: Yes.

DR. OLSSON: I have forgotten. Is I.V. nitroglycerin in the formulary?

DR. MARSHALL: I do not recall. I would have to go back and look.

DR. OLSSON: I -- that's why I'm asking. I don't remember, either.

DR. MARSHALL: Yeah.

DR. OLSSON: I think we need to head

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in that direction that -- I think we can all agree that I.V. nitroglycerin is -- is going to happen. And we've had discussions on it, so I want to at least make sure it's in the formulary.

DR. DAVIDOFF: It's currently only sublingual. It is not listed. I take that back. Under S.T. elevation, it is listed as I.V. or I.O. bolus in the current protocols listed on the new app.

DR. OLSSON: Okay.

DR. SCHENKER: Do I -- can I comment on other things? It's Jo Schenker.

DR. MARSHALL: Yes, please go ahead.

DR. SCHENKER: There's one comment about I.O. versus I.V. In our standing order, in our G.O.P., we do have language that says that I.V. and I.O. are interchangeable. So that -- that answers that point. And I believe Tridol is in the state formulary list of medications.

DR. GREENBERG: And I will add one other thing for those agencies that have first response. A.L.S. first response agencies are not an actual ambulance. There is a waiver process even after the E.O. expires to allow them to carry.

DR. DAVIDOFF: Ryan, can you say that

again? So A.L.S. first responders can carry it, but ambulances can't?

MR. GREENBERG: No. So there's a wait -- there's a process right now, which we are working on, and realistically within the next couple of weeks, we'll get out, to allow anybody to have a waiver to carry the glass vials. So ambulances ... service vehicle. There is -- there is a process ... in the current regs to allow that ... happen. The ambulance cannot.

Now, again, we are working on trying to change regs to have that ability to have a waiver process in place that would allow us to do it, but it doesn't exist yet.

DR. DAVIDOFF: Ryan, I hate to get down to nitty gritty semantics here, but actually E.S.V. vehicles can apply for a waiver and they can carry it. If they bring it to the ambulance, the ambulance is not stocking it. Will the ambulance be able to transport it?

MR. GREENBERG: I would say that's getting into nitty gritty. And I would think that as soon as they ... anyway, it would become acceptable because it's two hundred and fifty milliliters or

above, I would assume you drop below the two fifty mark once you start the process. But I think you're getting into the finer details. And I'm happy to have that discussion with you further offline if you'd like.

DR. MARSHALL: Just one thing to be clear, guys. ...

THE REPORTER: I'm having a very difficult time hearing.

DR. MARSHALL: Excuse me, yeah. Put yourself on mute, please. If you're not on mute, put yourself on mute unless you're speaking. Also, when you begin speaking, please state your name so that we can make sure that we attribute comments to the right individuals. Thanks.

DR. DOYNOW. ... If we do the collaborative protocol over the app, under the formulary, nitro is not listed. ... somebody else.

DR. MARSHALL: All right. Don, you're breaking up a lot. Your -- your audio is breaking up a lot. So did you say that nitroglycerin is not in the collaborative protocol formulary?

DR. DOYNOW: It's not in the formulary, specifically. It is in the actual -- you

know, under the protocols.

DR. MARSHALL: Okay.

DR. DAVIDOFF: This Davidoff. Don, if you look under the medication listing, nitroglycerin is listed for STEMI as an I.V. dosing. Under the list of medications or formulary, per se.

DR. DOYNOW: I mean it says five point eight medication formulary. I don't see it there, but maybe some reason I don't have an updated list. I tried updating it, didn't see there was anything missing. But okay, as long as you see it, I don't see it. But okay.

DR. MARSHALL: Any other -- any other comments either about nitroglycerin, the waiver, or any of the other changes in the New York City Unified Protocols?

DR. KUGLER: Hi. It's David Kugler.

DR. MARSHALL: Yes.

DR. KUGLER: May I? Thanks. So two things. Just a point of correction, the minutes say New York State, not New York City Unified Protocols. I believe that just needs to be corrected because we're not addressing the collaboratives. We're addressing New York City's version.

The second thing is something that goes back to prior to Director Greenberg, when the SEMAC tried to ask New York City to switch over to a particular protocol, which escapes me at the moment. And the decision at that time was to not require New York City to switch to that protocol because the expense of training the uniformed providers in the region would have been in the millions of dollars. And so we allowed them a pass on that protocol.

What I don't understand is now here's an opportunity for New York City to come in alignment with the New York State protocols at the same expense it would be to train their staff to this new set of protocols. But the -- I mean and -- and you have clearly said that there -- there was an effort to bring many of the protocols to reflect the New York State pre-hospital care protocols, just not all of them. I don't understand why the New York City REMAC can't switch to the New York State protocols and then add in their specialty protocols which is allowable under State regulations. That's my question.

DR. MARSHALL: Thank you, Dr. Kugler. That's a very good question. I think we've asked that question over the years, as we've --.

UNIDENTIFIED SPEAKER: Every time.

DR. MARSHALL: Every time. As we've gone from individual regional sets of protocols to a more global collaborative protocol, which encompasses the majority of regions, and I believe there's two regions that are not on the collaborative are Suffolk and New York City, although New York City's Unified Protocols -- it's not a -- it's not a new set of protocols and these are the same protocols that we've had before. And I'll let Jo speak to this in a second, but it was just bringing them into one document.

And I think, Dr. Schenker, you have some other comments on that?

DR. SCHENKER: Well, I -- I -- I -- the protocols haven't changed. So as Dr. Kugler suggested that, you know, retraining everybody to the collaborative protocols, if we're going to retrain to this, we're going to retrain to that. It's -- this is the actual same protocols that we submitted last year. It's just the A.L.S. have been added and clarified to match the most current literature.

So from the standpoint of retraining, we did do the retraining on this last year. We were

required by the State to have everybody onboarded with the Unified Protocols on January 1, and we met that deadline, I think, ninety-five percent. So we -- we are currently using these protocols, just clarifications, a lot of the stuff that we went over -- that is matching the most current literature and bringing things a little more streamlined.

I think that, you know, we've had this discussion multiple times about the State's Collaborative Protocol versus the New York City Unified Protocols. And, you know, we keep having this discussion, even on a regional level, to see what the feeling is. And I think that it really boils down to the medicine is not that different. It is a overarching difference of opinion of how to use protocols. The State has more of a guideline, and the New York City has more of a protocol because of the operational requirements of a system the size that we have.

We have been trying to mirror and -- and close the gap on the medicine, which is really the key to what we're talking about on a Medical Standards Committee. But I think a lot of the stepwise approach that we follow versus the bulleted

and more of a guideline that the State follows is the --- the overarching difference between the two.

But again, we all agree that the medicine is the medicine. The literature shows what the most current medicine is, and we're trying to bring our protocols to that point. I think that's the major difference.

DR. MARSHALL: Thank you, Dr. Schenker.

Any other comments on the -- on the protocols that are presented? Seeing none --.

DR. WALTERS: Lew, this is Brian Walters.

DR. MARSHALL: Yes, Dr. Walters?

DR. WALTERS: I have one question. Maybe you or Jo can answer. And -- and aside from the -- the difference in stepwise versus guideline that you just mentioned, Jo, and the difference in the protocols, how many other areas are there actually different in the medicine in the protocols, or what's on the standing order versus not in that? Is there any -- do you have any idea or sense of that or kind of a comparison of those two?

DR. SCHENKER: I mean, when I reviewed

it originally, you know when we had a discussion, a year and a half ago, or maybe it's more now I don't remember, there is very minimal differences. And I mentioned that the other time -- the -- the last time is that the medicine is the medicine. And we all agree that that pre-hospital medicine has, you know, certain evidence-based stuff that we're all following.

I think that a large part of it is just using the protocols is more of an operational tool, because of the size of our system. But the medicine is very close. I don't think there's any major differences in the medicine.

DR. MARSHALL: Yeah, I would agree with Jo, looking at both.

Okay. Any other comments, questions?

DR. HUDSON: Dr. Marshall, Don Hudson.

DR. MARSHALL: Yes, Dr. Hudson?

DR. HUDSON: Good morning, everyone. Happy to see you all. I'm -- just procedurally I want to make sure we're -- we got our ducks in a row. I'm looking at the collaborative protocols versus the Muru app. And I don't see in the collaboratives

where I.V. nitroglycerin is listed for that S.T. elevation.

I agree it's something we should move towards, as Dr. Olsson said, and wrap our hands around, you know, being able to implement this once the packaging issue is tackled. But I just want to make sure we have our references correct.

DR. MARSHALL: Is anybody taking a look at that? No?

DR. DAVIDOFF: Lew, it's Davidoff. It would appear that on the collaborative, I can't find a copy or list of the formulary, per se. And in the protocol, it only calls for sublingual nitroglycerin. I don't know what happened to the formulary, which is supposed to be part of these.

DR. RABRICH: The formulary's in there, and it's not listed. I'm sorry, it's Rabrich. It's not listed as I.V. in the formulary, either, that I know.

DR. DOYNOW: It's Don Doynow. Yeah, I couldn't find it either under the formulary, so it's something we need to add.

DR. MARSHALL: Okay. So that will need to be added to the collaborative?

DR. DOYNOW: Correct. I think it, initially, was a pilot program. And that may be why it never made it in there. I think that's the way Dailey originally started it.

DR. MARSHALL: Okay. So I guess, if -- if you wanted to do that, at -- at this meeting, we could probably -- could probably bring that forward as an addition to the collaborative protocols. And maybe for SEMAC, give you a chance to talk about it. Make sense?

DR. DOYNOW: Dr. Doynow. That makes sense, when we add it and then bring it to SEMAC.

DR. MARSHALL: Okay. All right. Any other questions or comments on the New York City Unified Protocols? No.

DR. BART: Can we call them the New York City Collaborative Protocols, instead?

DR. MARSHALL: New York City Collaborative Protocols? The New York City Unified Collaborative Protocols.

DR. BART: Oh, yeah. All right. I think I said that last time, too.

UNIDENTIFIED SPEAKER: But yeah, we're okay with that. You want to call it Unified

Collaborative, Unified, that's it ...

DR. BART: Jo, I'm just teasing. No, I rate -- let me spin things from the top of -- ... even from the format they are the same, like I see us getting closer and closer every time we bring this thing up. So I appreciate the efforts being put in on everybody's part.

DR. MARSHALL: Thank you, Dr. Bart.

DR. SCHENKER: ... when I came to you last year, presenting this, the goal is to get them closer. There are obviously operational ... city, but the medicine is the medicine and the goal is to get them as close as possible.

DR. BART: Yeah, and I think, as you pointed out, already -- already, Joe, I mean, our job here as a subcommittee, is to listen to you and to safeguard these protocols consistent with the medical standards for E.M.S. providers. And that's the question and answer.

DR. MARSHALL: All right. If there's no other comments, then we will vote.

Valerie, are you still with us?

MS. OZGA: Yes, I'm still here.

DR. MARSHALL: Can you do a roll call

vote, please?

MS. OZGA: I can.

DR. OLSSON: I have a procedural question first, please. Do we need a motion?

DR. MARSHALL: Yeah, I guess we do need a motion to approve the New York City Unified Collaborative Protocols as presented.

DR. OLSSON: And I would like to make that motion with whatever verbiage you decide.

DR. MARSHALL: Thank you, Dr. Olsson.

Is there a second?

DR. ALEXANDROU: Nick Alexandrou, second.

DR. MARSHALL: Thank you, Dr. Alexandrou.

Any further discussion? Seeing none, we'll proceed to a roll call vote.

Valerie?

MS. OZGA: I just found a couple members I missed through roll calls. So additional members of Medical Standards that are on this call is Dr. Matthew Maynard, Dr. Bombard, and Dr. Cooper, I believe is on also. So just to make a note of that.

Okay. Dr. Alexandrou?

DR. ALEXANDROU: Dr. Alexandrou, yes.
MS. OZGA: Dr. Bart?
DR. BART: Bart, yes.
MS. OZGA: Dr. Cushman?
DR. CUSHMAN: Cushman, yes.
MS. OZGA: Dr. Davidoff?
DR. DAVIDOFF: Davidoff, yes.
MS. OZGA: Dr. Detraglia?
Dr. Doynow?
DR. DOYNOW: Doynow, yes.
MS. OZGA: Mickey Forness?
DR. FORNESS: Forness, yes.
MS. OZGA: Donald Hudson.
DR. HUDSON: Donald Hudson, yes.
MS. OZGA: Dr. Kugler?
DR. KUGLER: Dr. Kugler, yes.
MS. OZGA: Jared Kutzin?
DR. KUTZIN: Jared Kutzin, yes.
MS. OZGA: Dr. Langsom?
DR. LANGSOM: Langsom, yes.
MS. OZGA: Dr. Marshall?
DR. MARSHALL: Marshall, yes.
MS. OZGA: Did Pam Murphy join? I don't think she's on.

Dr. Olsson?
DR. OLSSON: Olsson, yes.
MS. OZGA: Dr. Rabrich?
DR. RABRICH: Rabrich, yes.
MS. OZGA: Dr. Walters?
DR. WALTERS: Walters, yes.
MS. OZGA: Okay. Matthew Maynard? Dr. Maynard?
DR. MAYNARD: Dr. Maynard, yes.
MS. OZGA: Dr. Bombard, are you on? Okay. I know she's attempting to get on.
Dr. Cooper?
DR. BOMBARD: Bombard, yes.
MS. OZGA: Okay. Thanks, Tiffany.
Dr. Cooper, you might need to unmute yourself. Oh, I don't think he's on. Okay. Dr. Cooper, are you there?
Okay. Motion does pass. And that's the end of the -- of the roll call.
DR. MARSHALL: Oh, thank you. Okay. So moving on. The next item on the agenda is the viral pandemic protocol. And I'll ask Ryan to talk about this in a second. But we did have a telephone conference and we talked about this, actually, at the

last meeting in terms of what do we do with this current viral pandemic triage protocol, which is still active, but would be activated within a region based upon regional needs and conditions at the time.
So we had some discussion about revising this, to make it more general, to cover more types of disasters with the thought of keeping it in place and active, and again, being able to activate it at the regional level based upon local conditions, with some, you know, notification to the Department that you've activated it at your regional level.
So the thought was that we would have a workgroup that would take this document and modify it and bring it back to the next meeting, with the hopes that it would be a more generalized disaster response type of protocol, again, always in the background, and only activated by the region when -- when the region conditions require it.
So I'll ask Ryan, would you like to make some additional comments?
DR. COOPER: Dr. Marshall?
DR. MARSHALL: Hold on, Ryan, first. Hold on.
DR. COOPER: Dr. Marshall, this is Dr.

Cooper.
DR. MARSHALL: Yeah, Dr. Cooper?
DR. COOPER: Yes. Just as a point of ... I'm so sorry. I -- for some reason, my audio was not working when you called the roll call. I do vote yes for the New York City Protocol. Thank you.
DR. MARSHALL: Thank you.
All right, Ryan?
MR. GREENBERG: Hello, everyone, again. So speaking under Steve ... name this time, as you can tell I've moved around the building here.
Dr. Marshall, I think you were spot on, on what we're thinking about here, like the triage protocol, and essentially, you know, to think of it as creating a set of disaster protocols for the State, and those disaster protocols would be turned on or turned off by a region, based on situations or things that are going on.
So you know, let's say, you know, as we're going into, in theory, hurricane season. And if this past year, we'll probably get hit with one straight on. But as we go into, you know hurricane season, Long Island, Nassau, and Suffolk County may be hit with something and need to use, you know, a

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disaster protocol that doesn't need to be used in Buffalo. Or fast forward to an ice storm in the North Country.

So I think the thought process here would be to create not just a pandemic triage protocol, but a series of maybe, you know, a limited number of, you know, four or five, maybe -- you know, maybe ten disaster protocols that would be turned on or turned off based on what's going on in a geographic region.

Now, what this would also allow is for our paramedics and our providers to be able to still learn one set of protocols or a limited number of protocols, to know that this disaster protocol is in place, but not turned on, but is the same from region to region. It's not unique, it's not different, it's not each region creating their own, so there's less confusion. There'll be one set, and then the region will make the determination of whether to turn it on or turn it off.

This would also mean that it would be preapproved, we wouldn't be dealing with last-minute, you know, trying to create a protocol, or on short notice, or other things that -- that we've learned

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through this past pandemic can be challenging, and would allow us to have those in place and kind of just off to the side in a filing cabinet.

DR. MARSHALL: Any questions for Ryan? Or any questions about this plan? If not, I would ask that if anybody would like to volunteer, please do so. You can either email me directly or put it in the chat to -- to the group, and then we will set up a first meeting to start the process.

DR. MARSHALL: Okay. If there are no further questions on that, the next item on the agenda is community paramedicine. And I know that there was some discussion on the phone call. And here I'll ask Ryan, as well, to jump in. But we did have some question about what is going to be the status of community paramedicine once the pandemic is over and -- and -- and once in place is no longer a place, and what will we do with community paramedicine?

Ryan, you want to comment on that, wherever you are?

MR. GREENBERG: Absolutely. Still in Steve's office again, so it's Ryan, not Steve talking. So ... actually really excited about the

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community paramedicine front. As many of you know, through an executive order, we are permitted to have community paramedicine with a couple of limitations. But been pretty widely accepted.

We opened up the application process and have just under fifty community paramedic programs, covering forty counties throughout New York State. They've been partnered with local health departments and different agencies throughout the state, which has been really exciting. And the one that I -- I guess I just wasn't expecting, but it seems to be the most current, or the most recent partnership that's going on is partnering the community paramedic programs with the school districts to vaccinate the -- the -- the children in the school districts because their ability and versatility and the ability to get out there. So it's been a really positive thing.

All this is great, right now during while executive order is in place. However, as soon as that executive order expires, all the community paramedicine would go away. We are in, you know, discussions. We've made that very clear, you know, all the things that would no longer be possible. I

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don't perceive the executive orders going away too quickly. In particular, just because I think it will number the things that are happening around the state right now related to COVID and vaccinations and things like that are all under those executive orders. As well as there's the big unknown of if we will have to do a booster shot come the fall. And so, you know, I do think this will last through then.

That being said, I really think it's something that we need to address at a more global level in whatever way that is to, you know, put together a plan for long-term ability to have community paramedicine. It just continues to show the value of it, the strengths. And just again, fifty agencies around the state, doing community paramedicine is phenomenal when, three months ago, we had, you know, maybe three or four that were skirting whether or not they were doing community paramedicine.

So it's definitely shown the value of it. And also, a lot of really positive feedback from our community paramedics on how much they enjoy doing it. And I think, in part, that's, you know, getting to get out in the community and do something

different. You know, people are excited to see you in most cases. So it's a very different experience. So but I -- you know, I think that, you know, will yield more to our ability to keep paramedics longer and make it more of a career and, you know, give more options and pathways and roadmaps for people who are looking to stay, you know, as a paramedic, but, you know, have more options in what they want to do besides maybe just ...

End of report.

DR. MARSHALL: And thank you. Any questions for Ryan? Any comments, thoughts about how we should move forward? I hear crickets -- or cicadas, I guess, would be the term. No? Okay. All right. So we'll figure out how to move forward on that.

So the next item on the agenda is the i-gel supraglottic airway pilot project. This is out of Hudson Valley, if you recall. It was for use by E.M.T.s during cardiac arrest only. It was initially one specific agency. This came forward as a pilot project, was approved by Medical Standards. And it was approved by SEMAC, with some questions from -- some input from Training and Ed also commented on it.

There was one question in terms of -- in end tidal CO2 and the requirement to use end tidal CO ...

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airway.

And I have to admit I don't recall the outcome of that discussion. Hopefully, somebody else does. But at this point, I think that it's had all the approvals. I have to go back and check the SEMSCO minutes, but I do believe it was passed there, as well. It would have to go to the commissioner for approval as a pilot project.

The other part of this was that it was opened up during discussion at SEMAC and SEMSCO that it would be open to other agencies, and they would have to contact Hudson Valley to be included in the -- in the pilot project through them.

Comments? Recollections? Ryan? Steve? Is anybody there? Hello?

DR. BART: Is it in the vote of approval?

DR. MARSHALL: Say that again, Bart?

DR. BART: I'm having trouble finding that protocol for the pilot. The documents in the ... I just want to review it.

MR. GREENBERG: So Dr. Marshall, I

believe where we left it off at the last meeting was there was a group of people who you were coming back -- or they were coming back with additional edits. And it was working on determining whether or not you were going to make it a statewide pilot or just that region. And so I think that's where it was left outstanding.

There were certain questions, if I remember correctly. There wasn't specific quality benchmarks that you were looking for. And those were going to be updated. I don't recall seeing any updates or who was working on that part.

DR. MARSHALL: All right. I'll have to go back and look at my notes and see who was working on that.

Dr. Bart, I just forwarded, to your email, the document.

DR. PHILLIPY: Dr. Marshall, it's Mark Philippy. I think one of the questions that had come up earlier also was what would be the process for other agencies, slash, regions. We had mentioned contacting Dr. Murphy and the folks in the Hudson Valley that were piloting the project to inclusion, but we didn't really establish a way of doing that or

-- or publicizing that. So I think that also should be part of the project.

DR. BOMBARD: Hey, it's Tiff Bombard. My understanding was that we actually did open this to everybody and that you were to, as Mark said, just contact Dr. Murphy to gain entry to the program. And Dr. Murphy had some literature for whoever wanted to sign up and become part of the pilot with them. And I did have contact information from Dr. Murphy. I can send that to you guys when it's helpful.

DR. MARSHALL: Yeah, and that should be in the minutes. So --.

DR. OLSSON: Dan Olsson. Page twenty-four of the minutes is ... was when it starts the discussion about the i-gel. There's a couple paragraphs. It basically just mentions it and refer to Training and Ed. I thought there was more of a discussion on it than there -- than what I'm seeing. I think I'm looking at the SEMAC minutes. There might have been more in the Medical Standards.

DR. BART: In particular, what I wanted to review fresh here was -- was the procedure for other regions. This is ... specifically and, you know, the protocol ... I mean, I don't want to ...

on this thing. But the protocol might be shared in the inclusion for a ... agencies as far as the reporting side of it. I don't -- I don't anticipate that other people will take this. But if you -- if you make this wide and widely available, it becomes the new norm. And regardless of being part of a ... or not in the reporting structure that might exist through that study, it becomes new like, oh, we can do this, you should do this, too. And it will lose the opportunity that this is a pilot. That's my first comment.

And the second, which I don't think there's anything within the protocol itself talks about a ... in the anticipation of how many participants we're looking for, so that we can prove this demonstration project is actually effective or ineffective.

I know we've had that problem with a couple of studies in the past in which it was, like, well, how many times did we get this done? I don't know, it seemed to work. I think for administration like this, we're going to see -- we're going to have to see a little bit more than it seems to work subjectively. And perhaps some statistical analysis

... in these situations, we had X amount of providers statistically that were successful with it or on, you know, so many regions. I think the data that would go along with that would be valuable for all of us do to -- to look at this, because this would be a significant change of scope for B.L.S. providers. And if we were even going to propose this, and we all know that adding thirty more seconds to the curriculum of a B.L.S. course right now, would be contentious.

I'm not disagreeing. I actually love this. I just want to make sure the idea of sharing it along with some folks and the intended outcome are universal.

DR. WALTERS: Dr. Marshall, it's Walters. I -- so Dr. Bart, I -- I understand your concerns. I guess there's two ways to look at this. Are we -- because I do understand, and I don't disagree. Do we want to keep this smaller, more controlled to really do a pilot demonstration project? Or is there value in opening it up to try to get a larger number of uses to really look at the data? And if you're trying to do that in a timely fashion, is it better to open it up to -- to

different agencies?

And I don't know the answer. I'm just raising this as a point of discussion. And I -- I think we had a discussion last time and I don't think it made it into a motion or actually made it to the SEMAC. I don't remember if it was at Med Standards or the SEMSCO -- or Med Standards or the SEMAC. I don't think it made it to the SEMSCO. Do we -- do we limit this? If you do or you are looking for a certain number of uses in a certain amount of time, or you want to get a higher number of -- of data, do you -- do we limit this to just i-gel, or do you open it up to other supraglottic devices?

Because my -- my thought is you may get more agencies who already -- that their B.L.S. providers and an A.L.S. agency are already using one device, whether that's a ... a gel, whatever happens to be, do we want to include those and not make it specifically just for the i-gel?

Because my thought would be if this is successful, and I think it will be, if this does get moved to the B.L.S. scope of practice, I don't know that we're going to say only i-gel. I think, you know, we've never really taken the stance that you

can only use this one product or this one device or this one brand.

And if we aren't going to open it up down the road, is there value in opening it up now to look at those different -- even comparing, you know, successes, failures between the different devices, is that of use?

DR. BART: I -- I think that the -- ... I guess that's how its proposed here. If the demonstration is using i-gel and the trainings go along specifically with that, there is a lot of language in this protocol that talks about the insertion of supraglottic airway. However, the direct insertion that comes ... bullet points, specifically is related to the i-gel inclusive of the sizes of the i-gel, which is not universal for all supraglottic airways.

So I guess where I'm looking at this to say that it -- it will be controlled by Hudson Valley on this -- on this pilot and it's a demonstration project for -- for their providers. It looks like the test or -- I'm sorry -- the protocol is just designed for the i-gel. But I totally appreciate your point, Brian, that supraglottic

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airways as a blind insertion is really the skill that we're looking to introduce for B.L.S. providers and ...

And I can see it going that way. As such, it seems like if you're not using i-gel in your in your system right now, you'd be excluded from this particular pilot project, because it talks specifically about i-gel. And if we didn't limit it to there, I'd see other people saying, well, I use a supraglottic airway that's kind of like the i-gel, I'm going to include us in this as well.

So I guess I'm suggesting that a little tighter control on the who's going to be involved in this. It seems like you're going to have widespread interest in it. And you're going to, you know, see the potential losing control of that protocol and not knowing who's involved with it under ... particularly because this is using i-gel insertions. That was -- that was my comment to you.

DR. MARSHALL: Thank you, Dr. Bart.

Just -- just to read up on the minutes, so from the last SEMAC meeting minutes, this did come forward as a motion to approve the Hudson Valley i-gel project the way it was presented. And

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there was a vote, and it was opened statewide. So if any agency did want to participate, they would need to contact Hudson Valley in order to do that.

And several -- at least one region has done so and was waiting on Commissioner's approval. That did go to a vote. And that vote was almost unanimous. There was one abstention. But other than that, that's how far this got. It got up through SEMAC. And I guess the next step would be to go to SEMSCO and request Commissioner's approval.

If there's some desire to change what was presented in the protocol, then I think that that's a -- a discussion we should also have, as well.

Are there any questions on -- on that? That's on page thirty-four to thirty-six, by the way, in the SEMAC minutes of January, if anybody's interested other than me.

MR. GREENBERG: Dr. Marshall, it's Ryan Greenberg.

DR. MARSHALL: Yes, Ryan.

MR. GREENBERG: So I did have one -- I guess I'll put in my two cents on devices. I would suggest that you stick with one. And I -- and I

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would also suggest that we go more than Hudson Valley only from the point of view of the ability to get -- to have numbers to look at. I think if we just go in that Hudson Valley, particularly in that one area, that the number of cardiac arrests and the number of cardiac arrests without A.L.S. on scene, I think you'll start to really limit it.

The one question I would ask this group is what happens if it's a ... Medic unit that shows up? So it's an E.M.T. and a paramedic on a cardiac arrest? And what would the SEMAC be looking for or what do you think that, I guess, Med Standards would be looking for in this pilot? Do you have the E.M.T. perform the -- the function? Or is that something that nope, there's a medic on scene, they should be intubating or --?

And I think that would also affect your numbers and the research and how many you would get. Because if we leave the New York City area, it is a large amount of people -- large number of systems that run with an E.M.T. and a paramedic or an E.M.T. and a C.C. on a truck. And I think that that should probably be determined prior to.

DR. MARSHALL: I don't recall that

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specific question being addressed in the proposal and the pilot project that came forward, but -- just trying to take a look, but I don't really see. I don't see anything, quickly. I'll have to take a closer look.

DR. ALEXANDROU: Lew, it's Nic Alexandrou. Can I comment on that?

DR. MARSHALL: Yes, Dr. Alexandrou.

DR. ALEXANDROU: I have something in my notes that specifically had said that E.M.T.s to be trained to place the supraglottic airway in cardiac arrest, and then A.L.S. would also have to be dispatched to respond at the same time. So there would have to be a backup for the airway.

I'm assuming if there's a ... medic, that then at that point, the medic would take over and probably place a -- a -- an E.T. tube and the tracheal intubation. But that's what I have in my notes. So that was not, I think, a discussion specifically last time around.

DR. SCHENKER: Lew?

DR. MARSHALL: Yes.

DR. SCHENKER: It's Schenker. So I think that a lot of this is going to be based on the

data collection tool if you're doing a pilot project, whether it's the medic or the E.M.T. that intubated -- or placed an airway, I should say. There's plenty of literature that we all know about that says that in cardiac arrest, intubating might not be the best option. An alternative airway is probably a better option, in most cases, in order to not disrupt cardiac arrest, C.P.R., and everything.

So I don't know that, you know, even in New York City, we allow the medical director to determine if an alternative airway should be first or intubation should be first. I'm not sure how that is in the rest of the state or what other medical directors are doing, but I don't think that just because there's a medic and an E.M.T., that should preclude possible entry into a pilot project. And an E.M.T., if they perform the skill, and it's documented as such on a data collection tool, should be included in the data -- in the -- in the data set for the purpose of identifying if this is safe and appropriate to use going forward.

As far as one, I think the skill has to be similar, whether it's an i-gel or another type of L.M.A. versus a King L.T. I think the skill has

to be similar. The King has a little bit more, I guess, user comfort level that has to happen with it, versus a -- just a simple supraglottic L.M.A. type airway. Maybe that has to be considered in the pilot if the pilot was specific or not.

DR. ALEXANDROU: Lew, can I make another comment on Joe's comment, please? Nic Alexandrou.

DR. MARSHALL: Yes.

DR. ALEXANDROU: Yeah, there -- there's another comment I have here in my notes that I think we discussed, specifically, the King device. And we said that this would not include the King device. Just -- just to bring everybody up to date.

DR. MARSHALL: Yes, I recall that discussion, as well. Thank you, Dr. Alexandrou.

DR. OLSSON: I would like to make an observation. We seem to be discussing nuances of a pilot project, but I, for one, certainly don't remember all of the little intricacies involved in it. And I would suggest that we have access to the written text of that project, so that we can better define and refine our comments. Thank you.

DR. MARSHALL: Thank you, Dr. Olsson.

You know we can work -- we can certainly send it out again to all people to take a fresh look at it because it's been a while. And then we can have further discussion tomorrow at SEMAC. That might be a possibility.

Don, how does that sound for SEMAC?

DR. DOYNOW: Dr. Doynow. That sounds fine. I think it'd be a good idea. I'm trying to look through SEMSCO notes to see if we had brought it up, but I can't find anything there, from last time.

DR. MARSHALL: Okay. I will forward the document to Valerie now and she can send it out to the group.

If you would, please, Valerie?

If there's no further discussion on that, we'd like to -- the item is the SEMAC advisory for transfer of Ebola patients. So I'd like to ask Ryan or someone from the Department to make comments on that because --.

DR. GREENBERG: Yeah, so first I'll say, as far as the information that you'll send over to Valerie, we will get that up onto the portal so that everybody will have access to those documents. No problem at all.

And as far as the Ebola policy statement, I am going to switch the mic over to Steve Dziura so he can make an update on that.

DR. DZIURA: Morning, everyone. So the Office of Health Emergency Preparedness has asked if the SEMAC would consider the Ebola transfer policy statement that's been provided to you. The language is -- is open. That's -- that's the gist of what they're trying to get at. Essentially, they're looking for protocol that deviates from -- or advisory that would deviate from closest appropriate facility in the transfer of Ebola patients.

These are known Ebola patients that have gone -- have already been seen in a primary facility and are being -- I'm sorry -- have already been seen, are being transferred to a primary Ebola facility.

Obviously, this came up because of the recent outbreak in Africa. In the -- in the sudden beginning of screening procedures at J.F.K. brought this to light again. It is something that's been kind of stewing for -- for at least a couple years and they're -- they're looking for some clarification on the ability to bypass closest facility for ...

Ebola patients.

DR. MARSHALL: ... I just have a couple of questions. One is these known Ebola patients, are they coming from the airport and then going to an Ebola facility? Or are these patients who have been seen at another hospital and identified as a -- a positive Ebola patient and then inter-facility transport to the tertiary center?

DR. DZIURA: That's correct. The latter is the correct version of -- of what's trying to be accomplished. This is not for the initial presentation of an Ebola patient. It's for the transfer of an Ebola patient in the event that they were to decompensate en route to the transfer facility. This is to clarify that it's still more appropriate to continue to the transfer facility, as opposed to expose another hospital to this patient.

MR. GREENBERG: The other component and what's come up several times before is that often, if we are transporting a patient, an Ebola patient from -- not often but we're transporting a patient -- an Ebola patient from one hospital to another and the patient starts to decompensate, which is a high possibility based on, you know, the risk

and -- and severity of the -- the patient, that if we were to divert to a closer hospital in between the two, that the amount of time it would take for that hospital to prepare to accept the Ebola patient, versus the amount of time it would take to complete the transport to the specialized center would be almost equal in most cases. And that the specialized center is prepared and more versed to dealing with that type of patient.

DR. MARSHALL: Thanks. This is Dr. Marshall, I think it's perfectly reasonable during the inter-facility transport, an Ebola patient begins to decompensate to continue transferring to the -- to the facility that's capable of taking care of them without exposing additional, you know, pre-hospital or hospital providers. I think that that's perfectly reasonable. And then, you know, we have the means within the ambulance during the inter-facility transport to respond to that decompensation, whether it's fluids, intubation, or other mechanisms of treatment.

So anyone else?

DR. FORNESS: Dr. Marshall, it's Mickey Forness asking. There doesn't seem to be any

facilities in the mid-state region. Would some facility have to be declared in that area?

DR. DZIURA: So Office of Health Emergency Preparedness is in the process of re-verifying the facilities capable of accepting Ebola patients for long-term treatment. Right now, to my knowledge, New York City, there are a few and Buffalo -- or Buffalo and Rochester.

MR. GREENBERG: Buffalo. Long Island has one. ... list. But we can get the list -- well, you're looking at a list, but if you circulate, I do know that they are looking further into that one. And they are also looking into, you know, based on particular hospitals with a, you know, one possible fly the patient versus go by ground.

DR. MARSHALL: Thank you. Any other questions for Ryan or Steve?

DR. WALTERS: Dr. Marshall, it's Walters. I don't -- I mean I don't disagree with the intent of what we're saying, but Steve maybe you can clarify. Are we looking -- are you looking at changing the policy statement 2102 or is there another document you're looking at? I'm not sure what we're referring to right now.

DR. DZIURA: This is a new SEMAC advisory that would come out just clarifying that in the case of inter-facility transfer of Ebola patients, the closest appropriate facility is as outlined in the protocols today, on a decompensating patient would be disregarded in lieu of sending the patient to an appropriate Ebola facility and not exposing others. That's the gist of it, boiled down.

DR. WALTERS: Okay. So I understand. I mean, I guess -- I guess I would argue the closest appropriate facility is the one that's prepared to take Ebola patients but -- but I understand you want to clarify that a little bit.

Would it make more sense to update that policy statement on Ebola 2102 to add that specific language, as opposed to having a policy statement, then a SEMAC advisory, having two things that someone would have to refer to, to get all the information, put it into one combined document, if we're going to add this?

DR. DZIURA: So yes. However, that policy statement had to come out prior to this meeting and clarification of that particular item. So once the SEMAC advisory came out -- comes out, we

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can update that policy statement to reflect that change, as well, in reference, the SEMAC advisory. This -- it came down to being a SEMAC advisory because, while I agree with you, that closest appropriate should be considered the Ebola treatment facility, it can be argued that it's not clear in the protocol on a decompensating patient, and that they should go to the closest appropriate facility capable of treating an airway or cardiac arrest issue or some other issue from the decompensation.

So this just makes that very clear for everyone.

DR. MARSHALL: Thanks, Steve.

Do we have ... yet or is -- or not yet?

DR. DZIURA: I'm sorry; Dr. Walters and Lew, you covered each other up.

DR. MARSHALL: So I was asking if we have this draft advisory in writing yet.

DR. DZIURA: I believe -- didn't I provide that to the group?

DR. HUDSON: It is -- this is Don Hudson. It's it is up on ... It's in the SEMSCO May 2021 folder.

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Just while everyone's looking and I have your attention, I agree with Dr. Walters. It'd be nice if we had one stop shopping, rather than providers hunting around trying to compare documents if this, do that, go here, go there. It just seems simple to me, you know, in the case of inter-facility transport of Ebola patients under those situations that you divert from the established hospitals.

DR. DZIURA: Correct. As I said, if -- if this group decides to push forward the advisory to the SEMAC for approval, then the policy -- state policy statement ...

DR. MARSHALL: I'd have to look for the document. I don't see it right now, but.

DR. BART: Dr. Marshall, do we all have access to the items in the SEMSCO folder if we're not on SEMSCO? I don't think I can find that on ...

DR. MARSHALL: If you give me just a minute to find it on my computer, I can share the screen with you and put the language up.

MS. OZGA: I can also upload it to ... right now. What document are you looking at?

DR. BART: Okay. I found it.

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MS. OZGA: I thought we had all the -- all of them uploaded.

MR. GREENBERG: Val, I think the document might only be in the SEMAC file, not in Standards file. So if we just make sure that both of those are referencing in both.

MS. OZGA: Yes, I can. Which file do you need in Medical Standards again?

MR. GREENBERG: The draft SEMAC advisory ...

DR. DZIURA: Peter, can you ... share my screen? Okay. Can everyone see that?

MS. OZGA: Okay, everyone. I just put the SEMAC advisory in ... under the Medical Standards committee. So it should be there.

MR. GREENBERG: And as everyone is reading this, this is also a proposed SEMAC advisory. We can edit, we can shorten, we can --.

DR. LANGSOM: Lew, it's Yedidyah. I don't want to speak out of turn.

DR. MARSHALL: Yes.

DR. LANGSOM: Are we -- I'm confused. It almost reads as if we're dictating to hospitals, how they become a receiving facility for this. I

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guess I'm confused. I mean, I know that you know, F.D.N.Y. has a very specific policy, and I guess Nick could speak more to this, of who are the receiving hospitals. It's done in conjunction with Health and Hospitals and, and the regional E.M.S. committee to decide in terms of who are the appropriate Ebola receiving facilities.

I don't, I guess -- is the purpose of this document is to the hospitals or to the E.M.S. providers or the E.M.S agencies?

DR. MARSHALL: Yes. Yes. If I recall, I think that, you know, it's really the Department of Health itself, with the Commissioner's order, as mentioned here, hospitals that wanted to take on this specific role signed up to do so. It wasn't something that -- that E.M.S. necessarily put in place and it's requiring hospitals to do.

You know that in New York City, we at least, Bellevue has always been the local facility that would accept Ebola patients. And there's more now I'm aware of, but I think this would be the same for other regions. But I would suggest that people take a look at this, read it.

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This would be SEMAC advisory, Don, if we could have ... SEMAC? Does that sound reasonable?

DR. DOYNOW: That's fine. I think we need to look at it a little bit better. Some questions that are coming through on my phone about whether folks would need to continue C.P.R. if somebody were to arrest ... long distance until they got to a receiving center, or if the person arrested, would they need to go back to the initial sending. That's something we'll probably need to look at tomorrow.

DR. MARSHALL: All right. Thanks. All right, folks. So that was the last thing on the agenda, a specific item. So please take a look at that proposed advisory for more discussion tomorrow. And at this time, I'll ask if there's any old business. Seeing none, any new business?

DR. DAVIDOFF: Lew, this is Davidoff.

DR. MARSHALL: Yes.

DR. DAVIDOFF: I guess maybe Ryan or Steve, I'm not sure who's going to be able to help answer this. We have this new app called Muru, which lists the protocols, the collaborative protocols. We've had the collaborative protocol app, and there's

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been this P.P.P. app out there. There's three apps now that paramedics have access to, to look at these protocols.

It seems like the old telephone game for those of you who can remember back that far. Each time we get a new app, the wording changes a little bit. ... difference with the I.V. nitroglycerin ... the other. And more importantly, there's been some changes in the wording of excited delirium, the agitated patient and ketamine dosing. And I'm seeing more and more medics, thinking that the appropriate dose for an agitated patient, not excited delirium patient, but the agitated patient is two hundred and fifty milligrams I.M.

In the current political atmosphere, I don't want to see my agitated patients becoming ... and maybe having bad outcomes. And I wonder if there isn't some way we can kind of control what's going on with their, for lack of better word, social media apps. It doesn't seem like SEMAC, or SEMSCO, Medical Standards has any control over those.

DR. DZIURA: Thanks, Dr. Davidoff. This is Steve. That is exactly why we contracted for this particular app. We did a solicitation to the

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providers. This app came in at the rate -- contract rate and was approved.

This takes the P.D.F. app -- P.D.F. protocol directly from our website we provided to them that was approved by the commissioner, so approved by your group. It was submitted up. Whereas the other apps are -- we don't know exactly where they're pulling from or if they're all up to date.

And in some cases, they were doing -- they were created by the regional collaborative groups. And again, we assume that the language in there is right, but we're not always sure that the final copy that was approved by this group, the SEMSCO, and the commissioner, is what makes it onto the app. So this does give us exactly that control to be able to do that, going forward.

DR. DAVIDOFF: The original -- the original collaborative protocol, I thought, included I.V. nitroglycerin did not, yet Muru does. And if you look at the wordings on some of the -- I've not had a chance to look at all of them, but certainly if you look at the excited delirium, agitated patient,

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there's again some changes. So I don't know where Muru is getting their information from.

DR. DZIURA: So that's -- that's probably part of this issue is the collaboratives present their document to the SEMAC, and then SEMSCO, and during that process, there tends to be changes and discussion and movement that happens. We don't take that document before it goes to the commissioner for final approval and is signed off.

What -- what may be happening is that the other folks, be it the regional collaboratives or just the protocol providers or the protocol end providers, are just posting whatever was presented without the changes that were discussed in and made during meetings.

DR. MARSHALL: It's Dr. Marshall. Thanks, Steve.

I think, to echo Jack's concern, if I if I get this right, Jack, is really to reduce some confusion, we really need one source of truth, right. And whether it's in the collaborative app or the Muru app, or -- or the P.P.E. protocol app, but we just need -- funnel -- maybe funnel it all through one

funnel so that we have one source of truth so we don't create confusion amongst our providers.

DR. DZIURA: So as far as the collaborative app goes, that was paid for in -- in collaboration with multiple regional councils. And this will replace that. Their -- their contracts are probably expiring, but this was an agreement between all the program agencies who had been maintaining this in the state to take this responsibility over. Since really we were paying for it out of the ... locality funding anyway, through reimbursement to the councils. It just makes it cleaner.

As far as the P.P.P., those are independent app creators that are getting their source from somewhere and posting it that is not at the approval of the Department, nor does that require it. So that's why we've tried to push this as the state approved app, the source of truth.

DR. MARSHALL: Okay. So just so I understand, sorry, Jack, the collaborative protocol app will, at some point in the near future, go away and Muru will be the only New York State protocol app. Is that correct?

DR. DZIURA: Correct. The -- the Department will no longer be reimbursing the regions for their app that they have. So it's anticipated it'll go away. They've all said it will.

DR. DAVIDOFF: And I think that's a great concept. I'm all in support of having one source of information out there. But right now, out of the three, I think the Muru has least accurate information for our providers. I think someone at the state at a subcommittee, someone's got to be reviewing this and going through it and making sure it's worded properly and has the right information.

DR. MARSHALL: So yeah, thanks, Jack. Yeah, I think we need to make sure that it's accurate. We're not going to do that at this meeting right now. But perhaps we can set up a process with Steve and Ryan to figure out how it's being viewed and making sure that it's accurate when it goes out.

DR. ALEXANDROU: This is Nic Alexander. Can I just make one comment on that, as well?

DR. MARSHALL: Yeah, go ahead.

DR. ALEXANDROU: We looked at the Muru a little bit here at the fire department. And I have

to say that some of the hospital designations and what their sub-specialties are, are not as accurately reflected as we have them here on our -- on our system for hospitals.

So that needs to be looked at, as well, because members may be using those hospital designations to go to those -- to those hospitals and don't have the correct services. But they still work under our operations guide. So that will help, but outside where that may not exist, paramedics or E.M.T.s may be transporting to hospitals that don't have the proper services.

DR. DAVIDOFF: This is Davidoff, one more time.

DR. MARSHALL: One more question -- one more comment, Jack?

DR. DAVIDOFF: Another comment, yeah. The collaborative protocols had a very good feature built in for medical control members, which we don't have built into Muru. I don't know if that's something that can be done or not. But I know a lot of providers rely on that collaborative protocol app to make their call to medical control and they've lost that with the Muru.

DR. DZIURA: Dr. Marshall?

DR. MARSHALL: Yeah, go ahead, Steve. Question for you. Yeah.

DR. DZIURA: That is available and will be updated as we continue on with the app.

DR. MARSHALL: Okay. Thank you,

MR. GREENBERG: Dr. Marshall, it's Ryan. I would just also add in there, so you know, the bulk of the information from ... comes from the state website. And that includes the hospital destinations and, you know, specialty centers and things like that. ... to work with anyone who feels that information is not the most up to date, because that could mean that also that it's not the most up to date on our website, as well. And so we'd want to fix that immediately.

But as far as the hospital destinations and information on that one, again, that comes off of the D.O.H. website is where they're pulling information. So if the city is having slightly different information for nine one one destinations or something of that nature, then we should be taking a look at that, as well.

DR. PHILIPPY: Dr. Marshall, this is Mark Philippy.

DR. MARSHALL: Yes, Mark.

DR. PHILIPPY: So, I'm going to cut to the chase, just a little bit. I have had some conversations with Steven Blacker is one of the primary programmers and folks from the Muru app. He's been very responsive. He's agreed to work with our program agency and to reach in our REMAC, to try and address some of those local issues.

So as Director Greenberg suggests, I would ask anyone who's finding those issues, perhaps contact Mr. Blacker at that Muru through their -- there's a very robust help feature in the app that will allow you to do that. I know that the director and distributor and I will probably be talking about this a little bit more.

But it does have a lot of great features. It does have -- I do see this as kind of a beta version, because there are some things that will need to be cleaned up. But again, they've been very, very responsive.

DR. MARSHALL: Thank you, everyone. Thanks everybody. It's at -- we're at the end of our

meeting. So I think in terms of the -- the app, I think that we have some good direction on how to send in ... notices, errors, or what needs to be fixed.

So is there any other new business? If not, I'll entertain a motion to adjourn. Anybody want to make that motion?

DR. KUGLER: David Kugler. Motion to adjourn ....

DR. DOYNOW: Don Doynow, second.

DR. MARSHALL: Thank you. All in favor?

ALL: Aye.

DR. MARSHALL: All right. I'll see you all at the next meeting. Enjoy the rest of your day.

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

STATE OF NEW YORK

I, HANNAH ALLEN, 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 66, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 13th day of June, 2021.

HANNAH ALLEN, Reporter

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