2/7/2024 - Medical Standards - Troy, New York

NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS

DATE: February 7, 2024

TIME: 8:04 a.m. to 9:50 a.m.

CHAIR: JEFFREY RABRICH

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

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2 **APPEARANCES:**
AMY EISENHAUER
3 AMY PAILLIN
ART COOPER
4 BRIAN WALTERS
CARL GANDOLFO
5 CARLA SIMPSON
DANIEL OLSSON
6 DAVID KUGLER
DAVID MARKOWITZ
7 DAVID VIOLANTE
DON DOYNOW
8
DONALD DUVALL, JR.
DONALD HUDSON
9
DOUGLAS ISAACS
10 DR. LEWIS MARSHALL
GREGORY GILL
11 JARED KUTZIN
JASON HAAG
12 JASON WINSLOW
JEFFREY RABRICH
13 JEREMY CUSHMAN
JONATHAN BERKOWITZ
14 MARK DEAVERS
MICHAEL BENAMONTE
15
MICHAEL DAILEY
MICHELE FORNESS
16
MIKE MCEVOY
PAMELA MURPHY
17
ROBERT CRUPI
18 RYAN GREENBERG
STEVEN DZIURA
19 THERESA ALLEN
TIFFANY BOMBARD
20 VALERIE OZGA
YEDIDYAH LANGSAM
21
22
23
24
25

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2 (The meeting commenced at 8:04 a.m.)
3 **CHAIR RABRICH:** I'd like to call the
4 Med Standards meeting to order. For those of you who
5 don't know me, I'm Jeff Rabrich now chairing the
6 committee. I'd like to start first by thanking Dr.
7 Marshall. Who -- Dr. Marshall, as many of you know,
8 has been here quite a long time.
9 Well, it's over twenty-five years that
10 he's been participating in these meetings and
11 chairing this committee. And on behalf of everyone
12 here, we want to thank you for your many, many years
13 of service and we hope you continue to come and stay
14 involved on the committees. And -- and I'll turn it
15 over to you for any comments.
16 **MR. MARSHALL:** Thank you. Good
17 morning, everybody. I just wanted to thank all of
18 you for the honor and pleasure to work with you these
19 past twenty-five years and -- and my love for E.M.S.
20 In '92 I started teaching at the E.M.S. Academy. In
21 '97 I became a medical director for a fire
22 department.
23 In 2000, I represented REMAC. In
24 2003, I came on SEMAC. I stepped out of the room to
25 have a cup of coffee in 2006 and became chair of

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2 Medical Standards seventeen years ago, so the moral
3 is, don't step out of the room.
4 I've seen us grow from eighteen
5 different protocols where we would sit here and
6 discuss minutiae and drug dosages for hours on end
7 and review protocols for weeks on end. And we always
8 talk about or at least I talked about Statewide
9 A.L.S. and B.L.S. protocols. And I just want to
10 thank everybody in this room, not just those at the
11 center table, for all the work that you've done
12 because we're essentially there.
13 We essentially have Statewide
14 protocols. The medicine is the same whether you're
15 in Buffalo or out and around. So it's been a
16 tremendous job and you guys have done tremendous
17 work. And it has been, as I said, my honor to -- to
18 work with you and learn so much because you guys are
19 the smartest people on E.M.S. in the world. So thank
20 you. And I'll be in the back.
21 **CHAIR RABRICH:** Thank you. Thank you,
22 Dr. Marshall. And good advice, I won't get coffee.
23 It's too late, but -- all right. The attendance
24 sheet will be going around. Old business, I would
25 ask Mr. Violante and Dr. Murphy if you would give us

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2 a little update on how the i-Gel project is going.
3 **MS. MURPHY:** So I will introduce
4 David, who does all the work. I just -- I just sit
5 here. No, it's been an amazing development because
6 we thought, okay, we're going to start this little i-
7 Gel pilot project and God, it's exploded.
8 David brought together all the numbers
9 today and there's a lot of people that think, you
10 know, people that have helped us look at cases,
11 people that have been investigating and making sure
12 we're following everything. Just rolling out all the
13 education, getting everyone involved.
14 And of course the REMSCO office in
15 Hudson Valley, who's coordinating all the paperwork.
16 But it's been, you know, a process, something that
17 we've all learned from, and we're still learning
18 from. But David has the stats, so he'll present
19 those. It's amazing.
20 **MR. VIOLANTE:** All right. Good
21 morning, everybody. I am going to work on median
22 numbers, if that's okay with everybody. If you want
23 some averages, lows and highs, just -- just ask. I'm
24 happy to give that. I'm going to also look at data
25 that we have from two weeks ago which shows about a

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2 hundred and sixty-four insertions.
3 As of last week, we have up to two
4 hundred and thirty-nine insertions. We just haven't
5 crunched that particular data yet, so I'm going to go
6 off previous data that we have of a hundred and
7 sixty-four insertions. Of those one sixty-four, a
8 hundred and thirty-one made it to the State bridge.
9 And then out of those, we were able to
10 scrub down to get data on a hundred and two. And so
11 that's the data that I'm going to give you
12 information on. So we have a median age of -- of
13 seventy-one. It appears that if you're male, you're
14 twice as likely to go into cardiac arrest and have an
15 i-Gel inserted than if you're female.
16 Median weight is eighty-six and i-Gel
17 size of four. Median attempts is one, max of two.
18 And there seem to be no complications in ninety-two
19 percent of the cases. Other ones, there are
20 vomiting, somehow nausea and apnea which I would sort
21 of expect.
22 Patient's response thirty-three
23 percent, improve sixty-five percent, unchanged, not
24 recorded a -- a -- a couple percentage points there.
25 Time from dispatch until at patient is seven minutes,

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2 until first i-Gel attempt another seven minutes.
3 Confirmation meeting is zero.
4 So in that case we're looking at
5 probably an A.L.S. partner on the same unit that's
6 looking at and confirming that's in the right place.
7 From patient transport begun twenty-three minutes.
8 And then, time from transport to transfer of care
9 eleven minutes. Total patient time median is thirty-
10 one minutes.
11 Initial entitled, nineteen. Highest,
12 twenty-eight. Final, nineteen. And then, highest
13 SpO2 eighty-eight. We have nineteen percent that
14 expired in the emergency department and thirteen
15 percent have loss in emergency department. Forty-
16 five percent expired in the field, eleven percent
17 loss in the field.
18 In terms of regions, Mid-State has
19 thirteen uses. Central New York, twenty-one.
20 Wyoming, ten. Monroe Livingston, twenty. Nassau
21 REMSCO eight. And that goes down from there. So
22 those are some of the highest counties that have had
23 the use of the i-Gels.
24 And average patient time in those
25 areas is somewhere around thirty-five, forty minutes

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2 or so. And that's what we have at the moment, unless
3 there's any other questions. I -- I'm happy to
4 crunch the numbers again when we have a little bit
5 better data from the last one of the two hundred and
6 thirty-nine uses as well.
7 Something to note with that is that,
8 we've been communicating with the agencies. We have
9 about eighty some odd agencies in the program doing
10 this, and we're sending out quarterly notes about
11 what's working, what's not working and what we can
12 improve on.
13 How to get information to us, how to
14 use the Drupal. And in some of these agencies,
15 they're realizing through this program that their
16 charts are not getting to the State, and so they're
17 correcting some of those issues which sort of improve
18 the whole system, not just from the i-Gel
19 perspective.
20 And so our -- our latest thing that
21 we're working right now is using a mail merge from
22 Excel to show every agency what we have for their
23 data on a monthly basis so that they can then improve
24 data transmission from there. Some of the issues
25 with the data come from providers, making sure they

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2 put it in the right place in the P.C.R., not in the
3 narrative.
4 If it goes in the narrative, we have
5 no idea that it happened or not. Some of the dialect
6 issues among vendors. And so an i-Gel could be
7 considered an i-Gel, a supraglottic airway, a single
8 lumen, a dual lumen and a -- a supraglottic
9 intubation. There's a variety of ways that it comes
10 across that we all have to scrub for.
11 And then, just finally the -- the
12 movement of those things to the State level. If the
13 P.C.R. doesn't pass the State's schematron, it
14 doesn't get to the State, it doesn't get to REMSCO.
15 And so we're working through all that with the Data
16 Informatics team. They've been fantastic to work
17 with. And I'll take any questions.
18 **CHAIR RABRICH:** Thank you for the
19 report and -- and all the work on this. Does anyone
20 have questions about the project? Any thoughts on
21 how to kind of capture some of that data that seems
22 to be, you know, lost in transmission, so to speak?
23 **MR. VIOLANTE:** Yeah, I'll take any
24 suggestions on that.
25 **MR. WALTERS:** So I guess, how many --

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2 how many instances of, you know, P.C.R. data not
3 going through the bridge and being received is there
4 out of these?
5 **MR. VIOLANTE:** So I'll -- I'll just
6 refer to this information from -- from last week's
7 report that came in. And we have two hundred and
8 thirty-nine insertions, a hundred and seventy-seven
9 made it to the State bridge chart. Out of those, a
10 hundred and fourteen made it to the State report that
11 comes to us. Two thirty-nine, one seventy-seven, one
12 fourteen.
13 **MR. WALTERS:** Okay. That's a lot of
14 missing data.
15 **MS. VIOLANTE:** Yeah. That's a --
16 that's a lot of missing data, indeed.
17 **MR. WALTERS:** Right.
18 **MR. VIOLANTE:** So as we look at -- and
19 I know there was some discussion at quality metrics
20 yesterday. And that, I -- I think, as we move
21 forward, we all know that we need to have good data
22 collection input from the providers, but also make
23 sure it's getting translated and correct and
24 collected appropriately so that we can then make
25 educated decisions as the SEMAC, SEMSCO, Med

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2 Standards.
3 And I guess that that's one of my
4 growing concerns is that, you know, a hundred
5 fourteen out of two thirty-nine, you're not even
6 getting half the -- the insertions or half the data
7 that's out there. So we're not even getting a full
8 picture.
9 I mean, I think the data does tell us
10 that this is a successful project and there aren't
11 any big significant complications, which is
12 excellent. But it is concerning that we're only
13 getting fifty percent of the data -- less than fifty
14 percent of the data.
15 And I think that -- that's something
16 that, collectively, SEMAC SEMSCO, Med Standards
17 everybody in this room, we need to do a better job
18 at. And -- and I don't know the answer to that, of
19 how we do that. But I think it's very, very telling
20 that, and -- and maybe it's something that the Bureau
21 of Data Informatics, Peter, I don't mean to put you
22 on the spot, but something we need to look at is why
23 are we not getting this data the way that we should.
24 This -- this team is looking at data
25 from not only -- there's a few ways that it goes in.

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2 The region is looking for the P.C.R.s from the
3 agencies. There's a Drupal form that agencies fill
4 out and there's data that goes to the State.
5 And so when we look at all of those
6 variety of things, in some way a chart -- ninety-one
7 percent of the time a chart is available, it's
8 getting that chart and getting that information. So
9 yes, that is a concern.
10 **MS. MURPHY:** At this point,
11 (unintelligible) more than anything.
12 **MR. VIOLANTE:** Yeah. That's -- that
13 facet of this is something that sort of can broaden
14 out just from the i-Gel project to a number of other
15 things as well.
16 **MR. WALTERS:** Right. And -- and I
17 guess to that point, we're getting that data, which
18 is excellent. You guys have done a good job of
19 putting in some redundancies to get that data. But
20 if we were just to run metrics out of, you know,
21 image transfer, you know, and looking at the State
22 bridge stuff, we might be missing a lot of data.
23 And that's my -- my only concern or I
24 guess item for discussion.
25 **CHAIR RABRICH:** Yeah, it's good point.

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2 So -- yeah, so anyone who has suggestions or ideas to
3 help capture some of that data, I -- I -- I think
4 they would be welcome, right? So -- oh, Dr. Dailey?
5 **MR. DAILEY:** So I'm going to actually
6 argue that this project has shown us something that's
7 -- that's extremely important and given us
8 information that we knew already existed, right, on -
9 - on both topics.
10 **MS. MURPHY:** It's validation, right?
11 **MR. DAILEY:** Yeah. So you've
12 demonstrated that it is possible to do a good data --
13 data validation study and the data that we have in
14 spite of our best efforts and all of the work that
15 we're doing with these twelve different vendors that
16 we have across the State -- thirteen vendors, Peter?
17 **MR. WALTERS:** Seventeen.
18 **MR. DAILEY:** Seventeen vendors. I'm
19 sorry, is useless. The -- the bridge can't fix this.
20 This is too many different ways of documenting. As
21 you said, there's too many different languages that
22 are involved.
23 What we need is a group from the
24 SEMSCO with advisement from the SEMAC to make sure
25 that what we can do is come up with a plan moving

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2 forward for data in the State. Data needs to be
3 equally valid at the point that's it used and at the
4 point that's consumed.
5 And the information that we have to
6 make decisions as to what practice of medicine is
7 going to be across New York State has got to be spot
8 on. It can't be spotty. Right now, you're looking
9 at fifty percent of the data is garbage. That --
10 that can't be. And to -- to your credit, the
11 validation you're doing is absolutely perfect.
12 So you know, what do we do, I say we
13 give a thumbs up to the i-Gel project, let that move
14 forward and go full steam ahead into a project that
15 will actually allow us to have, first, an update to
16 our policies around data. And second, ultimately an
17 answer for how we're going to manage data across the
18 State.
19 **MS. MURPHY:** And I think, you know,
20 what you bring up, Dr. Dailey is really important
21 that, you know, we are trying to bring forward a -- a
22 project to really advance a level of training, a
23 level of skill. And we run into this process that we
24 need to have the data to support what we want to do.
25 We need to have real good data that

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2 says this works, this is what's happening. And thank
3 God these guys are so, you know, persistent. They're
4 trying in all venues to get exactly what we need and
5 to answer the question.
6 **MR. WINSLOW:** It -- just as a -- a
7 short term solution, don't -- don't you require all
8 the agencies that do the insertion to send you the
9 P.C.R.? Like, they're -- they should just email it
10 to you as the administrator for it and then you have
11 the data, regardless of whether the bridge works or
12 not.
13 **MR. VIOLANTE:** Right. Yeah, we're
14 continuing to work on that. That piece of it as
15 well, to be able to have agencies send the identified
16 P.C.R.s up to the Hudson Valley Region, which is
17 great. And then, we're going to have to hire
18 somebody to read every P.C.R. to -- to get through
19 the data, which is one of the reasons we wanted to go
20 through the State bridge.
21 A) To ensure that we could get the
22 data, that it flows, that it was available and that
23 it's available for a lot of other things as well.
24 But to answer your question, yes. And we're
25 continuing to work on that so that we have all of the

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2 data. It shouldn't have to go that process, though.
3 We shouldn't have to be -- we
4 shouldn't have to rely on paper in -- in the
5 electronic world that way.
6 **MR. WINSLOW:** Well, no you -- you're
7 not relying on paper as much as you're relying on the
8 agency to ensure that the managers of the program get
9 the information they need to do the data metrics. I
10 think if you rely on some of the issues with our data
11 transmission, I think you're missing fifty percent of
12 the data is unacceptable, I agree with the others.
13 Just require the agencies to send you
14 a copy. We get them electronically. They send it to
15 you by email.
16 **MR. VIOLANTE:** Right. Indeed. Yes.
17 **CHAIR RABRICH:** Thanks. I -- I just
18 wanted to give Ryan the opportunity to comment as
19 well on the -- around the data collection.
20 **MR. GREENBERG:** Good morning,
21 everyone. So there is one other thing that we are
22 going to try to think. Pete has been in
23 conversations with you as well. And that's related
24 to Biospatial. So we're going to put a trigger into
25 Biospatial to send to your email, Dave.

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2 Anytime the i-Gel is being used, the
3 problem that we're going to possibly have with it and
4 what we don't know if we'll be able to filter down to
5 is, will we be able to see anytime an E.M.T. uses an
6 i-Gel or is it any time an i-Gel is used in the State
7 and that -- that's just some limitations of the
8 system.
9 So it could work really well and
10 you'll get a trigger on something related to that or
11 it could be too much information because we're not
12 able to separate it out. And I think that will
13 actually be able to -- I think we're working on the
14 process at the moment.
15 And I think within the next month or
16 so we'll be able to at least start sending some data
17 to that. That will at least give you the trigger of
18 where it's happening and when it's, you know, where
19 it's being used. The next thing will be though is,
20 you know, is it too much?
21 **MR. VIOLANTE:** So I like that idea and
22 I think it's fantastic. I'm just -- we're just not -
23 - all of us are trying to work on where that
24 breakdown occurs because if the P.C.R. is not getting
25 from the agency to the State, then I won't have the

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2 data whether it's on the State bridge or Biospatial
3 or NEMSIS for that matter.
4 And so trying to figure out and really
5 get the solution to getting the data from the agency
6 to the State will help with all of this. And then,
7 all these other programs will work really well. Once
8 it's on the State bridge, it's -- it's perfect. We -
9 - you know, we can get that down, it's fantastic.
10 But it's -- it's getting to that
11 point, which ends up being a problem.
12 **MR. KUGLER:** So I think there's a real
13 opportunity here and thank you for, first of all,
14 starting this project. And then, being so passionate
15 and seeing it through. I think it's probably one of
16 the most exciting things for B.L.S. especially, as
17 we've seen albuterol come, check and inject, and
18 everything else, it's such a natural progression.
19 I think the bigger issue here is
20 obviously data. The nuance is also, if it's not
21 getting to the State, that means it's also not
22 visible to the hospitals in Image Trend Viewer. So
23 as we talk about truly integrating into healthcare
24 and truly becoming the extension of the hospital that
25 we always are and were, if -- if we don't address the

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2 failures of E.P.C.R., it -- it just touches
3 everything in my mind.
4 So I think that's where the rubber
5 meets the road. I just did want to ask, what's the
6 projected end date? And then, what is the next step
7 to get this to the national scope of practice? I
8 guess also, is there any other states doing similar
9 things that we could partner with to make that
10 happen?
11 **MS. MURPHY:** So we weren't given an
12 end date initially. We were -- we were really
13 looking at what would the findings be and how much of
14 a participation across the State. Initially, we
15 thought we were just going to do it in our region and
16 then we opened it up to the whole State.
17 But I have to say, everyone was very
18 enthusiastic about doing it. So to show, you know,
19 people wanting to participate, it's tremendous. You
20 know, I think that we really shouldn't stop it until
21 we get good data. We have to leverage technology
22 here. We -- these guys shouldn't have to scrub
23 through charts to find out what happen to the
24 patients.
25 And you know, God bless them all

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2 because they keep doing it so far. But we have to,
3 you know, say we're -- we want this to be successful.
4 We want to determine, is it something that we should
5 move along and push forward?
6 I like Dr. Dailey's comments, but I
7 think, you know, we have to leverage technology and
8 that's what this brought forward to us. It's like,
9 wow, what else are we missing?
10 **CHAIR RABRICH:** Yeah. So -- so really
11 great discussion. I -- I'm sorry, I didn't mean to
12 cut you off, but we -- we -- did you want to add
13 something?
14 **MR. VIOLANTE:** Yeah, no, I did want to
15 answer your other question about going to a national
16 scope. We've been in touch with E.S.O. from the
17 beginning of this, who's done a lot of the national
18 data crunching programs like this on correlating New
19 York's data to their national data of this and what
20 other states are doing and why they have on that.
21 And that's what we'll leverage to move
22 towards a national skill.
23 **CHAIR RABRICH:** Thank you. Thank you
24 for great -- great work and thank you for that
25 report. And just to summarize, Dr. Dailey's comment,

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2 I believe we heard a request for the SEMSCO chair to
3 possibly appoint a working group around data. So Dr.
4 McEvoy, so noted?
5 **MR. MCEVOY:** So noted. Thank you.
6 **CHAIR RABRICH:** Okay. Moving on to
7 our new business, we do have the collaborative
8 protocol, but I think it makes more sense to talk
9 about the alternative medication formulary and
10 hospice care protocols first that are in discussion
11 items because those will be incorporated into this.
12 So if we want to move to the
13 alternative medication formulary for drug shortages.
14 And then, we can open that up to discussion, if
15 anyone has anything. Dr. Cushman?
16 **MR. CUSHMAN:** Thank you, Dr. Rabrich.
17 Again, that medication formulary was previously
18 discussed amongst the protocol working group and
19 developed to be complementary to the -- the -- the
20 policy that was developed on the same title to
21 replace all the outdated stuff. So that, Dr. Winslow
22 took point on that.
23 We work collaboratively to make sure
24 that this medication formulary that would sit within
25 the collaborative protocols would be congruent with

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2 and would not have any conflict with the policy that
3 was approved by this body in, I believe, September of
4 last year. So that document is there for the body's
5 approval.
6 **CHAIR RABRICH:** Any other comments on
7 this? If not, we need a motion to approve this.
8 **MR. WINSLOW:** Motion to approve.
9 **CHAIR RABRICH:** Is there a second?
10 **MR. CUSHMAN:** Cushman second.
11 **CHAIR RABRICH:** Okay. Is there any
12 other discussion?
13 **MR. WINSLOW:** No, I just -- I just
14 would like to ask that the policy that was approved
15 in September of 2023 be finalized. It was sent to
16 the bureau in September. It should be able to be
17 posted on the website so that it can be live. Thank
18 you.
19 **CHAIR RABRICH:** All right. Let's vote
20 on this. Okay. All in favor of this protocol? Keep
21 them up. Okay. Anyone opposed? Any abstentions?
22 All right. Passes. Next, we'll go to the Hospice
23 Care Protocol. Which -- Dr. Cushman?
24 **MR. CUSHMAN:** Yeah. I -- I did not do
25 the work on this, but really appreciate those that --

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2 that -- that did this again was reviewed and vetted
3 by the -- by the protocol group. And then, de-
4 conflicted with any other protocols within the
5 collaborative to address care of our -- of our
6 hospice patients.
7 This is just editorializing. This is
8 actually really super cool at least locally working
9 with some of my home hospice folks that are really
10 looking forward to the opportunity to be able to
11 partner with E.M.S. when we arrive on scene
12 inadvertently to the hospice care in their last few
13 hours when family's freaking out.
14 And now, actually having some guidance
15 on -- on how to fulfill the wishes of the -- of the
16 dying individual at that point in time, so kudos to
17 the team for -- for pulling that together. And
18 that's, again, for this body's approval.
19 **CHAIR RABRICH:** Thank you. Is there a
20 motion to approve this protocol?
21 **MR. CUSHMAN:** Cushman moves.
22 **CHAIR RABRICH:** Thank you. Second?
23 **MR. WINSLOW:** Second.
24 **CHAIR RABRICH:** Thank you. Discussion
25 on the protocol, anyone have any other discussion or

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2 comments?
3 **MR. DAILEY:** Just -- just to highlight
4 that, you know, this -- this actually came out of an
5 article that I -- that I reviewed. And you know,
6 honestly, I think the idea that this body's endorsing
7 the fact that it's important to support people at the
8 end of life and how E.M.S. can have a role in that
9 and giving some guidance.
10 It is more educational than most of
11 our protocols, but I think that's okay because this
12 is going to be a relatively rare occurrence. But I
13 think it's a fantastic opportunity for our paramedics
14 to assist those in the community in crisis as Dr.
15 Cushman says. So thank you.
16 **CHAIR RABRICH:** Thank you, Dr. Dailey.
17 Any other comments? Okay. All those in favor of
18 this protocol, please raise your hand. Okay. Anyone
19 opposed? Any abstentions? Vote passes unanimously.
20 All right. Now, let's go to the A.L.S. updates as a
21 whole.
22 I believe we've discussed a lot of
23 this previously, but is there any -- any additional
24 comments you -- the protocol group cares to make, Dr.
25 Cushman?

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2 **MR. CUSHMAN:** Speaking first
3 specifically to the collaborative A.L.S. protocols,
4 there were some minor grammatical or little fixes
5 that were found through the -- through the review
6 process. I want to publicly thank Alex Kayser from
7 the -- from the department for all of his amazing
8 work in finding some of that minutia.
9 I know he wasn't alone, there were a
10 number of other bureau members that were involved in
11 that process that picked up a bunch of things that as
12 the good Dr. Fullargar recalls, you can look at this
13 a hundred thousand times, which I think I have. And
14 you still miss stuff on a pretty regular basis.
15 So the -- the -- the be all and end
16 all is that these protocols are -- are nearly
17 identical to that which was brought before this body
18 in September and approved at that time with the
19 addition of the two that we just moved. The
20 medication formula and the hospice care formula, and
21 there were no substantive changes to the medicine
22 throughout this document.
23 **CHAIR RABRICH:** Thank you. And thank
24 you to the group for all their -- their hard work.
25 Is there a motion to approve the collaborative A.L.S.

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2 protocols?
3 **MR. WINSLOW:** Motion to approve.
4 **CHAIR RABRICH:** Thank you. Second?
5 **MR. CUSHMAN:** Cushman second.
6 **MS. BOMBARD:** Bombard second.
7 **CHAIR RABRICH:** Thank you. Any
8 further discussion on these protocols?
9 **MR. WINSLOW:** I just want to thank
10 Jeremy. It was -- it was a lion's task and you did a
11 great job. I think all the changes are appropriate.
12 And is -- is important to go through these
13 periodically in once a year just to find those
14 little, small, grammatical or otherwise, you know,
15 nuances that really make protocols work when the
16 provider has them in front of them when they're
17 taking care of a patients.
18 So I just want to say thank you to
19 Jeremy and I approve them all.
20 **MR. GREENBERG:** So just something that
21 -- that the bureau has been working with Jeremy and
22 his team on for the past several months, it's been a
23 lot of fun. But you know, I -- to the bureau staff
24 who -- who helps with this one Gena and Steve Buccato
25 and Alex Cusar and several others all with

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2 (unintelligible) in -- in looking to each of these
3 and going through it.
4 But not only changing there, but
5 making a change log. And so that was, you know,
6 really important and going forward we're going to set
7 the standard that any protocol update and hopefully
8 from New York City or the collaborative, so it's
9 consistent for all providers have a change log
10 associated with it when it's submitted, even if it's
11 simple.
12 Because it is one of the things that
13 we are -- get asked for, what was changed. Yes,
14 there was a protocol update, there was this, there
15 was that. But can, you know, can someone break down
16 for me? Particularly with the collaborative
17 protocols, there was a lot done. The change log is
18 even more important.
19 I think it, you know, might be less if
20 it's, you know, shorter documents and things like
21 that that come up from the city where sometimes it's
22 smaller. But some sort of change log or something
23 that shows for the provider who turns and says, well,
24 do I need to sit with two protocols side by side or
25 can I, you know, have something that's a little bit

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2 easier to know what changed.
3 So there is an associated change log
4 that will go with these. We've all seen it. It's
5 attached to the documents. There's one for the
6 B.L.S. as well, which I think we're going to talk
7 about shortly. But if we can set that as a standard
8 going forward, we'll be working on our part with
9 Jeremy to assist him as -- as that happens as well.
10 So thank you for that one too. But
11 for those who are looking for what changed, you can
12 refer to the change log.
13 **CHAIR RABRICH:** Thank you. Any other
14 discussion on this?
15 **MR. DOYNOW:** One question has been
16 asked. When are we going to implement the changes?
17 When will it go into effect?
18 **MR. :** July.
19 **MR. DOYNOW:** July 1.
20 **MR. MCEVOY:** So it should be July 1.
21 But that also was based on it being voted on -- in
22 the December meeting, which is what I believe the
23 protocol -- you know, the policy statement is that it
24 votes on it. Protocols are voted on now once a year
25 at the December meeting, but there wasn't a December

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2 meeting due to a lack of a quorum.
3 So I believe that the time period
4 would still be the same, although I think it some
5 reason to have the issues with --.
6 **MR. WINSLOW:** No, I think that the
7 changes are -- are not substantial enough to delay
8 the July 1 update list. I -- I think we can do it by
9 July 1.
10 **CHAIR RABRICH:** Yeah, I would agree.
11 I think most people would want to stick with the July
12 1. I don't know. Do I hear any dissent? I don't
13 see any dissent -- Dr. Dailey.
14 **MR. DAILEY:** Sorry, I just did two
15 things really quickly that -- that I'd just like to
16 point out. The first is that the addition of
17 antibiotics for open fractures incredibly important,
18 something that STAC has been talking about, excited
19 that that's now going to be an opportunity and
20 exactly the right thing for us to do.
21 But the other one that I think is
22 incredibly important, given the -- the news that we
23 have seen over the course of the last, you know, six
24 months since the events in Aurora, Colorado, is
25 endorsement within our protocol to make sure that

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2 indeed we're using waveform capnography as soon as
3 practical in agitated patients who get sedation.
4 And while we didn't discuss all of the
5 changes in depth, those are the levels that -- that
6 these changes have gone to, to make sure that indeed
7 we're looking at what's happening nationally. That
8 we're looking on what opportunities we can partner
9 with our additional advisory bodies on in order to
10 make sure that the medicine for E.M.S. continues to
11 advance.
12 So the education from here that goes
13 to the regions, the agencies is going to be important
14 because we have to make sure it is also brought with
15 that same level of -- of -- of intensity.
16 **CHAIR RABRICH:** Thank you. All right.
17 Now that we've had discussion and we've decided on
18 the -- sorry.
19 **MR. MCEVOY:** In -- in light of that,
20 do -- because you're a little off kilter, do you want
21 to include in your motion to stay with the planned
22 implementation date?
23 **CHAIR RABRICH:** Sure. You go with
24 that in the original motion.
25 **MR. CUSHMAN:** I'll -- I'll -- I'll be

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2 happy to restate the motion that the SEMAC approves
3 the A.L.S. Collaborative Protocols for implementation
4 by regions no later than July 1, 2024.
5 **CHAIR RABRICH:** Thank you. And is
6 there still a second for that?
7 **MR. WINSLOW:** Second.
8 **CHAIR RABRICH:** Okay. Second. In the
9 absence of any other discussion, I don't see any.
10 All those in favor, raise your hand. Okay. Any
11 opposed? Any abstentions? All right. Thank you.
12 That passes unanimously.
13 **MR. GREENBERG:** So if this is approved
14 in SEMAC and SEMSCO obviously today we will post them
15 next week or so up on to the website with it below
16 saying these are being implemented on this date, but
17 they'll be up there with the change logs as well.
18 **CHAIR RABRICH:** All right. Thank you.
19 Our next agenda item is the New York City protocol
20 changes. So there are three protocols in there that
21 you'll see there's the anaphylaxis, there's
22 childbirth, and then there's a vaccine protocol. We
23 can go through them one -- one by one or just let's
24 discuss them as a group.
25 We'll start with anaphylaxis. Any

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2 comments or questions or concerns regarding the
3 anaphylaxis protocol? I think most of the language
4 there was to clean up the definition of being in
5 anaphylaxis, and then the addition of ipratropium
6 with the albuterol. Okay. The changes to the
7 childbirth protocol. I mean, childbirth Dr. Isaacs,
8 did you want to comment on this at all or?
9 **MR. ISAACS:** Sure. So the initial
10 E.M.S. Chief standards in 2021 had changed it to an
11 E.N.T. level skill that nuchal cord is part of an
12 abnormal delivery and previously had been E.M.R.
13 level. And so we feel locally that this is a need
14 for us.
15 We believe that's the reduction of
16 nuchal cord is a critical step in a normal delivery.
17 Looking our data since 2019, C.F.R. arrives on scene
18 and has to manage a nuchal cord about three times a
19 year prior to the B.L.S. and A.L.S. arrival. So we
20 have continued to taught our C.F.R.s the practice and
21 protocol. And now, we're bringing this up here.
22 **CHAIR RABRICH:** Thank you. Any
23 comments or questions on the childbirth protocol?
24 The -- the last protocol in the packet is the vaccine
25 administration protocol. Okay. Any -- is there any

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2 motion to approve the New York City protocols?
3 **MR. CUSHMAN:** Cushman so moved.
4 **MR. WINSLOW:** Second.
5 **CHAIR RABRICH:** And a second.
6 Discussion -- further discussion on the protocols?
7 Boy, no one has much to say today. All right. If
8 there's no other discussion, all those in favor of
9 these protocol changes, raise your hand. Okay. Any
10 opposed? Abstentions? Okay. It passes.
11 The next item is the B.L.S. protocol
12 update. Any discussions on the B.L.S. protocol or
13 comments?
14 **MR. CUSHMAN:** Again, the document is
15 nearly identical to that which was brought forth to
16 this body in September with, again, the notable
17 change of the hospice protocol which -- which does
18 engage our -- our E.M.T. partners. And the
19 medication formulary is restricted just to those
20 medications that are within the scope of the E.M.T.
21 And again, kudos to Alex and the team
22 for that change log because they made look really
23 nice a lot of random notes for me.
24 **CHAIR RABRICH:** Thank you. Is there a
25 motion to approve these with the implementation date?

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2 **MR. CUSHMAN:** So moved.
3 **MR. KUGLER:** Second.
4 **CHAIR RABRICH:** Okay. Any further
5 discussion on the B.L.S. protocol update? All right.
6 All those in favor of the B.L.S. protocols updates,
7 raise your hand. Any opposed? Any abstentions?
8 Okay. Also carries unanimously.
9 All right. Some other discussion
10 items, there is a, it's -- it's -- somehow it's not
11 on the agenda, but you received the -- the Scarsdale
12 VAC protocol, the antibiotic protocol. So I wanted
13 that open up to discussion. And Dr. Berkowitz, if
14 you want to start the discussion?
15 **MR. BERKOWITZ:** Yeah, so the
16 Westchester REMAC approved a pilot program in our
17 region for this -- this agency to carry and use
18 antibiotics in their population. They have a lot of
19 patients who they respond to, that they -- that they
20 believe this would help.
21 Similar to what Dr. Dailey said, we
22 think there's opportunities in pre-hospital with
23 being able to carry and -- and utilize antibiotics.
24 Their program is focused on patients who -- there
25 would -- there would be a prescription or an order by

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2 a physician as well.
3 So there's some -- a little debate
4 that we had on whether this falls under the
5 prescription medication assistance existing resource
6 within the collaboratives or not, which is kind of
7 open to this group in terms of to interpret whether
8 this falls under that and we don't even need
9 approval.
10 But either way, I think it's an -- an
11 opportunity to discuss. But we did vote and approve
12 it unanimously at the Westchester REMAC. And so I'm
13 supportive of this effort.
14 **CHAIR RABRICH:** Thank you. Other
15 discussion on this antibiotic protocol? Yes, Dr.
16 Cushman.
17 **MR. CUSHMAN:** You know, this -- this
18 brought up, I think, a really important discussion
19 for this -- for this body to further discuss because,
20 you know, fundamentally what we're -- I -- I think
21 it's important to consider the precedent that we may
22 set related to the practice of community paramedicine
23 versus the practice of, if you will, nine one one
24 emergency response.
25 Traditionally, our protocols have

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2 addressed non-specific patient orders for the
3 direction of patient care by E.M.S. personnel in the
4 field as a result of a non-scheduled emergency visit.
5 And as a result, this body has always, at least
6 around that I have been, Dr. Marshall may recall
7 previous to that, but he's been smiling too much the
8 entire time.
9 I've never seen him smile so much at a
10 -- at a Med Standards meeting. That -- that this
11 body has always been very, very cautious and somewhat
12 conservative, and appropriately so, in what
13 medications, what indications, for what reasons via
14 what mode and so forth given the tremendously
15 heterogeneous population that we serve.
16 Move forward, we had the opportunity
17 with vaccinations which propelled paramedicine into
18 really the world of -- of more so real community
19 paramedicine for very, very good reasons. Also, non-
20 specific patient administrations done under the
21 oversight of a physician, health commissioner,
22 whatever it happened to be for a -- a specific cause
23 and event.
24 At that time, you will notice, there
25 is not a protocol in the B.L.S. protocols, the

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2 collaborative protocols, or whatnot related to the
3 administration of vaccines because that is not
4 generally it's -- it's been consistent with our
5 approach.
6 So -- so the discussion that my
7 colleague and I have been -- have been having is --
8 is, as we move forward with community paramedicine
9 initiatives, is the placement of a protocol for the
10 administration of generally patient-specific targeted
11 interventions that are within the scope of the
12 provider that is delivering that intervention
13 appropriate for A set of protocols.
14 My -- Jeremy's opinion is that I
15 really don't like putting it in a Statewide
16 collaborative protocol. From a community
17 paramedicine program perspective, if you've seen a
18 community paramedicine program, you've seen a
19 community paramedicine program. One size fits one
20 has physician oversight in this protocol.
21 As -- as I understand it, this is
22 antibiotic administration for very specific
23 identified critical conditions. And we're not
24 expecting that the paramedic is going to determine
25 which antibiotic to give. They are being told,

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2 you're going to give Cushman a couple grams of Vanc
3 because of whatever I have that week, right?
4 And so they are simply the vehicle for
5 that delivery, not, if you will, cognitively making
6 the determination as to, does Jeremy get this
7 antibiotic for that. And so -- so you know, as -- as
8 we move forward with this in legislation pending and
9 so on and so forth, I -- I worry about frankly
10 setting the precedent, to be clear, I fully support
11 this program.
12 And I think my colleague understands
13 that me bringing this up is not because I don't
14 support it, I absolutely do. But we will continue to
15 have this issue of -- of frankly delaying the
16 evolution of community paramedicine in the State of
17 New York if we have to bring every medication, which
18 is frankly ridiculous, right?
19 As it is right now, we have paramedics
20 managing antibiotics every day on an inter facility
21 transport. We have them managing a heparin drip
22 every day. That's not in our protocols at all, but
23 they are doing it because the route and method of
24 administration is within their -- their scope.
25 The prescribed medication assistance

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2 protocol that was just approved by this body which is
3 frankly just updated, it's always been there, you
4 know, very, very clearly says, right? Administration
5 of any patient's prescribed medication for the
6 condition it is prescribed for using a route of
7 administration within the practitioner's scope of
8 practice.
9 To me, that falls under here. And so
10 if a C.P. program as -- as managed and approved by
11 the Bureau in whatever regulatory structure exists
12 there is certainly required to have the physician
13 oversight all of the other stuff that is requisite
14 for that.
15 As long as the things that they are
16 doing are within the scope as defined within our --
17 our protocols, routes of administration, stuff like
18 that. I mean, I don't think you're doing intrathecal
19 injections any time soon.
20 To me -- touché, touché. Very well.
21 Again, that -- that's why I think we should have this
22 discussion and identify some path forward because the
23 direction that we go will -- will set us in different
24 ways So that's where I'm coming from.
25 **CHAIR RABRICH:** Thank you.

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2 **MR. GREENBERG:** So I guess the first
3 question is, and this is to Jeff Rabrich. Is it for
4 the C.P. program or is it for outside of the C.P.
5 program?
6 **MR. HUDSON:** As Don said, yes. I
7 think it would be utilized -- potentially be utilized
8 by both. Although, I think the biggest use is going
9 to be within C.P. And I think that what Jeremy is
10 saying is -- is -- is reminiscent of the discussion
11 we had many moons ago when we were presented with
12 interfacility protocols from a region and this body
13 said these are fantastic protocols.
14 We fully support, but we are not going
15 to vote on them, if I remember correctly because this
16 -- this is not what we vote on. And it's kind of
17 advanced scope paramedicine and we want that to
18 flourish with minimal -- without -- without burden.
19 Is that accurate, Jeremy, from, you know --
20 **MR. CUSHMAN:** As -- as --.
21 **MR. HUDSON:** -- an -- as an analogy?
22 **MR. CUSHMAN:** Yeah. In our facility,
23 I think there's -- I don't want to open that can of
24 worms. But I think there's still the big question as
25 to is that actually under Article 30 anyway, because

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2 these are Article 28 transports. But -- but -- but I
3 think similarly.
4 I -- I think, you know, we -- we look
5 at the advancement of, if you will, nine one one
6 E.M.S. medicine and the addition of I.V. antibiotics
7 or oral antibiotics for very specific indications --
8 a very specific medication for a very specific
9 indication of a very specific circumstance that this
10 body, I think we all agree, is the right way to go.
11 I would offer that if it doesn't exist
12 in here, then it -- it -- it -- it can't be given
13 just as a method of routine nine one one work, right?
14 It would -- it would have to be as part of a
15 community paramedicine program.
16 If we get to the point, if -- if this
17 body eventually believes, just -- we should be giving
18 antibiotics for -- for undifferentiated sepsis, then
19 we need to have the conversation of what does that
20 look like and what antibiotics do we feel are safe,
21 appropriate, and indicated in those circumstances.
22 **MR. HUDSON:** Thanks. So just one --
23 one quick thing. You know, under the -- the nice
24 thing about, you know, using the -- the prescribed
25 medication assistance protocol is that, it requires

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2 essentially a physician order or prescription. Which
3 means, this -- which is as to Jeremy's point, is very
4 different.
5 And so we're -- we're in a different
6 world right now where, you know, paramedics are
7 taking care of patients where doctors are having
8 visits with the patient around the same time in --
9 documenting in their E.M.R.
10 Putting notes in their -- putting
11 notes and orders in their E.M.R., which is very
12 different than the -- the -- the kind of what -- the
13 -- the undifferentiated part of -- of E.M.S. So you
14 know, I am comfortable if -- if -- if this body were
15 to say, we're supportive and you can use this -- you
16 can use this -- this protocol.
17 I do think that with one of the
18 questions then becomes, what about the carrying? Is
19 that an issue that -- that -- that there's going to
20 be an ambulance that's going to have, let's say, that
21 there's two grams of vancomycin on -- on it.
22 Again, I think there are some
23 analogies on the inter facility side that are
24 worthwhile. Well, vaccines, right?
25 **MR. CUSHMAN:** Yeah.

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2 **MR. HUDSON:** So I -- I think it's --
3 it's -- it's -- it's an open discussion and I think
4 that, you know, I'd like to -- I think my point is.
5 **CHAIR RABRICH:** Thanks. I mean, Dr.
6 Olsson first, and then, Dr. Dailey.
7 **MR. OLSSON:** Thank you. I'm still
8 trying to figure out what I was trying to figure out
9 to ask. The word vertical has me a little
10 disoriented because I don't think it's going to fit
11 into the collaboratives.
12 It might fit under a community
13 paramedicine protocol, but maybe that should have a
14 separate term. If it does include or use the term
15 protocol, then what I certainly have come to know as
16 our protocols, then all of these medications would
17 need to be in the State formulary or E.M.S.
18 formulary, I would guess.
19 So I -- I agree with what's been said,
20 I think it's an interesting concept. But it just
21 doesn't seem to fit into what our normal nine one one
22 day in the life of a paramedic is. And I -- I think
23 that for me personally that separation needs to be a
24 little more clear than it is right now. So thanks.
25 **CHAIR RABRICH:** Thank you. Dr.

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2 Dailey.
3 **MR. DAILEY:** I think there's a couple
4 of different things that are really important with
5 this. The first is, that as a community paramedicine
6 program, this acts under direct oversight from a
7 physician, right?
8 And I think that making sure that we
9 maintain that line and that there isn't a screep, you
10 know, some type of -- of weird scope creep into
11 randomly treating people who we think might have
12 something which quite frankly terrifies me.
13 Particularly, since we won't know
14 where it fits into the documentation, and ultimately
15 how we're going to provide any oversight to it on a
16 broad basis. The other thing I think is really
17 important to remember is that community paramedicine
18 is something that's developed to fill voids in care.
19 You know, there is certainly going to
20 be concern from the education department and from the
21 board of nursing in terms of where this falls, in
22 terms of where a nursing scope lands. And I can see
23 that as a -- as reasonable, but at the same time, we
24 have some crossover between the two.
25 And honestly, I see things

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2 particularly like the visiting nurses and community
3 paramedicine as being two hands fitting into gloves
4 in order to make sure that that patient gets adequate
5 care and can stay in the home when possible.
6 I think we have to make sure that
7 we're endorsing those relationships, supporting those
8 so we can get the, if you will, the biggest bang for
9 the buck and the best patient care we can.
10 **CHAIR RABRICH:** Thank you. Other
11 comments? Yes.
12 **MS. BOMBARD:** Dr. Olsson, would you be
13 more comfortable with this if it was called a
14 guideline instead of a protocol? Is it the protocol
15 word that's --?
16 **MR. OLSSON:** I can't say what I'd be
17 more comfortable with other than not a protocol, so
18 you know. And -- and again, I don't -- it's just --
19 just one of those funny feelings I get, that just
20 doesn't seem like it meshes with what we're talking
21 about for community paramedicine's standard of care
22 for routine and exceptional antibiotic administration
23 in extreme cases of potentially questionable sepsis.
24 **MS. BOMBARD:** That's a lot.
25 **MR. OLSSON:** You can abbreviate it,

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2 I'm sure it'll condense down. No, I -- I don't --
3 it's just -- it's just me.
4 **MS. BOMBARD:** For what it's worth, I -
5 - I agree. I think that community paramedicine can
6 be governed by the local purveyor of community
7 paramedicine. I don't know that, that's something
8 that we need to get involved in here.
9 **MR. GREENBERG:** So this is part of the
10 dilemma that's up at the moment. Is this something
11 that is done on a low acuity emergency call or a low
12 acuity incident? In which case I would say, it's a
13 protocol. If it is something related to community
14 paramedicine, then you'd probably say it's a
15 guideline.
16 However, I will also say the issue
17 that we are dealing with in the bureau is we have
18 many great community paramedicine pilot programs that
19 are out there that are doing wonderful things. Some
20 of which have asked to change things or do more or do
21 less or things like that. Actually, doing less is
22 easier. We can -- we can say, you can do less.
23 There's no obligation for you to do
24 something. But doing more becomes a little bit more
25 problematic because it is in community paramedicine

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2 world as approved as of May 10th, 2023 when it became
3 legislation. So what they were approved to do on
4 that day is what they're permitted to do today.
5 And unfortunately, there's not that
6 pathway to expand even though the bureau would love
7 to see certain things expand. So I don't know if
8 that helps our decision or not on -- on things like
9 that. I think, you know, I think there's an
10 opportunity for a pilot program, absolutely.
11 I think, you know, if this pilot
12 program maybe is for low acuity situations that that
13 would be here, and I would think that that would be
14 something that would be passed from this group as,
15 you know, a protocol for a pilot program that is a
16 low acuity response.
17 If it is for the community
18 paramedicine, I think everybody here can opine on it,
19 but I don't know that we can change it just based on
20 the legislation and the way that it was passed. But
21 I would encourage you to opine on it and -- and maybe
22 even, you know, voice support or something else.
23 I think that's important too because
24 then we can bring that back and further discuss it,
25 you know, up with the commissioner's office and

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2 things like that. If this is, you know, where we're
3 trying to go or where-- not we, but where programs
4 are trying to go and what's trying to come out of it
5 as well.
6 So there -- there could even be two
7 different, you know, kind of options on that and
8 maybe even to take both in order to try and advance
9 this and move that forward.
10 **CHAIR RABRICH:** Thanks. Don?
11 **MR. DUVALL JR.:** I -- I have to agree
12 with Dr. Cushman's thoughts. As -- as community
13 paramedicine evolves and as we're seeing this rapid
14 expansion, I'm -- I'm reminded of something I read at
15 the beginning of community paramedicine growth and
16 the gist is the best way to stifle growth of a new
17 program or an evolution is to over regulate it.
18 And I think what Dr. Cushman says is
19 reasonable. And I think when you don't have a
20 specific medication for a specific problem, but you
21 do have robust physician oversight in your community
22 paramedicine program. We need to let those programs
23 grow without the restriction of a protocol that may
24 be updated once a year.
25 And we need to let community

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2 paramedicine grow, encourage that growth, foster that
3 growth within the bounds of the law which it sounds
4 like we can do with assisted medication
5 administration. It sounds like the only issue is
6 figuring out how to carry the meds outside of the
7 formulary.
8 But that seems like a relatively easy
9 lift if the provider carried a card or a document
10 from the physician oversight that authorized them to
11 maintain a supply of those medications. And then,
12 they can change them week to week or month to month
13 based on what they determine the needs of the
14 community are and what their role is in providing
15 that care to communities.
16 So don't -- I encourage you, from a
17 field provider's perspective, don't seek to over
18 regulate something that we're still not sure what
19 it's going to be.
20 **CHAIR RABRICH:** Thanks. Dr. -- Dr.
21 Cooper.
22 **MR. COOPER:** Thank you. And
23 congratulations on your ascension to the Marshall
24 Chair of Medical Standardism. You know, one point
25 that I -- that I think infrequently or I'm sorry,

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2 frequently gets lost in this discussion is the -- is
3 the issue of scope of education. And we often speak
4 of scope of practice, you know, as driving education.
5 But the two are served mutually, you
6 know, should we say very closely linked. As long as
7 under our laws and regulations the SEMAC has a role
8 in -- in ensuring together with SEMSCO an appropriate
9 educational base for our paramedics who in fact are
10 credentialed under Article 30, which falls within our
11 bailiwick.
12 It does seem to me that we have a
13 responsibility to ensure that the scope of education
14 matches the, you know, the scope of practice that is
15 being advocated. Whether we're speaking about, you
16 know, a nine one one response or whether we're
17 speaking about community paramedicine. I don't think
18 that's been well worked out.
19 I'm not arguing that there needs to be
20 absolute and complete uniformity or standardization
21 across every community paramedic program. That's --
22 that's not the -- the -- I -- I don't think that
23 would be in anyone's best interest at the present
24 time.
25 But -- but I do think that as more and

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2 more, you know, novel treatments are introduced into
3 the paramedic scope of practice, that we collectively
4 SEMAC, SEMSCO and the Bureau have a -- really a very
5 sacred responsibility to ensure that the scope of
6 education matches what's being, you know, what's
7 being asked.
8 It's not as simple as saying, well,
9 you know, they're -- paramedic is just being asked to
10 give a medication by a route which -- with which he
11 or she is familiar based on, you know, current scope
12 of practice. You know, recognition of, you know, the
13 indications, contraindications, side effects, et
14 cetera, of the medications involved.
15 For example, a treatments involved is
16 absolutely critically important. That's why, you
17 know, the physicians anywhere -- anywhere around this
18 table go to medical school and do residencies, right?
19 And that you know, we all understand the need to
20 ensure that community paramedicine continues to grow
21 because the fact of the matter is that there are not
22 enough physicians or visiting nurses out there to
23 accomplish the task of, you know, the low acuity
24 responses that Director Greenberg was -- was
25 referring to a few moments ago.

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2 But I -- I just urge that we tread
3 very, very carefully in this area and pay maybe a
4 little bit more attention to scope of education than
5 we have in -- in the past as community paramedicine
6 continues to roll out Statewide. Thank you.
7 **CHAIR RABRICH:** Thank you. Yeah. I -
8 - if I'm hearing your comments correctly, it sounds
9 like this may be right for a -- a working group to
10 kind of look at this and -- because it keeps coming
11 up with community paramedicine and --.
12 **MR. COOPER:** That's not my call.
13 **CHAIR RABRICH:** No, I know. But that
14 -- that's what I'm getting out of some of your
15 comments. I don't know if you -- I -- I think maybe
16 before setting up a working group, maybe we can talk
17 between this meeting and next meeting.
18 **MR. COOPER:** Yes.
19 **CHAIR RABRICH:** And -- and maybe plan
20 out that and determine if a working group is -- is
21 needed for that. But it -- but it might be. And I'm
22 definitely, you know, on that front, you know,
23 related to -- well, I guess we'll just -- I'll leave
24 it that. But I definitely understand where you're
25 coming from.

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2 I think one of the things that's
3 important too is to talk about, and Jeremy, it -- it
4 came up, and as well as about the protocols of, you
5 know, roles and responsibilities of the SEMSCO and --
6 and things like that. And the opportunity from some
7 changes that occurred last year with, you know,
8 moving from just being for emergencies and -- and
9 expanding beyond that.
10 Which, you know, what we saw in
11 legislative change last year. So you know, it also
12 might be the right time to sit and talk about that,
13 you know, and maybe there is a set of non-emergency
14 guidelines as opposed to protocols.
15 Because I do feel that the world of
16 non-emergency lives in a, a different environment
17 often with one with, you know, when we talk about
18 inter facility transports or critical care transports
19 and things of that nature. They are going under a
20 doctor's order. They -- they're not going under a
21 medication that's come out of nowhere.
22 It's very specific to what it is.
23 This committee has done amazing work over many years
24 and I think, you know, it's going to continue to
25 grow. But now it might also be the point to where,

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2 you know, there is a set of guidelines that comes out
3 for the not -- non-emergency for the critical care
4 side of things.
5 Again, guidelines that I would
6 probably even like to say is out there today, but
7 maybe came in front but wasn't voted on in the past
8 or other situations of that. So timing wise of that,
9 you know, we could be sitting at that. And that
10 might be the right time.
11 **MR. COOPER:** Yeah.
12 **CHAIR RABRICH:** And it might answer
13 some of these other questions.
14 **MR. COOPER:** (unintelligible).
15 **CHAIR RABRICH:** Yes, because it keeps
16 coming up. Dr. Winslow.
17 **MR. WINSLOW:** Yeah. In -- in our
18 regional REMAC, we don't approve inter facility
19 transport protocols. In the four years I've been in
20 SEMAC, we don't approve inter facility transport
21 protocols. This kind of fits more like that and
22 belongs in like the resources section of the
23 collaborative protocol document.
24 Maybe it has like a community
25 paramedicine bullet and then guidelines there just

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2 underneath the inter facility transport one. And
3 then, you can leave it to the regional community
4 paramedicine and medicine programs and their medical
5 oversight what they wish to put in there.
6 **MR. GREENBERG:** So I'll remind you
7 there are two very separate things. Community
8 paramedicine is one thing, kind of sits over here.
9 It's a pilot program, has very specific legislation
10 that goes to it. Very specific, you know,
11 requirements to it.
12 On the other side is emergency,
13 whether that be high acuity, high stakes, high fill
14 in the blank or low acuity. That's on this side that
15 -- you know. And if you're saying it should be in
16 there as a guideline and setting, you know, different
17 portion and appendix to be part of the medicated
18 assisted protocol, which is in there today, that's
19 fine. But then, that's sit on this side.
20 The paramedicine is on that side. And
21 I understand we're in a time where some things are
22 blurred. And that's okay. I think that goes back to
23 down the side of, you know, of as we advance as a
24 profession, some of that's going to happen. And for
25 me, don't over regulate. I agree. I -- I understand

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2 where you're coming from.
3 But that also doesn't mean that we can
4 not look at the things that are in place and not put
5 the -- look at the legislation that is in place. But
6 in areas that possibly offer opportunity for a little
7 bit more gray, then there's opportunity for that.
8 In areas where there's not, we need to
9 sit by this. One of the other things that will come
10 up is, you know, just related to, you know, what's
11 permitted or what's not and obviously, but we'll get
12 to that.
13 **CHAIR RABRICH:** Don.
14 **MR. HUDSON:** So as a non-physician, I
15 would never suggest that we're over thinking this,
16 but I like Dr. Cushman's example of heparin. I mean,
17 we've had it on the ambulances in some regard for
18 decades and it's not that we've looked the other way,
19 but it was sort of assumed that this is not a purview
20 of, you know, quote, unquote, emergency ambulance
21 operations.
22 I think, if I'm hearing everybody
23 correctly, we all agree that as we transition and,
24 you know, weave our way through this gray world as
25 E.M.S. evolves into other non-traditional E.M.S.

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2 roles, which is a great thing, that this is an
3 instance where we want awareness of what's going on
4 without needing to give the endorsement of what's
5 going on.
6 So I would say, is this a case where
7 we want the local REMAC to know without making it a
8 protocol or endorsing it and bringing that to the
9 SEMAC again for awareness and let each level then
10 decide on a case by case basis, nope, this is okay,
11 keep doing what you're doing as long as the
12 education's there and the equipment's there and
13 everything's there, good job.
14 Versus, no, we're going to need to
15 vote on this one. This one's going to have to be a
16 protocol. And -- and again, I -- I understand how
17 we're always mindful of fracturing things further,
18 but I mean, let's face it. As we evolve, we're going
19 to have to come up with processes for this.
20 **MS. BOMBARD:** And to Dr. Winslow's
21 point, again, I think we can treat this a lot like we
22 have in inter facility protocols. In which case
23 REMAC needs to be made aware and have a discussion
24 about it, and we do not, necessarily.
25 **MR. HUDSON:** And -- and Dr. Bombard, I

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2 would say, unless that REMAC then feels let's pass
3 this up, you know, that's what I mean by a case by
4 case basis is, now this one seems okay, we'll let the
5 State know. Versus, no, we're going to kick this up
6 the chain and see what the big boys say.
7 **MS. BOMBARD:** Sometimes it's going to
8 get kicked to us just because it's interesting. And
9 that's fine. But I don't think that, if it's not
10 interesting, we need to continue spending our time.
11 **CHAIR RABRICH:** Thank you. Great
12 discussion. I think, you know, more to come about,
13 you know, how we go about this, what we call it, I
14 think, there'll definitely be further discussions on
15 this. Anyone has any other comments on this? We'll
16 move on to the next. Yes, Dr. Berkowitz.
17 **MR. GREENBERG:** I'm sorry your time
18 has run out in front of this committee.
19 **MR. BERKOWITZ:** So I'll --
20 **MR. GREENBERG:** First, try to make it
21 to a mic that works. There you go. Thank you.
22 **MR. BERKOWITZ:** So -- so you know, I
23 am, you know, I am, you know, tasked in my region to
24 a -- to support the agencies that are trying to
25 innovate in our region and do things. So I would

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2 like to get some element of -- of closure aside from
3 --.
4 **CHAIR RABRICH:** Would you like to make
5 a motion, sir?
6 **MR. BERKOWITZ:** So you know, I think,
7 Jeremy, do you have a motion that you're thinking of?
8 But I want to say -- I want to say before I do that,
9 I want to say one -- one thing real quick. That --
10 that, when you think about, you know, community
11 paramedicine, you know, I think there's a big
12 difference between when we are using paramedics in a
13 community health function where they are doing --
14 working on their offline medical direction with
15 protocols and guidance to do things like vaccination
16 or even a well-check visit where there's -- there's
17 no doctor involved with that visit.
18 There's a lot of programs about that,
19 you know, readmission reduction. There's stuff with,
20 you know, dementia. There's -- there's great
21 programs out there where -- where -- where they're
22 functioning in a community health manner and -- and
23 there's no doctor who's seeing the patient.
24 That is very different than what we're
25 talking about here and actually what happens with

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2 inter facility, where there is a doctor with orders,
3 where there are notes in the chart. So you know, the
4 -- the brass tacks comes down to risk in a lot of
5 cases.
6 And when there's a note in the chart,
7 that doctor so and so says this, and a -- a -- a --
8 an actual visit, an encounter number. All the things
9 that as the physicians, you know, we understand is a
10 part of the -- of the -- of the -- of the patient
11 record in a way that's different than what's in the
12 E.P.C.R.
13 When that's there and that order, it
14 is a different type of community paramedicine than
15 kind of vaccination or you know being dispatched for
16 a well-check as part of a program where a doctor
17 never got involved. So I want to make that
18 distinction. And then -- and then -- and then, turn
19 it over to Jeremy.
20 **CHAIR RABRICH:** To -- to craft some
21 sort of motion whether its --
22 **MR. BERKOWITZ:** (unintelligible)
23 **CHAIR RABRICH:** -- (unintelligible) to
24 support the concept or --
25 **MR. BERKOWITZ:** Yes, I do have to

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2 advocate for --
3 **CHAIR RABRICH:** Basically, what action
4 item would you like is what we're asking.
5 **MR. GREENBERG:** So just before you go
6 to your action item. So I think even if you were to
7 put it forward as an action item, it's a very
8 specific thing, it's a very specific area. And then,
9 you know, if we have to look at it further from our
10 side to further clarify where it should sit or live
11 or how it should, I think if this body was to support
12 that that gives us that pathway to do those
13 additional things.
14 And then, we can move forward from
15 there. Does that seem reasonable? Just remember all
16 the change log stuff we did.
17 **MR. CUSHMAN:** Ryan and I are
18 exchanging kind of confused looks at each other,
19 trying to read each other, I guess. But so yeah, I -
20 - I'm with you. I -- I kind of want some -- some
21 closure. And so I've written the following, which I
22 still don't know is the right thing, but at least it
23 gets it out there. And perhaps if we need to
24 wordsmith between meetings, we can.
25 **MR. GREENBERG:** And if this motion is

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2 written on there, will you also email that to Teresa
3 directly after so she doesn't have to try and capture
4 every word that you said?
5 **MR. CUSHMAN:** I'll be glad to do that.
6 But yes, I'll --
7 **MR. GREENBERG:** Great.
8 **MR. CUSHMAN:** -- I'll figure out how
9 to get it there. But I -- I guess conceptually what
10 I'm trying to do is summarize what I think the
11 conversation is and that's this. The SEMAC believes
12 that the administration of medications using a route
13 within the practitioner scope of practice is within
14 the practice parameters of a community paramedic
15 program and may be administered with direct medical
16 oversight in a patient-specific order for such
17 medication. Period.
18 **MR. WINSLOW:** I -- I -- I'd like to
19 second just to discuss it.
20 **CHAIR RABRICH:** Okay.
21 **MR. WINSLOW:** But --.
22 **CHAIR RABRICH:** Yeah. So let's start
23 the discussion again.
24 **MR. WINSLOW:** I'd like to start it
25 with, does this need to be done and does it need to

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2 be done here is unclear.
3 **MR. CUSHMAN:** Jim, I'm -- I'm with
4 you, but I -- I also believe that we have the
5 opportunity to really start setting the precedent
6 that perhaps we don't need. That -- that we can set
7 the standards to, you know, as -- as my colleague has
8 -- has mentioned, that we're -- again, community
9 paramedic programs are all somewhat unique.
10 But if we're talking about a medic --
11 a patient -- patient-specific order, that is
12 therefore by definition requiring a practitioner's
13 relationship with that patient in making the
14 determination of that, versus, a community health
15 initiative which is taking undifferentiated patients.
16 If we have to address that at some
17 point in time in the future, we can figure out how to
18 navigate that at some point in time in the future.
19 But I would also say in just, you know, Dr. Winslow,
20 from your side, that -- that, although this may not
21 be the place where something for C.P. gets approved,
22 it's absolutely the place where discussion and
23 support of the medicine and initiatives behind it can
24 be discussed and supported.
25 And I think that is equally as -- as

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2 important in some of those things that are moving
3 forward.
4 **CHAIR RABRICH:** Dr. Cooper -- I'm
5 sorry. Jared and then Dr. Cooper.
6 **MR. KUTZIN:** You know, I -- I
7 appreciate the -- the entire conversation and I agree
8 with what Dr. Cushman and Dr. Dailey said earlier. I
9 think the motion as it's made is a bit broad in that
10 the statement are regarding, you know, being able to
11 administer medications just because there's a route
12 that's available really does lend itself to
13 significant scope creep.
14 And I think that we need to really
15 partner with other agencies and have this discussion
16 because I think that there needs to be a demonstrated
17 need for this type of -- this type of initiative.
18 And I would agree, I'm not even sure that this body
19 is the proper body to deal with this as the protocol
20 that has been submitted as written is really about
21 long-term care, follow-up care, not emergency care.
22 **CHAIR RABRICH:** Thanks. Dr. Cooper.
23 **MR. COOPER:** I'm not sure that, you
24 know, that Dr. Cushman, that we're quite ready for
25 the closure that is desired. I -- I -- I'm concerned

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2 that -- that we haven't really necessarily thought
3 through all the ramification of -- you know, of
4 what's being suggested by this motion.
5 I -- I don't really know who's going
6 to be providing the direct medical oversight. You
7 know, how it's going to be -- how it's going to be
8 provided. And, you know, a direct patient order, you
9 know, individual patient order is, you know, is
10 something that has not -- shall we say been
11 traditionally part of, you know, paramedical
12 practice, you know, in our State at -- at large.
13 It is certainly part of some community
14 paramedicine programs. There's no question about it.
15 But I think personally we're putting the cart before
16 the horse a little bit. I -- I -- I think we need to
17 think about this a little bit before we take -- take
18 such a step. And I don't think we're ready for the
19 closure.
20 And you know, I think we will be soon
21 if we sit down and think about it. But I -- I just
22 don't think I don't think we're quite -- we're quite
23 there yet. And I would -- I would vote against this
24 motion for that reason. Thank you.
25 **CHAIR RABRICH:** Dr. Bombard first,

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2 then Dr. Winslow again.
3 **MS. BOMBARD:** I would argue that there
4 is plenty of precedent for this, that we do this
5 every day, a million times a day. Whenever we write
6 protocol -- whenever we write physician orders for
7 inter facility transport, which we do a million times
8 a day. We do exactly what this guideline, protocol
9 is addressing, right?
10 And the person that is directing this
11 is the medical director for the community
12 paramedicine program that is the physician that is
13 overseeing it. That is the physician that's
14 responsible for the consequences of it. And so I
15 think those questions are actually answered.
16 We have lots of precedent for writing
17 orders for paramedics to do things. And -- and we
18 have oversight that's delineated by the program. So
19 I'm all in favor.
20 **CHAIR RABRICH:** Dr. Winslow.
21 **MR. WINSLOW:** Yeah, I think we should
22 tread lightly here because it is new. I also think
23 we don't want to set ourselves up as a body, the Med
24 Standard subcommittee or the SEMAC of having to
25 approve every single one of these as they come along.

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2 Nor, do we want to put it in writing
3 that we don't at this point because it's still
4 developing. I think we should generally support the
5 development and continued development of community
6 paramedicine, but not make a formal motion at this
7 time.
8 **CHAIR RABRICH:** Any other comment?
9 Dr. Dailey.
10 **MR. DAILEY:** I think the only other
11 thing that I would throw into this is, you know, the
12 idea of supporting community paramedicine programs, I
13 think is extremely important. But I think this again
14 becomes something that's fulfilling regional needs.
15 And we need to make sure that these
16 programs are all being vetted at the regional level,
17 not for approval, but for understanding and
18 acceptance of what other things will be brought to
19 bear there. So all of the physicians in the room at
20 that REMAC meeting, all of the participants in the
21 system that are a part of that regional council,
22 which is why we have these regions, can understand
23 what opportunities are being brought for patients
24 within that region.
25 If we remove that regional component

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2 of this and we just have agencies starting programs
3 on their own with approval somewhere outside of the
4 regional level, we will lose significant
5 opportunities that could otherwise bring benefit to
6 our patients.
7 **MR. DUVALL JR.:** Would it be
8 appropriate for this committee to ask SEMAC to issue
9 an opinion that reflects Dr. Cushman's thoughts that
10 we already have protocols in place that allow for
11 paramedics to administer through already approved
12 routes of administration -- medications with a
13 written order patient specific for a physician?
14 And let it go at that until we can
15 revisit the idea of whether there needs to be a more
16 substantial set of guidelines or protocols. If -- if
17 the perception is and -- and if the interpretation is
18 that what this protocol seeks to do is already within
19 our scope of practice, within our protocols, again,
20 I'd ask that and I'm not advocating that, that this
21 is the wild west.
22 But please don't over regulate it and
23 don't over think it. Let's figure out how to make it
24 work and go from there.
25 **CHAIR RABRICH:** All right. I don't

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2 see any other discussion.
3 **MR. CUSHMAN:** Yeah, I can -- truly Dr.
4 Dailey, I think what is critical in your comment is
5 that we're trying to do two things at the same time
6 which is truly how do -- how do we regulate C.P.
7 programs and what level of regulation is that. And
8 it is likely some combination of that which is done
9 at the Bureau and Statewide level.
10 And I, a thousand percent agree with
11 stuff that has to happen at the local level which or
12 -- or the regional level which understands the -- the
13 -- the -- quite frankly, the practice nuances in that
14 community and -- and the specific needs in that
15 community.
16 And that those needs are actually
17 being met in a -- in a meaningful way and not just
18 because we have something that we can throw on the
19 truck and use and call ourselves community
20 paramedics. At the same time I think we are
21 challenged by where really does all of these fit in
22 the grand scheme of -- of paramedicine.
23 Is it thirty, is it twenty-eight, is
24 it some new article that we come up with, I don't
25 know. In the end, I -- I -- I really -- honestly, I

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2 don't care whether or not this -- this motion moves
3 forward. I wanted to get something out there so we
4 could have the discussion, right?
5 And -- and fundamentally, if this
6 discussion helps foster the perspective of this body
7 and their opinions at least voiced to the director of
8 the bureau so they know roughly what we're feeling
9 and some of the areas that we need to -- to do, then
10 -- then, so be it.
11 There is no question, you know, the
12 work from innovations, the work from this body and so
13 forth needs to start happening with haste or it will
14 be defined for us and not by us.
15 **CHAIR RABRICH:** All right. Thank you.
16 So we do have your motion out there, so we need to
17 take some action on it. We'll second it? Yeah,
18 we'll second -- we seconded it for the purpose of
19 discussion. So we need to take some action on the
20 motion, so Dr. Kutzin.
21 **MR. KUTZIN:** Can we -- can we just re-
22 read the motion, please?
23 **CHAIR RABRICH:** Sure. Dr. Cushman,
24 could you re-read your motion?
25 **MR. CUSHMAN:** Yeah, so the motion --

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2 hopefully, I didn't change it at all. The motion was
3 the SEMAC believes that the administration of
4 medications using a route within the practitioners
5 scope of practice is within the practice parameters
6 of a community paramedic program and may be
7 administered with direct medical oversight and a
8 patient specific order for such medication, period.
9 **CHAIR RABRICH:** All right. All those
10 in favor of that motion, please raise your hand.
11 (Off the record; 09:22 a.m.)
12 (On the record; 09:23 a.m.)
13 **CHAIR RABRICH:** Three, four, five,
14 six, seven -- seven, all opposed? One, two, three,
15 abstentions. Okay. I got seven, three and three
16 okay, so, uh-huh, it carries, yeah. So the motion
17 does carry. All right. You don't look happy, Dr.
18 Berkowitz?
19 **MR. BERKOWITZ:** No, it's just more
20 discussion at SEMAC.
21 **CHAIR RABRICH:** Yes, exactly. All
22 right. So -- and let's move on to a non-
23 controversial action items. So the sunset of the
24 C.C. curriculum which has been sent to us from
25 Training and Ed. Mr. Hudson, would you care to

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2 present, I don't know if we have it to put up but the
3 -- the recommendation that was sent from Training and
4 Ed?
5 **MR. HUDSON:** I'll stall Theresa. So
6 as they pull that up, just some background, so the
7 discussion's been had at Training and Ed revolving
8 around the planned and eventual sunset of the
9 E.M.T.C.C. level of care. So at last December's
10 meeting, Training and Ed put forth a motion that
11 we'll pull up and read to the SEMSCO, laying out a
12 time frame and a plan for its sunsetting.
13 SEMSCO, I believe, saw fit to then
14 relegate that to training --sorry, to Med Standards
15 and to SEMAC which -- we're in total agreement with
16 for physician oversight and direction. So that's why
17 it comes back here or in partnership with the other
18 committees we're looking to formulate a sensible and
19 logical plan that gives people a future, maintains
20 system integrity, all related to what we're all here
21 for, which is patient care.
22 **CHAIR RABRICH:** Thanks. I -- I don't
23 know if you have the other one with the details of
24 the -- the sunset.
25 **MR. HUDSON:** (unintelligible).

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2 **CHAIR RABRICH:** Yeah.
3 **MR. HUDSON:** And it's --
4 **CHAIR RABRICH:** No, no -- it's --
5 yeah, it's -- well, it can't read anything yet but
6 it's coming up. We -- we'll read it once, it's --
7 it's up there. Don, do you have it in front of you
8 to read or?
9 **MR. HUDSON:** I do not.
10 **CHAIR RABRICH:** Okay.
11 **MR. HUDSON:** I'm working on it as
12 Theresa's also.
13 **CHAIR RABRICH:** Okay. Dr. McEvoy, can
14 you give a synopsis of it?
15 **MR. HUDSON:** (unintelligible) --
16 **MR. MCEVOY:** Oh, there you go. As
17 it's not really contentious, I don't want to be
18 misquoted, so that's --
19 **CHAIR RABRICH:** Yes.
20 **MR. MCEVOY:** Why I want to have the --
21 **CHAIR RABRICH:** It's up there now.
22 **MR. HUDSON:** I cannot read it.
23 **MR. MCEVOY:** I can't read that either.
24 **CHAIR RABRICH:** Motion to SEMSCO to
25 communicate with the --.

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2 **MR. MCEVOY:** I think somebody closer
3 to a screen --
4 **CHAIR RABRICH:** Yes.
5 **MR. MCEVOY:** Maybe --
6 **CHAIR RABRICH:** Maybe --
7 **MR. MCEVOY:** Hold on, I can read it.
8 Screens being exchanged. A motion to SEMSCO
9 commensurate with the acknowledged concerns regarding
10 the curriculum, scope of practice, comparable
11 standards, blah, blah. All expired E.M.T.C.C.s can
12 continue to refresh at the A.E.M.T. level via
13 established processes indefinitely which would be the
14 C.M.E.
15 The final E.M.T.C.C. to paramedic
16 bridge will commence in April 2026 to coincide with
17 the following. The A.L.S. collaborative protocols
18 will remove E.M.T.C.C. level of care when implemented
19 on the annual revision timeline, July 1, 2027. All
20 currently certified E.M.T.C.C. shall expire.
21 Their certification shall expire at
22 midnight on July 1, 2027. And they'll automatically
23 be re-certified at the A.E.M.T. level for the
24 duration of their current cycle. P.C.R.s would
25 reflect E.M.T.C.C. by their new level at the same

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2 time.
3 **CHAIR RABRICH:** Thank you. So it's
4 brought to us for discussion and then I think, you
5 know, the question of, as a -- as a physician group,
6 how do we feel about that date, about the sunset? My
7 understanding is that the curriculum for the C.C.
8 level was last updated in 1996, I was told.
9 And as well as the maintenance of
10 protocols for this level. So I'll open it up to
11 discussion. Dr. Winslow?
12 **MR. WINSLOW:** Yeah, I -- I'm in
13 support of this motion. I come from a county that
14 has transitioned over the last five years,
15 approximately three hundred E.M.T.C.C.s to bridge to
16 become paramedics. We have approximately a hundred
17 and thirty something left of which we feel most are
18 not active.
19 And they've had plenty of opportunity
20 over the last five years even through COVID to have
21 multiple ac -- abilities to bridge, if you will. So
22 I think we've certainly done our due diligence to
23 allowing those that wish to move up -- to move up.
24 And I think that it's time to call the question.
25 **CHAIR RABRICH:** Thank you. Are there

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2 comments? Maybe we could ask Jerry to come up and
3 give -- give a summary if we could about, we're at
4 with the -- oh --
5 **MR. GREENBERG:** More to this -- to the
6 survey.
7 **CHAIR RABRICH:** Yeah.
8 **MR. GREENBERG:** Maybe just some of the
9 key points of some of the feedback that we got. I
10 know will come out in May but if you can just, for
11 those of you who are unaware, there was an E.M.T.C.C.
12 survey that went out to all the core sponsors as well
13 as others. It's still up on the alert. It's still
14 open.
15 We have about five hundred -- so we
16 have about five hundred or so active E.M.T.C.C.s. We
17 got about six hundred and fifty respondents on the
18 survey.
19 **CHAIR RABRICH:** Okay.
20 **MR. GREENBERG:** So just put that out
21 there.
22 **MR. DUVALL:** Point of privilege, the
23 gentleman down at the end said clearly call the
24 question, so that should end the discussion.
25 **MR. GREENBERG:** Well, we got to vote

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2 to call the question.
3 **MR. WINSLOW:** I meant it's time to
4 draw the line in the sand.
5 **MR. GREENBERG:** Right, you were not
6 literally --
7 **MR. WINSLOW:** Not specifically --
8 **MR. GREENBERG:** --calling the question
9 --.
10 **MR. WINSLOW:** -- in -- in the
11 Robert's rules manner.
12 **MR. GREENBERG:** Okay. No calling the
13 question.
14 **MR. WINSLOW:** I'd like the discussion
15 to continue.
16 **MR. GREENBERG:** Thank -- thank you for
17 clarifying that, doctor.
18 **MR. DUVALL:** Choose your words wisely.
19 **MR. GREENBERG:** Yes. I apologize.
20 **CHAIR RABRICH:** Yep. While we're
21 waiting for that any other discussion?
22 **MR. HUDSON:** So I -- by some -- during
23 some time just give me the cut off. So obviously,
24 the concern on all levels properly. So is, you know,
25 we don't want to strip an area of needed services.

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2 We're all desperate for what we have. We all need
3 every, you know, man on deck, per se.
4 So the flip side to that argument or
5 the -- the counter discussion is what opportunities
6 are there, what successes have been had in bolstering
7 systems in the absence of C.C.s? And I would
8 suggest, you know, regions take a real hard look at
9 A.E.M.T. level as sort of the modern-day equivalent
10 of where the E.M.T.C.C. began.
11 And if it meets their patient care
12 need from a pseudo A.L.S. perspective with lifesaving
13 skills and not a whole lot of fluff. The other thing
14 is we had a presentation from Allegheny County, thank
15 you to them. They were one of the regions that at
16 December's meeting expressed pretty grave concerns
17 that of their fourteen or so sixteen or so
18 E.M.T.C.C.s., none of them had bridged, they can't
19 travel to do it. And everything else.
20 It was only by them coming and voicing
21 their concerns as -- as we want at these committees
22 that they worked with Northwell didactic online
23 bridge sponsor and a local core sponsor to get, I
24 believe, the number was twelve of their fourteen
25 C.C.s into a bridge program to maintain it an A.L.S.

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2 level care in their region.
3 So it can be done, if regions have
4 concern, obviously those concerns are warranted but
5 they do have a resolution.
6 **CHAIR RABRICH:** Thanks.
7 SPEAKER 24: So yeah, just a couple
8 quick numbers here. I mean, we -- we broke it down
9 by each one of the proposals, each four and for three
10 of them, the first, second and for at least for the
11 first two. So the collaborative protocol question
12 and the expiration. And their expiration be the most
13 significant one.
14 Overall, we had about five hundred and
15 fifty-one responses that we tallied on this
16 particular thing. And they were pretty split. So it
17 was approximately about forty-seven percent, don't
18 necessarily support this. And forty-five, four
19 percent do. Ten -- about eight percent were neutral.
20 And if you take the C.C.s out of that
21 and they're the ones that responded, it
22 overwhelmingly sways it to sixty-six percent do not
23 support, so they were a significant number into that.
24 So if we take the math and do it the other way, so
25 overall, if you look at the numbers going down, it

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2 was pretty much split between the two with about
3 seven to eight percent do not support overall.
4 There was a larger percentage of
5 individuals for transparency who felt that allowing
6 them to continue indefinitely through the C.C. -- for
7 the C.M.E. program that was about almost sixty
8 percent of respondents. But other than that, that
9 was the overall tally of it.
10 **CHAIR RABRICH:** Thank you. Any other
11 comments?
12 **MR. HUDSON:** So then, just for Med
13 Standards to be aware training Ed's putting forth a
14 seconded motion at SEMAC, SEMSCO reaffirming our
15 belief in what you see before you.
16 **MR. RABRICH:** Uh-huh.
17 **MR. HUDSON:** So if you'd like that
18 modified in some way, as -- as I think the question
19 before the group is, now is the time.
20 **CHAIR RABRICH:** Yeah, that or for this
21 group to make a motion to support this as well, so.
22 **MR. GREENBERG:** As written.
23 **CHAIR RABRICH:** As written, yeah. Any
24 other comment? Would anyone like to make a motion?
25 **MR. WALTERS:** Dr. Rabrich --

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2 **CHAIR RABRICH:** Yes, Dr. Walters.
3 **MR. WALTERS:** -- make a comment. So
4 my -- my REMSCO actually had sent a letter
5 recommending or suggesting that we extend this to
6 2030. Now, I think a lot of us agreed.
7 **MR. GREENBERG:** Hold the mic a little
8 bit closer.
9 **MR. WALTERS:** Sorry. That the -- a
10 lot of us agree that the time has come, that we see
11 the issues with the C.C. standard and some people
12 probably propose moving it forward sooner. The
13 reason for that 2030 deadline was that a lot of the
14 C.C.s going to the paramedic level in our region are
15 not using the bridge which is available to them but
16 they are doing it through advanced standing in the
17 local paramedic class.
18 And there's some advantages to that
19 locally. That class only runs every other year just
20 because of numbers. And so the next one isn't until
21 January of 2025, the beginning and then, January of
22 2027. So the concern was the ability for those
23 existing C.C.s., particularly in Allegheny County as
24 mentioned to be able to have time to go through the
25 local paramedic program and -- and become paramedics.

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2 Now, after hearing yesterday from --
3 from Bonnie, from Allegheny County, they've come up
4 with a solution to address that for the majority of
5 their C.C.s. And looking at the other two counties
6 in our -- our REMSCO, there's only a handful of -- of
7 C.C.s. So I think in light of that, there's not a
8 whole lot of practicing C.C.s who will not be
9 retiring in the next couple of years in our region
10 that would perhaps benefit from a prolonged deadline.
11 Which I think, again, a lot of us would -- would
12 argue against a prolonged deadline. So that said, I
13 do think that we need to look at the availability of
14 both the bridge in our regions and be discussing this
15 and local paramedic programs to get as many of these
16 C.C.s to paramedics, you know, to the paramedic level
17 as quickly as possible.
18 My -- my point here and that I'd like
19 to bring up and -- and not that it changes where
20 we've come from or -- or where we are right now but
21 these timelines or proposed timelines, we discussed
22 when we first discussed the sunsetting of the C.C.s
23 and we didn't set a deadline and many of us at the
24 time wanted to set a deadline.
25 And I think because of some of these

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2 discussions, some of these C.C.s across the State
3 thought this is going to continue indefinitely. I
4 will be able to continue with C.M.E. re-
5 certification. And some -- for some of them, that
6 was a disincentive to maybe bridge sooner than now.
7 So we are where we are but I think
8 that as we go forward and we make changes from this
9 body or we change our -- our educational standards,
10 our scope of practice, things of that nature, I -- I
11 would encourage us to really set some guidelines from
12 the beginning -- timelines from the beginning and not
13 kick the can down the road because I think it really
14 then puts our providers at a disservice of trying to
15 get them the education to upgrade, to change their
16 level or to make appropriate decisions for their
17 career.
18 You know, they could have had several
19 more years to do this and -- and granted they had the
20 warning. I'm not saying they didn't but because we
21 didn't push the issue and there was no deadline, many
22 of them said, well, I'll just wait to see how this
23 plays out. And -- and I think that -- that -- that
24 puts them in a position that they could have made a
25 better, more opportune choice sooner had we

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2 established firm timelines from the get go.
3 **MR. GREENBERG:** So Dr. Walters,
4 correct me if I'm wrong, is what you're saying is you
5 believe that there should be a defined sunset date,
6 possibly longer like 2030, but that the bridge
7 program maybe ends in 2027 and those who still want
8 to bridge after that would have to use advanced
9 placement through a traditional paramedic program
10 with it.
11 **MR. WALTERS:** So that wasn't what I'm
12 saying but I think that's an option. What -- what I
13 -- what I was saying in a round about way I was
14 saying that there are some people that I think would
15 like, you know, to see the sunsetting before 2027. I
16 think there are some like my region who sent a letter
17 saying it should be longer 2030.
18 I think in light of what we've heard
19 from Allegheny County yesterday and my region and
20 looking at the data and the number, the hand full of
21 providers at the C.C. level, again, in our region, I
22 personally think that the 2027 deadline is -- is
23 appropriate.
24 **MR. GREENBERG:** Right.
25 **MR. WALTERS:** That again, my REMSCO

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2 sent a letter saying they think it should be 2030 but
3 I think looking at the advances since that letter was
4 drafted in our last meeting and looking what's going
5 on across the region in Allegheny County like we
6 heard yesterday, I -- I think 2027 is a reasonable
7 time frame.
8 **CHAIR RABRICH:** Yeah. Yes, Dr.
9 Bombard?
10 **MS. BOMBARD:** The -- we have a large
11 percentage, although not a large number of active
12 critical cares in my region. And because of that,
13 the REMAC physicians in my REMAC sent me forth with a
14 message that they would prefer a later sunset date as
15 well because of the -- the large number of practicing
16 critical, it's not even number, it's ninety-five
17 critical cares that are active in our region but our
18 region is tiny, right.
19 And so this is a large percentage of
20 our A.L.S. providers not a large number of our A.L.S.
21 providers. Also, paramedic programs at least,
22 traditional paramedic programs are -- are pretty
23 scant on the ground where we are. And so yes, if you
24 -- you have the opportunity and want to bridge, that
25 is certainly an opportunity for you.

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2 But if you want to go through a
3 traditional paramedic program, you're going to need a
4 little more breathing room. I agree, lesson learned,
5 going forward, we need to set a date where we're
6 going to set a date and we need to be strong about
7 that and brave, right, because otherwise we look a
8 little disingenuous when people interpret this as
9 we're going to sunset by attrition and then, are
10 unhappily surprised when we don't do that.
11 So I think good -- good for us. We'll
12 learn our lesson moving forward. But I did want to
13 communicate that request from my REMAC.
14 **CHAIR RABRICH:** Don?
15 **MR. HUDSON:** So you know, from the
16 Training and Ed committee, many of us on Training and
17 Ed were involved in the first discussions involving
18 sunsetting. Many of us were then involved with at
19 the time Andy Johnson, to formulate what we know now
20 as the bridge. So I'm saying there's a historic
21 perspective. So I agree that setting of time frames
22 may have muddied the waters here back then or the
23 lack thereof.
24 I don't think that was done for any
25 reason other than there was a lot of unknowns at the

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2 time. We certainly didn't have numbers or data or
3 statistics as we do today. The fear or probably
4 assumption was that we are still as a State,
5 especially, in most regions, quote unquote, most
6 regions, so still reliant on C.C. that now's not the
7 time to set that date.
8 That being said, I think we find
9 ourselves in a much different position today. We
10 sort of -- I hope, know what we don't know. We have
11 a better sense of statistics and numbers. I would
12 offer to, if it puts people's fears to rest or -- or
13 gives an option to providers, you know, for whatever
14 reason, if the E.M.T.C.C. has not yet bridged and we
15 are to adhere to these sunset time frames that are
16 proposed.
17 Bridging now would allow them to seek
18 advanced standing in a full paramedic original
19 indefinitely in the future. So it sort of resets
20 their clock at the New York State paramedic level.
21 And quite honestly, unless somebody has a different
22 view or a different slant on it, the only thing the
23 bridge doesn't give you is the ability to leave New
24 York State as a paramedic because you don't qualify
25 for National Registry.

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2 Other than that, you are a New York
3 State paramedic as am I. So there's really no
4 downside to it. And -- and I guess, if a region or a
5 provider or an agency had -- like we saw with
6 Allegheny County has concerns, please bring them to
7 us and we can find a way to keep you going.
8 I guess, in closing -- I'll leave it
9 as the question as I see it from Training and Ed
10 before this committee is, do you extend these time
11 frames. Do you stick to these time frames or do you
12 alter these time frames? Other -- unless somebody
13 has something that we're not seeing.
14 **CHAIR RABRICH:** Thanks. Dr. Dailey?
15 **MR. DAILEY:** So I'm extremely
16 impressed by what Allegheny County did in seeing a
17 problem coming up with a solution, seeking -- seeking
18 out and then, moving towards a solution. You know,
19 we're -- we're speaking out of both sides of our
20 mouths at this table, right? Out of one side we're
21 saying we need to advance community paramedicine,
22 support advancement of this profession, continue to
23 do everything that we can to improve patient care in
24 the State.
25 Now, the other is that we will

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2 continue to maintain a credential that has not had
3 updated education since before I graduated from
4 medical school. Right. That's really problematic.
5 Quite frankly, I was originally asked about that date
6 of 2027 and I thought it was too long.
7 I still brave, we look at Monroe,
8 Livingston County, you know, region who removed
9 critical cares from their practice ten years ago,
10 maybe more. All right. And I see that there are,
11 you know, significant portions of the State that
12 still do have penetration of those critical cares.
13 I think 2027 is giving us three years
14 -- three more years for people to make the right
15 decision and move up or down. And for us to just
16 finally to sunset, this vestigial piece of New York
17 State E.M.S. history, so that we can move on at an
18 appropriate national scope of practice level.
19 **CHAIR RABRICH:** Thanks. Don?
20 **MR. DUVALL:** Do you know there is
21 another way that you could manage these timelines?
22 And that would be in the next round of collaborative
23 protocol updates, just to remove the scope of
24 practice for critical care and replace it with
25 A.E.M.T. No scope of practice, no protocols, that'll

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2 set your timeline wherever you want it. And that's
3 within the purview of the SEMAC.
4 **MR. GREENBERG:** I think that's an
5 option.
6 **CHAIR RABRICH:** I think the goal here
7 is for a nice smooth transition and for agencies and
8 providers to be prepared for when that time is going
9 to come. So that it can transition in a manner that
10 it -- and I will say and kind of Don and to your
11 point, there's -- there's been some of the feedback
12 that's come back that said, okay, well, why don't you
13 let C.C.s just sunset.
14 You know, when they -- or so -- let
15 C.C.s go on forever to refresh until they leave the
16 field but just continue to scale back what they can
17 do. Kind of similar -- kind of facet of what you're
18 talking about. And I think you achieve that by
19 setting a sunset date and by allowing them to go to
20 A.E.M.T.
21 Essentially, you're saying they're
22 moving to that protocol set but you're also leaving
23 the card that says A.E.M.T. on that as well.
24 **MR. DUVALL:** For the record, I was
25 involved in Training and Ed when this topic first

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2 came up years ago. And I supported the idea of
3 removal by attrition. We didn't set a timeline and a
4 few people have admitted that. My understanding at
5 that time was we were going to allow for critical
6 care techs to age out through continuing medical
7 education.
8 I believed that was the right thing to
9 do at the time. Over the years, my views personally
10 may have changed a little bit, but I'm a firm
11 believer in the idea that you don't make a promise
12 you're not willing to keep. And if we made that
13 promise in the beginning, I don't really feel right
14 about tagging a timeline to it now.
15 But that's why -- that's why I offered
16 an alternative pathway to get where you want to be.
17 **CHAIR RABRICH:** Thanks. Dr. Winslow,
18 did you have something else you wanted to?
19 **MR. WINSLOW:** Yeah, and just -- just
20 remind everyone, it's not like they're not going to
21 be providers in the system. You know, they're going
22 from an unregulated and un -- not reviewed curriculum
23 as an E.M.T.C.C. to something that we have good
24 control over the A.E.M.T. So I -- I think that
25 they're going to become an A.E.M.T. as a positive at

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2 that time. It's not that they're disappearing.
3 **CHAIR RABRICH:** Right. Thank you.
4 Would someone care to make a motion with regards to
5 Training and Ed's?
6 **MR. WALTERS:** Uh-huh.
7 **CHAIR RABRICH:** Oh, Dr. Walters, did
8 you want to say something?
9 **MR. WALTERS:** Just -- no, I was going
10 to say I -- I agree with Dr. Winslow to a -- a degree
11 but I think there's also the potential that they are
12 losing some skills and some things that are currently
13 in their scope or that they're able to provide to the
14 public in a response that they would not be able to
15 at the A.E.M.T. level.
16 And I'm not disagreeing about the --
17 the upkeep of the curriculum or the standard or the
18 regulation but -- but that is a very real effect in
19 some of these areas.
20 **MR. DUVALL:** To be honest though, I
21 keep hearing the -- the comments about how the
22 curriculum is old and how the curriculum hasn't been
23 updated. But I should probably remind you with
24 C.M.E. re-certification. I said in the class of 2000
25 and obtained my first paramedic certification, I did

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2 maybe one traditional refresher.
3 Since then, I have not been back to a
4 traditional paramedic refresher. I have not seen the
5 curriculum as it updates other than through C.M.E.
6 re-certification and keeping my skills up. So if the
7 C.M.E. programs that the current critical care techs
8 are enrolled in and engaged in are robust, the idea
9 that the C.C. original curriculum hasn't been updated
10 in thirty years shouldn't be a factor. We're not
11 offering that class anymore to anybody.
12 **CHAIR RABRICH:** All right. So with
13 regards to what we've been asked by Training and ED
14 does someone want to make a motion to either support
15 this as is, as amended, not supported and anyone have
16 an action item?
17 **MR. DOYNOW:** I will make a motion that
18 we support the motion from Educational committee --
19 **MR. COOPER:** Second.
20 **MR. DOYNOW:** -- as it stands.
21 **CHAIR RABRICH:** Is that -- yeah.
22 Repeat the motion again, I'm sorry.
23 **MR. DOYNOW:** That -- that we support
24 the -- the -- the suggestion of the education
25 committee as --

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2 **CHAIR RABRICH:** Thank you and I think
3 --
4 **MR. DOYNOW:** -- as stated.
5 **CHAIR RABRICH:** Yes. And Dr. Cooper
6 seconded it, I believe.
7 **MR. DOYNOW:** Okay.
8 **CHAIR RABRICH:** There's been a lot of
9 discussion, so all those in favor of this, raise your
10 hand. One, two, three --
11 **MR. GREENBERG:** (unintelligible).
12 **CHAIR RABRICH:** Yeah, can -- maybe
13 we'll do a roll call on this one. Can we do that or
14 what's that? It was requested, Dr. Greenberg. Do we
15 have to do it if it's requested?
16 **MR. GREENBERG:** It's not --.
17 **CHAIR RABRICH:** Wait, let me -- yeah,
18 we can.
19 **MR. GREENBERG:** You need two hands or
20 you can?
21 **CHAIR RABRICH:** All right. Let --
22 let's try hands again and see if we can get a quick.
23 All in favor? Raise them high. Three, four, five,
24 six, seven, eight.
25 **MR. GREENBERG:** I'll need two, eleven,

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2 twelve.
3 **CHAIR RABRICH:** All right. All
4 opposed? One, two. Okay. Abstentions? Two and
5 two. So I have twelve, two and two, the motion
6 carries.
7 All right. Any other items of new
8 business? All right, seeing none, I will entertain a
9 motion to adjourn. All right. All in favor of
10 adjourning? Excellent. Thank you.
11 (The meeting adjourned at 9:50 a.m.)
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1 2/7/2024 - Medical Standards - Troy, New York
2 STATE OF NEW YORK
I, ANNETTE LAINSON, do hereby certify that the foregoing
3
was reported by me, in the cause, at the time and place,
4
as stated in the caption hereto, at Page hereof; that
5
the foregoing typewritten transcription consisting of
6
pages 1 through 95, is a true record of all proceedings
7
had at the hearing.
8
IN WITNESS WHEREOF, I have hereunto subscribed
9
my name, this the 27th day of February, 2024.
10
11
ANNETTE LAINSON, Reporter
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