

12/4/2024 - Medical Standards - WebEx
NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS

DATE: December 4, 2024

TIME: 8:05 a.m. to 9:22 a.m.

CHAIR: JEFFREY RABRICH

VENUE: WebEx

Reported by Danielle Christian

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2 **APPEARANCES:**
3 ALBERT SHIH
4 ARTHUR COOPER
5 BRIAN CLEMENCY
6 BRIAN WALTERS
7 DANIEL OLSSON
8 DAVID KUGLER
9 DAVID VIOLANTE
10 DONALD DOYNOW
11 DONALD DUVALL
12 DONALD HUDSON
13
14 DOUGLAS ISAACS
15 GINA WIERZBOWSKI
16
17 JARED KUTZIN
18 JASON WINSLOW
19 JEFFREY TAKAMI
20 JONATHAN WASHKO
21 MAIA DORSETT
22 MICHAEL DAILEY
23 MICKEY FORNESS
24 MIKE MCEVOY
25 RYAN GREENBERG
STEVEN DZIURA
THERESA ALLEN
YEDIDYAH LANGSAM

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(The meeting commenced at 8:05 a.m.)

CHAIR WALTERS: All right. All right.

Good morning. As you see, Dr. Rabrich could not be here today. And so I have agreed to chair this meeting and this meeting only, and he guarantees me he will be back for the next Medical Standards meeting.

I'm going to hold him to that, but I'd like to call the Medical Standards meeting to order. And as you -- if you haven't signed already, the attendance sheet is going around.

We have a few items on the agenda today. Mostly updates in that. And so if there's no other issues, I think we'll just get right into the agenda.

Starting with our old business, the first thing on the agenda is the clinical data integrity TAG. And I know Dr. Dorsett, there was some discussion at Quality Metrics yesterday and some other conversations about data integrity.

If you'd like to give us an update.

MS. DORSETT: Move this a little closer. So to remind people, the goal of the data integrity TAG, which is really a data quality TAG, is

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2 to make recommendations to improve the quality of
3 data that we are collecting for New York State, and
4 really E.M.S. data and the domains of data quality
5 are completeness, consistency, accuracy, timeliness,
6 accessibility and consistency.
7
8 Initially, when we met, we first
9 thought about what are the domains that all E.M.S.
10 data is used for, and we came up with patient care
11 and quality improvement, public health research, and
12 reimbursement.
13
14 And we've decided that we're going to
15 first focus on patient care and quality improvement
16 because that's sort of like distance from the patient
17 and clinical care.
18
19 We've come up with sort of two initial
20 focuses. We've developed a survey to get people who
21 are using E.M.S. data for those purposes to talk
22 about what are the facilitators and barriers
23 currently so that we can use that data to make
24 recommendations.
25
26 One of the things that we're looking
27 for, I've developed -- we have it as a red cap is
28 people to pilot. It's pretty clunky right now to
29 pilot it and then get some people who you interact

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2 with, like stroke coordinators or trauma coordinators
3 to give us feedback on the survey before we
4 distribute it more widely.
5 The second component of that is using
6 sort of a case study to look at the root cause of why
7 we have lack of data completeness or accessibility.
8 And it's sort of fortuitous that the
9 National Airway Collaborative is happening. We're
10 trying to use the State data bridge to look at
11 verification of advanced airways with capnography.
12 I think this has a lot of relevance
13 both from the B.L.S. I-gel project, as well as
14 thinking about the expansion of scope of practice in
15 New York State.
16 One of the things that we found in our
17 region when we looked to pull data from the bridge is
18 that a lot of the advanced airways are just missing
19 from the bridge. And it's different. It's not just
20 one vendor where that data is missing.
21 And so we're proposing that what we do
22 is we do a root cause analysis of what are all the
23 failures. Like why are we not able to pull
24 intubations, right, as a region to see like how many
25 intubations are happening in a region and are those

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2 things being verified.
3 So that's -- that's like the nitty
4 gritty in the role while we collect more information
5 about all the other stakeholders and data for patient
6 care and quality improvement.
7 **CHAIR WALTERS:** Thank you. I know
8 there was a lot of discussion about some of that
9 missing data, things not getting from the bridge, and
10 then conversations about where do we go from here and
11 how do we fix it?
12 Which is ultimately I think what we're
13 looking for. So -- so I appreciate the update. I
14 don't know if anybody else has any other thoughts or
15 concerns on the data integrity as we move forward, or
16 any comments on that? Dr. Dailey?
17 **MR. DAILEY:** I think the only thing I
18 -- I really have to add is that I'm really glad that
19 Dr. Dorsett's engaged in this, looking forward to
20 this moving forward.
21 I think this is probably the single
22 most important thing that we can do in terms of
23 advancing E.M.S. in New York State. We have to have
24 good data.
25 We have to be able to have this data

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2 accessible for patient care and hospitals, not only
3 in the emergency department, but ongoing. And it has
4 to be available to those data registrars. This is a
5 significant issue at the STAC.
6 It's a significant issue for stroke.
7 And it's a significant issue every day in the
8 emergency departments. So I am extremely excited
9 about where we have a real opportunity here.
10 **CHAIR WALTERS:** I would agree. And I
11 think that as we look at how we make protocol changes
12 or scope of practice changes, we want to make them
13 data-driven decisions and the ability to get good
14 data.
15 Obviously, we need that good data, not
16 just data because if we make decisions off the wrong
17 data or incomplete data, then that obviously isn't
18 going to be the right choice for us.
19 So I think this is very important, I
20 appreciate you bringing that forward and continuing
21 to drive it forward. Moving on then, the next item
22 on the agenda under old business is the blood
23 implementation. And is Gina in the room there? Here
24 she is. Thank you.
25 **MS. WIERZBOWSKI:** Good morning. Just

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2 a quick update on the blood regulations, as the group
3 is most likely aware the law adding the ability for
4 ambulances and A.L.S.F.R.s to carry and administer
5 blood products prehospital has been signed.
6 So we have been working diligently
7 over the last year or so on a framework. We've
8 actually been working with Wadsworth's input and they
9 have been extremely helpful in guiding us and giving
10 us different suggestions and things that we need to
11 take into consideration.
12 At this point, we are ready to
13 reconvene a meeting of our original advisory group
14 that we convened last year. I think it was about
15 March or so.
16 So we're -- Ryan would really like to
17 try to have that meeting in December so we can move
18 them forward because, obviously, regulations take
19 time. So if you were on that original group, please
20 look for an invite.
21 If you would like to be put on that
22 group to sit in and hear what we have, what we've
23 been working on, you're more than welcome to join us.
24 And the package will likely be put
25 forth as an emergency enactment because we understand

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2 (Pages 5 to 8)

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2 the need to give guidance to agencies that are
3 willing to participate in a program.
4 **CHAIR WALTERS:** And I guess, Gina,
5 just one question. What is -- is there any proposed
6 timeline at all?
7 **MS. WIERZBOWSKI:** I -- so
8 theoretically, we would like to have the package to
9 regulatory affairs by early next year to start the
10 process. We have already done a concept paper for
11 them, so they know that this package will be coming
12 and that's the first step in the process.
13 And they -- we received no negative
14 comments or, you know, indications that they wouldn't
15 be from the group that we would be unable to move
16 that forward as an emergency regulatory package.
17 I -- I mean, generally speaking, a
18 regular pathway is about two years, so we're hoping
19 that putting it forth as emergency will shorten that
20 up quite a bit.
21 **CHAIR WALTERS:** All right. Thank you
22 very much. Any questions for Gina? Dr. Isaacs?
23 **MR. ISAACS:** Good morning. A.B.B.R.
24 are coming out with their recommendations in January.
25 Are you going to be reviewing those to see to kind of

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2 align the -- the regs with those?
3 **MS. WIERZBOWSKI:** Yes, we are aware
4 those are coming out and we will definitely be taking
5 a look at those, Dr. Isaacs, to make sure that we
6 don't miss anything important in that update.
7 **MR. ISAACS:** Thank you.
8 **CHAIR WALTERS:** Any other questions or
9 comments?
10 **THE REPORTER:** If I can have your last
11 name, Gina?
12 **MS. WIERZBOWSKI:** Gina, G-I-N-A, last
13 name W-I-E-R-Z-B-O-W-S-K-I.
14 **CHAIR WALTERS:** All right. Thank you,
15 Gina. All right. Moving on then to new business.
16 That takes us to the collaborative protocol updates
17 and approval.
18 I know we discussed this at the last
19 meeting, I think in depth. Most of those changes we
20 have already discussed, I think. But there was a
21 collaborative protocol working group meeting
22 recently.
23 We did talk about a few other things;
24 the change log and those protocols are in Boardable.
25 But Dr. Dailey, do you want to just give a couple

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2 quick updates, if you would?
3 **MR. DAILEY:** Thank you. So there's
4 two different ways we can do this. I can certainly
5 read the entire change log as we have it in the
6 Boardable app already, or we can just go through
7 quickly and if there's any discussion, we can go to
8 that.
9 And I think that probably would make
10 more sense.
11 **CHAIR WALTERS:** I think unless anyone
12 has any objections. We've gone through this at the
13 last meeting. I don't think there were many
14 substantial changes since then. And so -- and it is
15 in Boardable for everyone to review.
16 So I think if you just want to hit the
17 highlights, that would be sufficient.
18 **MR. DAILEY:** Thanks, Brian. So the
19 first is cardiac arrest. Adult asystolic or P.E.A.
20 arrest right the way through to ventricular
21 fibrillation, I suspect every physician at this table
22 has a slightly different opinion on this.
23 We had long discussions and decided
24 that we would establish a maximum of five doses of
25 intravenous epinephrine as part of the course of that

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2 cardiac arrest.
3 And that's something that I think is
4 well open to discussion here should or if anybody
5 have an opinion. No opinions this morning? Wow.
6 **MR. MCEVOY:** Can you substitute
7 saline?
8 **MR. DAILEY:** It has to be
9 enthusiastic. As I said, I'm not going to go through
10 all of the cardiac arrest ones. Lidocaine added as
11 with appropriate indications.
12 One wording change that we think is
13 particularly important giving paper that came out of
14 Oregon. Consider vector change for refractory
15 shockable rhythms for all provider levels.
16 In my practice, that's three shocks.
17 And then change that -- change the vector of the
18 pads. I think the most important thing here is
19 actually going to be the educational element that's
20 got to go into our -- our teaching.
21 Clarified in key points over allergy
22 and anaphylaxis that C.F.R. and higher may use an
23 autoinjector. E.M.T. and higher may use syringe
24 epinephrine. Adolescent agitated patients, we
25 removed haloperidol, it is very rarely used anyway.

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 2 Added in medical control option for
 3 olanzapine, either sublingual or intramuscular. We
 4 added the language back that if an agitated patient
 5 goes into cardiac arrest, refer to the appropriate
 6 protocol and give bicarb.
 7 Agitated patient adults, again,
 8 removed Haldol, added in olanzapine, and the same
 9 language for including bicarb. Pediatric bradycardia
 10 added in considering chest compressions from marked
 11 bradycardia with depressed mental status. This is
 12 all per A.H.A.
 13 We reordered some things, including
 14 epinephrine and atropine in order to reflect that
 15 epinephrine would be the first line drug in pediatric
 16 bradycardia.
 17 Pulmonary edema, sublingual nitro is
 18 allowed under A.E.M.T. and higher as a standing
 19 order. I.V. is restricted to paramedic only. And as
 20 a reminder to this group that is I.V. bolus dosing
 21 only, not drips.
 22 Hypoglycemia, we had a north country
 23 moment and we made sure to add maple syrup as an
 24 option for treating hypoglycemia. We stole that from
 25 Vermont. But we did note that this has to be New

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 2 York maple syrup.
 3 **CHAIR WALTERS:** I think that was the
 4 most robust discussion we had actually on the call.
 5 **MR. DAILEY:** I think it was actually.
 6 Heat emergencies, we changed -- we added palms and
 7 soles as cold pack placement locations, so some of
 8 this was very important discussion.
 9 Amputation, we added moxifloxacin for
 10 all levels and Cefazolin for paramedic only for
 11 amputation with delayed extrication given that an
 12 amputation is nearly by definition a open fracture.
 13 And we clarified moxifloxacin is for
 14 adults only and we added pediatric dosing. Same
 15 under musculoskeletal trauma. Trauma associated
 16 shock, we all remain hopeful for the initiation of
 17 pre-hospital blood products and are really thankful
 18 that department's going to pursue the idea that it's
 19 being done under emergency regulations.
 20 Clarified T.X.A. indications for O.B.
 21 as well. Under formulary, we clarified the
 22 requirement for one antiarrhythmic. Obviously, an
 23 agency can carry two should they choose.
 24 And an oxygen administration under
 25 E.M.T., we added supraglottic airway placement if

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 2 equipped and trained in the adult cardiac arrest
 3 patient as regionally approved.
 4 Clarified under A.E. -- A.E.M.T.,
 5 supraglottic airway instead of advanced airway.
 6 Removed the requirement for a viral filter under key
 7 points. Revised that providers may only place an
 8 endotracheal tube or a supraglottic airway if they
 9 utilize waveform capnography for its initial and
 10 ongoing monitor of patient airway patency.
 11 And added for E.M.T. or higher
 12 consider PEEP five centimeters of water titrated up
 13 to ten centimeters of water under medical control
 14 considerations additional PEEP and that's if equipped
 15 and trained with PEEP credits. Thank you.
 16 **CHAIR WALTERS:** Very good. Thank you.
 17 Dr. Dailey. I just have one question for you. Maybe
 18 you know, because I know in our region the RTAC was
 19 talking about moxifloxacin versus cefazolin for --
 20 for frac -- open fractures and amputation.
 21 Has the STAC weighed in? Have they
 22 approved that or do you know? Have they looked at
 23 that at all?
 24 **MR. DAILEY:** The STAC had weighed in
 25 on -- on the idea of giving in -- giving antibiotics.

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 2 **CHAIR WALTERS:** Okay.
 3 **MR. DAILEY:** Since moxifloxacin is
 4 relatively expensive medication, my expectation is
 5 that it will probably be a request that we switch
 6 that to Keflex at some point, rather than moxiflox.
 7 But the moxifloxacin is the only oral
 8 antibiotics that have been used by the -- by the
 9 military for a long time for open fractures. So
 10 that's where it came from.
 11 **CHAIR WALTERS:** Understood. Thank you
 12 very much.
 13 **MR. DAILEY:** Yeah, that -- that by the
 14 way, actually was driven by trauma. Brian, that was
 15 -- that was driven by -- by trauma because it was one
 16 of the -- one of the metrics that was most frequently
 17 missed at the trauma centers as they were looking at
 18 their open fractures.
 19 **CHAIR WALTERS:** Thank you. And just
 20 as a reminder, if we approve these and move these to
 21 the SEMAC today, these would be published -- these
 22 changes will be published in January, and then would
 23 not take effect until July 1st, consistent with some
 24 of the timeframe discussions we've had over the last
 25 year.

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2 So with that being said, I know a lot
3 of people were on that collaborative protocol
4 discussion that are in the room today. Is there any
5 other comments, discussion or concerns about what's
6 presented in the change log on Boardable or anything
7 that Dr. Dailey has highlighted for us.
8 If not -- if there's no discussion or
9 concerns, then I think I would entertain a motion to
10 approve the collaborative protocol changes and change
11 log as presented and to move that forward to the
12 SEMAC. Dr. Dailey made a motion. Is there a second?
13 **MR. WINSLOW:** Second.
14 **CHAIR WALTERS:** Dr. Winslow, any
15 discussion?
16 **MR. WINSLOW:** I'm in support of the
17 changes.
18 **CHAIR WALTERS:** I'm sorry, can you
19 repeat that?
20 **MR. WINSLOW:** Sorry, I'm in support of
21 these changes.
22 **CHAIR WALTERS:** Very good. All right.
23 Then if there's no other discussion, all in favor,
24 say aye.
25 **ALL:** Aye.

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2 **CHAIR WALTERS:** Any opposed? Any
3 abstention? The motion carries. And we'll take that
4 to SEMAC later today. Thank you. Thanks Dr. Dailey.
5 And then moving on under new business,
6 the next item on the agenda is a proposed glucagon
7 pilot project. And I think Dr. Winslow, if you would
8 like to discuss that.
9 **MR. WINSLOW:** Yes, I have E.M.T. Jeff
10 -- Jeff Takamine, T-A-K-A-M-I-N-E from the Flanders-
11 Northampton Volunteer Ambulance Company in Suffolk
12 County.
13 This project was his idea. It went
14 through the Suffolk County REMAC on two different
15 occasions. And a couple of updates were made and
16 there is support from the region to request a pilot
17 program be done.
18 Since it's his project, I thought he
19 could present it. Theresa, you have the slides.
20 Thank you.
21 **MR. TAKAMINE:** Good morning. My name
22 is Jeffrey Takamine. I'm the chief of operations for
23 Flanders Northampton Volunteer Ambulance, which is a
24 small agency down on Long Island, right where it
25 forks. So we're pretty far out.

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2 I'm just going to wait for the slides
3 so I could go through here.
4 **MR. MCEVOY:** It's a State projector.
5 **MR. TAKAMINE:** All right. That's
6 fine. It's all -- I think Dr. Winslow uploaded it to
7 Boardable so everybody can look at it. Basically, I
8 had this idea because the B.L.S. provider cannot
9 really do anything for a hypoglycemic patient, if
10 they're unable to accept oral glucose or they're
11 unconscious or anything like that.
12 What's it? Perfect. So I proposed
13 this to my medical director, which is Dr. Lincoln Cox
14 and I also ran it past Dr. Winslow. And they both
15 supported the idea.
16 There are other states that surround
17 us that allow this for B.L.S. providers as well as
18 Oregon also allows and trains lay people to
19 administer I.M. glucagon in emergencies.
20 So it's definitely proven to work in
21 other states. So I do think that it will improve the
22 outcomes of patients in the absence of an A.L.S.
23 provider.
24 **MR. WINSLOW:** Do you want to have them
25 skip down to where the protocol is, where they

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2 updated it?
3 **MR. TAKAMINE:** Yeah.
4 **MR. WINSLOW:** Could you scroll down to
5 where the protocol is, where he redlined it. There
6 it is.
7 **MR. TAKAMINE:** That's how the current
8 protocol reads as it is. I did make a template to
9 change if we were to move forward. It is actually
10 the next slide that the actual changes are shown.
11 They are shown in red.
12 Yeah. So right now, at E.M.T. level,
13 it stops after administerial glucose and then it's
14 just transport to the hospital. So the proposed
15 change is to check a blood glucose level and identify
16 if the patient is hypoglycemic, and then administer
17 I.M. or I.N. glucagon at the appropriate dose and
18 request A.L.S. as soon as possible.
19 And then if A.L.S. was to arrive on
20 scene or once you get to the hospital to reevaluate
21 blood glucose to document a trend. Yes.
22 **MR. WINSLOW:** Can you scroll down a
23 little bit more? A little more. Good. Anything
24 else you want to cover?
25 **MR. TAKAMINE:** I don't think so. So

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2 this project is for adults only. I did some data
3 mining and the best information I was able to get
4 over a ten-month period is there were seventeen
5 administrations of glucagon by A.L.S. providers.
6 There were -- and out of a total of
7 three hundred plus hypoglycemic patients, fifty-nine
8 had been administered oral glucose. Many patients
9 improved by taking their own carbohydrate --
10 carbohydrate rich or maple syrup type beverage or
11 substance.
12 And there were only thirty-one
13 administrations of I.V.D.-10 by A.L.S. When I
14 further looked into this, there were eleven cases
15 where a B.L.S. provider had a documented low blood
16 sugar with altered mental status and would've been a
17 candidate for this because they were not able to
18 receive oral glucose.
19 I know they're small numbers, but
20 those are important cases if one of those could be
21 helped. I also know that there are several agencies
22 surrounding the -- the Flanders-Northampton Agency
23 willing to participate and we could buy the --
24 purchase product in bulk, which would decrease its
25 cost, which was one concern.

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2 So we'll entertain any questions, but
3 we're essentially moving what is currently an
4 A.E.M.T. skill to the B.L.S. provider since they are
5 already trained under check and inject to give I.M.
6 administration of epinephrine under the anaphylaxis
7 protocol.
8 There would really be no additional
9 burden on education other than to go over the
10 medication and how to reconstitute it.
11 **CHAIR WALTERS:** Do you have anything
12 else you wanted to say? Okay. Any discussion?
13 **MR. DAILEY:** We've actually had
14 extensive -- extensive discussions in the past about
15 the idea of using intranasal administration for
16 glucagon.
17 Most significantly, the ideas behind
18 why you would give an intranasal medication as we do
19 with Naloxone. And most of the concerns for provider
20 safety are not things that are significant there
21 initially in those hypoglycemic cases that require
22 the use of glucagon because the patient is completely
23 unresponsive.
24 I would really caution us to stay away
25 from intra -- intranasal administration. If somebody

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2 needs to have hypoglycemia corrected, that drug
3 should be given intramuscularly so we know exactly
4 what the administration is, we know that the
5 medication has gotten where it's going to go.
6 I would suggest that for basic life
7 support providers at basic life support agencies that
8 don't have that immediate A.L.S. backup, this is an
9 excellent idea. And I think the idea of scope creep
10 while it be -- is real, in this case, this is
11 something that actually will potentially benefit, as
12 you said, Jason, a small portion of patients. But I
13 think it's real.
14 We've tried to get the information
15 before in terms of how many patients that are treated
16 by E.M.S. arrive at the hospital with persistent
17 hypoglycemia to really know what the answer is.
18 And we've never been able to get that
19 information. It would be nice to be able to know
20 what that denominator really is. But once we get
21 past this, we remove the intranasal.
22 This is a project specifically for
23 basic life support agencies without A.L.S. backup and
24 get it done with under standard oversight. I think
25 it's a very reasonable thing.

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2 I would not do it as a pilot in
3 Suffolk alone. I would open it up Statewide because
4 there are significant number of B.L.S. agencies that
5 this might apply to who would be interested in doing
6 it.
7 But I would absolutely make sure that
8 this is a very clear, if trained and equipped, and
9 not something that is a mandate for any B.L.S. agency
10 out there that does not have the financial
11 wherewithal to be able to carry this expensive
12 medication.
13 **MR. WINSLOW:** Thanks, Mike. And the
14 other thing it prevents is that question of how
15 secure is this airway? You know, right now, when
16 you're -- when you're dealing with a patient with
17 hypoglycemia, they're not normal mental status at
18 baseline.
19 Are you going to take the risk of --
20 of having a lot of potential airway compromised? You
21 know, you've seen the patient show up in the E.R. and
22 they've got like pink drool coming out of their mouth
23 and they're not really -- that's not a good airway.
24 I'd rather give it intramuscular
25 glucagon than oral glucose in a questionable airway.

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 2 Is there any other thought or discussion? Yeah.
 3 **MR. DUVALL:** Yes, I can appreciate the
 4 concept. But as Dr. Dailey alluded to, I'm ever
 5 mindful of scope creep as Dr. Dailey called it, or
 6 skills creep as I refer to it.
 7 You -- you know, we at various times
 8 talk about the increases in duration of E.M.T.
 9 training and the difficulties that poses. But then
 10 we talk about adding things which -- and Dr. Winslow
 11 admitted are -- are very small numbers of patients
 12 that would benefit.
 13 I see this as different and I -- it
 14 actually was brought up as a discussion last week. I
 15 see this as a different sort of treatment than the I-
 16 gel, which, you know, I could -- I could a hundred
 17 percent get behind because that's a -- a definitive
 18 treatment that does have -- have the ability to
 19 affect survivability.
 20 But I really am not sure I'm as
 21 comfortable with adding medications because do we
 22 next month add Versed for basics for active seizures?
 23 Do we add dexamethasone? Do we -- but
 24 -- but the problem is then we wind up in a spot
 25 eventually that we just got through with regard to

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 2 critical care techs versus paramedics.
 3 I would suggest that the A.E.M.T.
 4 level is the place for additions of things like
 5 glucagon for patients. I don't -- I don't know that
 6 I'm comfortable with it being added to the B.L.S.
 7 level. That's just my thought on it.
 8 **MS. DORSETT:** I actually would say
 9 sort of the opposite. I think this is exactly the
 10 type of thing that should be added to the B.L.S.
 11 level, right.
 12 We don't have a lot of data than an I-
 13 gel is better than B.B.M., honestly. But we all know
 14 that people suck at manual ventilation, which is why
 15 I want I-gel at the B.L.S. level because I think it's
 16 actually an easier skill than bag mask ventilation
 17 for a lot of people to learn.
 18 As far as lifesaving, this is
 19 potentially lifesaving if you don't have access. And
 20 honestly, if you think about it, I send patients home
 21 with glucagon who get prescriptions for insulin.
 22 For patients who have glucagon at
 23 home, and it actually falls under the protocol for
 24 people to be able to assist patient in the
 25 administration of medications by a route that you are

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 2 credentialed to do so.
 3 So technically, if a patient has
 4 glucagon at home, an E.M.T. who's credentialed to do
 5 I.M. injection can administer the patient's glucagon
 6 with the assistance of the family already under
 7 protocol.
 8 So this is just expanding for the
 9 patients who don't actually have glucagon sitting in
 10 their house. And untreated hypoglycemia is life
 11 threatening if you don't have access.
 12 And while some places in our system,
 13 right, I have lots of A.L.S. available, I don't think
 14 -- we almost never use glucagon in our system when I
 15 run the numbers to the point where it wasn't actually
 16 a reasonable for us to even keep carrying it given
 17 the cost.
 18 But I think for places that don't have
 19 A.L.S., it makes a lot of sense. Looking at the
 20 data, I don't see that much data to say the
 21 difference between intranasal and intramuscular.
 22 There isn't any data really in
 23 unconscious patients about the difference of
 24 absorption, but in a systematic review that looked at
 25 it in conscious patients, there was no difference in

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 2 the absorption between I.M. and intranasal.
 3 And there is a pre-hospital study that
 4 looking at response to intranasal glucagon for
 5 hypoglycemic patients. The numbers are piddly,
 6 they're tiny.
 7 But there was like thirty-five percent
 8 response for hypoglycemic patients that was all
 9 paramedic administered.
 10 **MR. GREENBERG:** Maia, it could just be
 11 that you're not getting the charts that have all the
 12 glucagon in it. Sorry, sorry, too soon?
 13 **MS. DORSETT:** No, because I look at my
 14 own agency data. I have a glucagon report.
 15 **MR. GREENBERG:** Okay. Just checking.
 16 **MR. WINSLOW:** The -- the original
 17 pilot project that Chief Takamine wanted to do was
 18 for simply intramuscular, which is also a little less
 19 expensive from the vendor that we have on -- had
 20 discussions with.
 21 I -- I think I would like to put it
 22 back to simply, I.M. intramuscular with the idea of
 23 being, let us study it for a year and report back
 24 next year on how this works before we then give it to
 25 the whole state, kind of the way the B.L.S. I-gel

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2 project worked from a region first.
3 They are low numbers and I don't want
4 to keep someone from doing it. If someone else
5 wanted to do this, they could add to our pilot
6 program and I would help them, but I don't want them
7 to have to go through the expense at this point if
8 they have that as a concern.
9 So I -- I'd like to just make it an
10 adjustment that it'd be intramuscular only and for
11 adults and to ask permission to move it forward to
12 SEMAC as an approved pilot program.
13 **CHAIR WALTERS:** Dr. Dorsett, did you
14 have a comment?
15 **MS. DORSETT:** One of the dangers
16 there, right, is that your numbers are too low
17 because then you have ten -- ten patients in two
18 years, whatever it is. So I think getting other
19 people in a similar situation where you have low
20 accessibility to A.L.S. --.
21 **MR. TAKAMINE:** We have fifteen
22 agencies ready to go.
23 **MS. DORSETT:** Okay.
24 **MR. TAKAMINE:** Sorry. That's how we
25 were able to get the vendor, vendor to put the cost

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2 down. We actually have a lot of agencies interested
3 in this project in our Fork's.
4 The the North and South Fork of Long
5 Island is very rural, with long response times and
6 long transport times.
7 **MR. GREENBERG:** I don't think it's a
8 number of agencies willing to participate. I think
9 it's a number of patients that would actually fall
10 into the criteria of not having a paramedic, not
11 having this, not having that, and then needing the
12 intervention.
13 If I remember correctly, and feel free
14 to have -- someone, correct me if I'm wrong, the --
15 the I-gel project, which was supposed to start just
16 in the Hudson Valley region, didn't start just in the
17 Hudson Valley region because Dr. Dailey decided that
18 he wanted Statewide.
19 And -- and it -- and it worked and it
20 helps with the numbers and things like this. And
21 Dave Violante said, he'll be happy to facilitate any
22 new pilot project that is coming along. So that's
23 why he walked up to the table to say he would like
24 to.
25 **MR. VIOLANTE:** I -- I felt it from the

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2 back of the room that this was going to happen. And
3 so I just felt it better just to come right up and
4 say it.
5 So yeah, that is the way it happened
6 with Hudson Valley region. It did go Statewide
7 initially -- immediately. And certainly, I'm happy
8 to help in any way possible to facilitate any of this
9 as well with you.
10 **MR. GREENBERG:** And -- and I will say,
11 you know, just from some lessons learned, I
12 definitely think there are some lessons learned on
13 the I-gel project that we'd want to clean up.
14 This is being proposed as a pilot
15 project, so it would have to go in front of the
16 commissioner to get approval for it. I will tell
17 you; I don't think there is barriers, there is
18 nothing, you know, crazy on this one or, you know, on
19 scope or anything of that nature, but just in -- in
20 process. And I think Dr. Clemency is also --
21 **MR. CLEMENCY:** Yeah, I think this is
22 great. I've got nine agencies that are asking me
23 just about this last week, so I think there'll be
24 wide interest.
25 Just a clarification, it's listed as

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2 one milligram per ml, so we want to just make it one
3 milligram without the (inaudible)
4 **MR. WINSLOW:** Correct, correct. And
5 yes, I would -- I would be happy to have the Suffolk
6 County REMAC foster the program if it wants to go
7 Statewide -- Statewide similar to the way Hudson
8 Valley offered to sponsor the B.L.S. I-gel project.
9 So if there are agencies outside of
10 Suffolk that want to participate, they can -- they
11 could use our REMAC and our -- our office to assist
12 in that process.
13 **CHAIR WALTERS:** And I have just two
14 questions, Dr. Winslow. Number one, like you
15 mentioned, we do check and inject for epinephrine,
16 right, so I.M. injections are already in the B.L.S.
17 scope for -- and most agencies are doing that.
18 What do you see as far as training
19 time for this pilot program or -- I mean, it should
20 be pretty minimal, right? It's just a -- they
21 already check glucoses. They can already do I.M.
22 injections.
23 It's just drawing up a different
24 medicine. So is there any -- do you have any
25 suggestions on proposed training or time or any of

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2 that?
3 **MR. WINSLOW:** Attached to it, if you
4 scroll down, is the educational program. We just
5 don't want to burden everyone with it. You can just
6 read it yourself.
7 But essentially, it's a two to three-
8 hour program where they review the indications and
9 how to reconstitute. And it could be done even
10 faster by some agencies, but we would actually give
11 the materials to anyone that wanted to participate,
12 especially if it went Statewide.
13 **MR. DOYNOW:** Well, it's coming up to
14 my turn. Jason, what's -- what's the cost going to
15 be you buying in bulk?
16 **MR. TAKAMINE:** It depends on the
17 vendor. We were able to get a cost of a hundred and
18 ten dollars per dose with purchase of fifty or more.
19 I was then able to secure because the shelf life is
20 twelve to eighteen months.
21 One of the hospitals willing to take
22 an exchange program, if they're going to move forward
23 and run out toward the end of the shelf life, so I
24 think both of those things will keep the cost down.
25 They were thinking of two

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2 administration purchases, you know, two -- two doses
3 in each unit. And that's why we have about fifteen
4 agencies on board because we would -- did the math.
5 And that's about fifty ambulances. Does that sound
6 right?
7 **MR. DOYNOW:** Yeah.
8 **MR. WASHKO:** Mr. Chair, just a -- a
9 quick thought too on -- on these kinds of situations.
10 You know, that we've got a -- a recent precedence
11 with blood from C.M.S. where they've allowed finally
12 billing for a new, you know, capability on the
13 ambulance by going from A.L.S. one to A.L.S. two.
14 Maybe as we look at these challenges,
15 that's one of our issues. There is no funding to
16 support, you know, in the reimbursement system this
17 type of effort and there should be.
18 So I'm wondering is, while we're also
19 looking at doing this, should we maybe try to lobby
20 at least the State Medicaid Office to see if there's
21 an administration of a drug by a B.L.S. provider that
22 there be an allowance for that maybe at an A.L.S. one
23 rate or something like that.
24 Something to propose out there so that
25 we can start to get these kinds of things paid for

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2 because it -- it -- it shouldn't be a barrier for --
3 for -- for entry for patients.
4 So I think there's an-- there is a
5 precedence now. So let's use -- take -- use that
6 opportunity with the State and at least give it a
7 shot as we move forward.
8 And I don't know if there's other
9 interventions done at the B.L.S. level that also
10 potentially could qualify for that but should be
11 something I would think we'd want to pursue as a
12 group.
13 **MR. WINSLOW:** And can you just state
14 your name for the stenographer?
15 **MR. WASHKO:** I'm sorry. Jonathan
16 Washko. Yeah, and -- and Mike just said we'll call
17 it B.L.S. two. I like that.
18 **MR. TAKAMINE:** Thank you, Jonathan.
19 No, I appreciate that. And again, I think there is
20 value here, even if it's ten or eleven patients in a
21 ten-month period, which is what I was able to
22 identify.
23 That's ten patients who didn't get
24 care that could have. So please consider this.
25 **MR. GREENBERG:** Just one thing. So

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2 what's the ultimate goal at the end? And -- and I
3 ask that from a more of a national level than
4 actually a State level.
5 And this is some things that, again,
6 lessons learned from I-gel and you know, talking
7 about from the beginning, whether it be research and
8 the process and the ultimate goal is -- is the
9 ultimate goal to submit this to, you know, the
10 national side of things and to try and move glucagon
11 to the B.L.S. level is the ultimate goal just to keep
12 this to a -- a State initiative.
13 **MR. WINSLOW:** The idea is --
14 **MR. GREENBERG:** Is there a thought
15 process?
16 **MR. WINSLOW:** -- the idea is to study
17 it first. And that's what I think I -- I -- I'd like
18 to be able to get it as a pilot program. I don't
19 think it's ready for a protocol adjustment.
20 I also want to set the precedent that
21 we do active research and find a problem and fix it
22 and then we then put it into the protocol, like I
23 like that process, like B.L.S. I-gel.
24 And yes, I think as soon as we move
25 this in this direction, there's already four states

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2 that have it as their state protocol. So we could
3 consider adding it at some future.
4 **MR. GREENBERG:** And the reason I ask
5 ahead of time is because we did run into some things
6 now at the end of the I-gel project that are
7 questions that had we been looking at it since the
8 beginning just would've made at the end a little bit
9 easier, nothing bad, nothing negative.
10 But this is why I'm saying, you know,
11 ultimate goal, if we're looking to move the needle on
12 a national front that -- I'm getting the look.
13 **MS. DORSETT:** That's just my face.
14 **MR. GREENBERG:** Yeah. That -- no, but
15 it's the epitome from the quality side if we're
16 looking at it, you know, moving that needle there are
17 some things sometimes that is easier to look at from
18 the beginning, but we should know what that is and
19 maybe ask some questions, and then make sure that
20 they're included.
21 **MS. DORSETT:** And what I was going to
22 say is, right, this is quality improvement around
23 time to hypoglycemia treatment as a metric, which is
24 the thing you need to look at.
25 This is not research and I think it's

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2 important because if this was researched, I would
3 actually have to do community consent to change the
4 protocol.
5 That's why like pilot projects are not
6 things that were like intranasal Splenda for
7 hypoglycemia, right? Like that would be researched
8 where I actually have to get prospective consent.
9 So I think the words we use actually
10 really matter when we call it like a study or a
11 research. We need an I.R.B., we need prospective
12 consent. We need community education.
13 This is saying I have a problem of
14 untreated or delayed treatment of hypoglycemia and
15 time to reversal of hypoglycemia as a patient-
16 centered metric.
17 And we are doing this as a pilot of a
18 change theory of how we're going to change that,
19 which is quality improvement work or else it's
20 sketchy from a research perspective.
21 **MR. MCEVOY:** I would say one other
22 thing about words matter. When Mr. Washko was
23 talking about lobbying for change with C.M.S., we
24 should use the word advocates since as a group we do
25 not, cannot lobby.

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2 **CHAIR WALTERS:** And I do have, I guess
3 just one question. David, since you're still down
4 there, correct me if I'm wrong. I think one of the
5 issues during the I-gel project was the multiple
6 intervention codes for I-gel that we were getting.
7 Is that -- that right? Is this
8 something where we should identify or look at making
9 sure that everybody is using the same intervention
10 code for I.M. glucagon so we can gather good data
11 Statewide as we move forward, like set that up from
12 the beginning?
13 **MR. VIOLANTE:** Right. And so that
14 would be one facet of this in addition to making sure
15 that we get the data and reaching out to agencies
16 involved and -- and that piece of it.
17 And so I think those are facets we
18 have to work out with the vendors to make sure that
19 you're tracking the right data in the right way and
20 they can get the right data in the right way all the
21 time.
22 **MR. WINSLOW:** It's part of the
23 education that's part of that two to three hours is
24 they show exactly how to chart it and where depending
25 on what E.P.C.R. vendor they're using.

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2 **MR. VIOLANTE:** That also ends up work
3 on the vendor side to make sure that while providers
4 are putting that in in the front end, truly that's
5 what's coming out of the back end and then coming up
6 to the State.
7 So certainly, we'll help with that.
8 And I'm sure the data informatics team is -- would be
9 delighted to be a part of ensuring all this happens
10 as well, as we continue to work on data integrity in
11 the State.
12 **MS. DORSETT:** I was going to say that
13 the -- the key data point that actually gets charted
14 is the initial hypoglycemia because the inclusion
15 criteria of the patients you want to look at is not
16 by patients that got glucagon, it's patients who were
17 hypoglycemic.
18 That's the inclusion of who I want to
19 look, right? And what was time to resolution of a
20 patient's hypoglycemia and does -- for patients
21 treated B.L.S.
22 So that's -- right, a B.L.S. care --
23 like a scope of practice where it was cared for by a
24 B.L.S. patient where it's hypoglycemia and have we
25 actually improved time to hypoglycemia treatment by

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10 (Pages 37 to 40)

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2 implementing glucagon.
3 And so I -- I don't haven't reviewed
4 your education, but I think that would be a key
5 component, is hypoglycemia goes into the vital sign
6 field.
7 **MR. WINSLOW:** And the other part of
8 the -- of -- of the project was regardless of the
9 length of time of transport, they have to do another
10 blood sugar either at patient transfer in the
11 emergency room or if an A.L.S. provider showed up and
12 they're transferring care or having assistance from
13 A.L.S.
14 So you have two data points and then
15 we can decide over what time course. When I spoke to
16 a pharmacist who specializes in this area, the time
17 to efficacy for glucagon is ten minutes and so it
18 depends on the transport time.
19 But in this location where that is
20 going to be every transport, this would be very
21 useful.
22 **MR. GREENBERG:** This last question,
23 what's a time period or -- Brian, I think you
24 mentioned the training time on how long you think
25 that would take, but ideal -- when would you be

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2 looking to start?
3 How much lead time do you think you'd
4 need especially understanding, you know, if it did go
5 from a Statewide type?
6 **MR. WINSLOW:** We're ready to go as
7 soon as we approved. In fact, we've been waiting
8 about six months, they've been working on the
9 educational programming, it's already ready to go.
10 **CHAIR WALTERS:** So I guess my only
11 question is while -- I mean, this is where you're
12 going, Ryan, is while the education and -- you've got
13 all the infrastructure in place to go in your region,
14 are we able to at the point where we can roll that
15 out and enroll everybody across the State, number
16 one.
17 And number two from the data
18 collection standpoint, David, and -- and some of the
19 lessons learned from the I-gel project, are there
20 things that we need to put in place on the backend,
21 work with the vendors before just starting this right
22 away. Those would be my only -- only questions.
23 **MR. WINSLOW:** Yeah. I mean, I
24 anticipate that if this is approved as a project here
25 and that SEMAC and SEMSCO it still needs to go to the

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2 commissioner and that's an inherent two to three
3 month delay, would give us the time needed to get all
4 those things in place.
5 **CHAIR WALTERS:** I think that that
6 makes sense and that would be -- I think give us the
7 time to do that. And I would just make sure that we
8 would then get those things in place before it gets
9 signed and before we roll it out that those are
10 already operational. Dr. Clemency.
11 **MR. CLEMENCY:** It would seem with that
12 timeline it would make sense to try to aim for July
13 1st so that agencies can do protocol changes and do
14 training for this if they're interested in doing it.
15 **MR. WINSLOW:** That -- that's
16 acceptable to us.
17 **CHAIR WALTERS:** And then this is just
18 going to be intramuscular at this point. Is that
19 what I hear?
20 **MR. WINSLOW:** Yes.
21 **CHAIR WALTERS:** Dr. Cooper.
22 **MR. COOPER:** Thank you, Mr. Chairman.
23 You know, my New York State geography is probably not
24 as good as that of some others in the room, but if
25 I'm not mistaken, Flanders is the home of the big

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2 duck. Is that right?
3 And it's just really a couple of miles
4 from Riverhead, right, where there's a hospital. You
5 know -- you know, I -- I have no objection to the
6 fundamental premise here.
7 You know, there are patients, of
8 course, who you know, for whatever reason, either
9 can't get to a hospital or can't get A.L.S., you
10 know, in a short period of time and, you know, use of
11 either oral glucose if they're able to tolerate that
12 from airway point of view and so forth, you know, or
13 glucagon, you know, does make sense.
14 But I -- I'm just a little confused as
15 to why Flanders, you know, because you are so close
16 to, you know, a hospital in a -- in -- you know, in a
17 -- in -- in a part of the State that, you know, is
18 not entirely, you know, bereft of resources.
19 And so maybe you could tell us a
20 little bit about that and -- and -- and perhaps why
21 there and what perhaps, you know -- you know, could
22 be done to focus on, you know, the concerns raised by
23 Dr. Dorsett that we're really looking at very rural
24 areas here that might need this rather than, you
25 know, a -- for lack of a better term, semi suburban

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2 area like -- like Flanders.
3 **MR. TAKAMINE:** Yeah, we are very close
4 to a hospital, however, the -- if the patient is
5 unconscious, it is -- it can be difficult to
6 extricate them from the home or wherever they're
7 located, which can take a considerable amount of
8 time.
9 Which if they're unconscious or if
10 they're -- you know, they're heavy and they -- it
11 takes a lot of time to get them out of the home,
12 which then will delay the transport to the hospital,
13 even though we're so close, the actual patient
14 interaction can last forty-five minutes to an hour
15 easily.
16 I've had many circumstances where that
17 has happened and the patient could have benefited
18 from this.
19 **CHAIR WALTERS:** Dr. Dailey.
20 **MR. DAILEY:** It's in -- it's
21 interesting, I appreciate Dr. Cooper's question.
22 It's -- it's not the question I thought Dr. Cooper
23 was going to ask. I thought he was going to ask why
24 we would restrict this to just adult patients, which
25 doesn't make any sense to me at all.

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2 Particularly, when I think about kids
3 new to the treatment of -- of their disease, who may
4 very well end up in situations where they're managing
5 their sugars poorly and end up hypoglycemic. So I
6 would definitely want to allow this for all levels or
7 all ages.
8 **MR. TAKAMINE:** That discussion came up
9 at our REMAC as well, and we thought we would leave
10 it to this group maybe with some guidance to decide
11 traditionally projects are done adult first have.
12 However, I am willing to take the
13 guidance if we think that it should be open to
14 pediatrics. I don't know if Dr. Cooper has a
15 specific comment if this would or would not be useful
16 in children.
17 **MR. COOPER:** I -- I certainly
18 appreciate Dr. Dailey's concerns and he's quite right
19 that, you know, that children who are new into their,
20 you know, their treatment for diabetes, you know,
21 could very well find themselves in a situation where
22 they're profoundly hypoglycemic and you know, whereas
23 -- you know, whereby, treatment with glucagon could
24 be helpful.
25 Certainly, you know, the pediatric

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2 resources on the east end are not quite what they are
3 a little closer to the -- little closer to the city.
4 That's one thing.
5 Another thing, of course, is -- is on
6 the -- on the counterpoint there, in follow up to
7 your concern earlier about moving these heavy
8 patients, most kids are not that heavy and could
9 probably be moved pretty quickly.
10 That having been said, you know, we --
11 we have the, you know, the issues of, you know,
12 recognition, you know, of, you know -- of, you know,
13 a disease process like this in -- in children.
14 I mean, we all know that, you know,
15 that hypoglycemia generally manifests as a sort of a
16 adre -- adrenergic type of crisis in terms of its
17 symptomatology.
18 You know, so I -- I personally think
19 that in general, it's useful as you suggest to
20 collect some data, you know, in older patients before
21 moving to the pediatric age group.
22 But I'm also, you know, deeply
23 sensitive to Dr. Dailey's absolutely correct
24 concerns. Thank you.
25 **CHAIR WALTERS:** So -- and I would just

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2 -- to go back on -- on the -- the timeframe question,
3 I think that most of us have worked very hard with
4 our crews over the last several years to say, if you
5 have someone who has some type of time-sensitive
6 critical illness, the time to treat them is in the
7 house.
8 Not until you -- don't wait until you
9 extricate them, right? Whether they're hypoxic, they
10 have an unstable arrhythmia or they're hypoglycemic,
11 we should be treating those in the house.
12 And I think that fallacy of the crews
13 are going to extricate somebody and be to the
14 hospital in five minutes, we know it doesn't actually
15 happen.
16 Even if you're on the first floor,
17 sometimes good circumstances, it takes ten minutes to
18 get out of the house and into the truck. And so I
19 think this is certainly one of those things that --
20 that we want to treat as soon as we identify as soon
21 as possible, right in the house, not -- I don't think
22 it's a transport time to the hospital.
23 I think it's that whole time from
24 being at the patient, to the extrication, then to the
25 hospital. And so I think there is -- regardless of

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2 how close you are, I think there is a potential time
3 saving, like Dr. Dorsett pointed out.
4 It's the time to treatment of the
5 hypoglycemia -- hypoglycemia or reversing the
6 hypoglycemia. So I -- I would just keep that in
7 mind. My -- I guess, you know, and Dr. Cooper and
8 your thoughts and -- and Dr. Dailey about pediatrics,
9 right, we -- it's already in -- this is also in the -
10 - the protocol for E.M.T.s at the -- for pediatrics
11 already, right?
12 The dosing administration is weight
13 based, at least in our protocol of greater than, or
14 less than twenty kilograms being either point five or
15 one milligram of glucagon.
16 So it's not a whole lot of dose
17 calculation or -- or difficulty in that. And -- and
18 I think that, certainly, hypoglycemia is just as, you
19 know, concerning or critical in a pediatric patient
20 as it is an adult patient.
21 And I would argue we probably have a
22 harder time getting on some of these small kids
23 getting I.V. access and giving D10 in the field where
24 glucagon may be, you know, more advantageous in those
25 situations.

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2 So I think that extending that to the
3 pediatric population is something we should think
4 about or -- or discuss. And -- and I know there's
5 concerns or should we get data, but -- but maybe we
6 should entertain that or have a little bit more
7 conversation about that.
8 **MS. DORSETT:** I was going to say
9 that's going to -- I think it's a good idea, but it
10 complicates the education because neonates, which is
11 one of the cases where you encounter hypoglycemia in
12 the field, should not be getting glucagon, right,
13 because they have no glycogen in their body.
14 And so that might actually lead to a
15 delay in other care. So thinking about the
16 pathophysiology associated with it, like I -- if that
17 happened, I would specifically exclude neonates and
18 make that part of the education.
19 **MR. WINSLOW:** Maybe the right
20 compromise is since twenty kilograms is the -- the
21 weight at which you give the adult dose, which is
22 one, we just limit it to patients above twenty
23 kilograms and that would exclude the neonate issue.
24 So I'm willing to do that and that
25 will help a whole bunch of small kids who may just

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2 have started with their diabetes regiment, many of
3 whom are going to be sent home with glucagon to have
4 at their home anyway.
5 **MR. DOYNOW:** The only other question
6 is, should we add an educational component on how to
7 disconnect their insulin pumps, assuming they're on
8 insulin pump, which many of these kids would be. I
9 mean it's easy enough to do.
10 **MR. WINSLOW:** Thank you. Yeah, we can
11 add that.
12 **CHAIR WALTERS:** Don?
13 **MR. HUDSON:** Good morning, everyone.
14 Don Hudson. So invariably, in case anyone's
15 wondering, the coffee must be kicking in because the
16 incessant texts from my shadow government is
17 beginning to chime in here from the education
18 perspective. So thanks for waking up and paying
19 attention.
20 That being said, so there's always the
21 question of scope of practice and how this fits in.
22 I would suggest to the group that this one's an easy
23 lift and actually probably provides us some
24 opportunities to exercise and learn some of the
25 vulnerabilities that we uncovered via the I-gel

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2 project.
3 So what I'm talking about specifically
4 is, thankfully, one of the benefits of COVID was the
5 addition of -- the emergency addition to the E.M.T.
6 scope of practice in 2021 for intramuscular
7 medication administration to the E.M.T. level.
8 And the caveat to that on the national
9 scope of practice document page twenty-eight is
10 medication -- I'm sorry, medical direction should
11 ensure appropriate clinical experience and education,
12 including the separate skill of medication
13 preparation, medication dilution, filling a syringe
14 from a multi-dose vial and changing the needle on a
15 syringe.
16 So even though we can, you know,
17 recall that that specifically was for immunizations,
18 it also allows us an opportunity to sort of stretch
19 our legs if medically appropriate here for this case,
20 glucagon intramuscular injection to the E.M.T. level.
21 The other thing I think we have an
22 opportunity here is we can work within that, unlike
23 clearly the B.L.S. I-gel, which was clearly a leap
24 forward. We can work within these already
25 established boundaries within the scope of practice

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2 to do this easily.
3 I think the greatest benefit of the
4 pilot program would not be to see if the medication
5 works, which we know it does, or if E.M.T.s can use a
6 syringe, which we know they can, but also to exercise
7 the backend of our data capture in a cleaner
8 environment since glucagon in intramuscular and the
9 provider administering the medication is already
10 latent in all of our P.C.R. platforms.
11 So I think it would be a nice way that
12 we could take a step back from the data side to see
13 if the changes we've made and the discussions we've
14 had actually have improved our ability to do pilot
15 programs in this much easier lift and cleaner
16 environment, therefore -- therefore allowing us to be
17 a little bit more aggressive in future projects.
18 So I think it's a good thing and I
19 think we should endorse it.
20 **MR. WINSLOW:** I'll say through the
21 Boardable discussion platform, there was one other
22 addition that we made. Should a patient receive
23 glucagon and improve, such as a person with known
24 diabetes and then want to refuse treatment or care or
25 R.M.A., that medical control will be consulted and

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2 they have to have a consultation with a physician.
3 I think that's an important thing to
4 protect our B.L.S. providers in this project.
5 **CHAIR WALTERS:** Good. Thank you. And
6 thank you, Don, for those comments.
7 **MR. HUDSON:** I'm sorry, the only
8 caveat to that after I was trying to make things
9 easier, let me try and not overly complicate. So
10 since there are glucagon auto-injectors available on
11 the market, would this also potentially include that
12 if a well-funded agency saw fit to spend even more
13 money?
14 **CHAIR WALTERS:** Don, I think the --
15 **MR. WINSLOW:** We didn't -- it was not
16 the original intent of the project due to the cost
17 factor. We don't have a problem with an agency
18 wanting to use that mechanism of injection. But we
19 had not added that to the project for the cost
20 factor.
21 **MR. HUDSON:** And I agree. I suggest
22 that, not to complicate it, but just to get it out in
23 the open. I think the sensible thing would be start
24 with syringe and let's see where it leads.
25 **CHAIR WALTERS:** Dr. Clemency?

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2 **MR. CLEMENCY:** I just want to get back
3 to the discussion of age. I think Dr. Dorsett made a
4 really important point about glucagon in the neonatal
5 patient, but there's nothing magic about a B.L.S.
6 provider giving it versus E.M.T. giving it.
7 And if we're concerned about glucagon
8 for neonatal patients, I think we should put a
9 footnote for all providers in the -- in the
10 hypoglycemia pediatric protocol, but then allow this
11 for all pediatric patients that an E.M.T. or
12 paramedic would be able to give.
13 **MR. GREENBERG:** So I do believe you
14 just did a protocol update. I think a modification
15 to the protocol update if you needed to at this time
16 would be probably an ideal situation and I'm sure I
17 can work with that team to -- to make that.
18 Just one thing to -- and Dr. Winslow,
19 I don't know if you've approached this on this one.
20 Has Training and Ed, or has, you know, this pilot or
21 anything had discussions on that side on what the
22 training is and from the educator point of view, or
23 maybe Don can talk on that.
24 **MR. WINSLOW:** Well, I think he just
25 covered it when he said it's already in the scope of

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2 practice, but if there is further discussion, I -- I
3 don't see this as a heavy lift on the education. I
4 really do not.
5 **MR. HUDSON:** Yeah, I think -- I mean,
6 it is scope of practice for E.M.T.s to handle
7 syringes and withdraw medication from a vial. The
8 nuance would be reconstituting the powder form here,
9 which I think if rec -- I recollect, you might have
10 actually been a thing in the early days of
11 immunization, was that -- am I recollecting that
12 correctly?
13 But either way, you're talking not
14 hours and hours and hours of additional education to
15 add a skill that no one's even heard of. They know
16 how to use a syringe or they should, we can revisit
17 that.
18 Glucagon, you know, is fairly easy to
19 learn if, you know, you look at the right slides. I
20 mean, I don't know how many slides there would be to
21 learn what glucagon is and how it works. And you
22 stick it in the muscle and if they get better, they
23 get better.
24 I mean, I don't want to make it less
25 than it should be, but I don't think it's a heavy

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2 lift. And I -- I support it.
3 **MR. GREENBERG:** I would bring it up as
4 often the educators do whenever we talk about adding
5 more things, more medications, more to a already very
6 condensed thing, again, very supportive of it. Just
7 responsive to lessons learned from other things.
8 And, you know, as it comes along.
9 **MR. HUDSON:** I -- you know, just to
10 use, as you say, I'm adding and replying to texts as
11 we speak. So let me put that down so I can talk.
12 Everyone is mindful of not fracturing our hard work
13 to realign our levels of care in New York State to
14 match the nation.
15 We don't want to go down the paths
16 that we have in the past where we have an E.M.T. in
17 Suffolk is different than an E.M.T. in Fulton or what
18 have you.
19 I don't think this is that hill to die
20 on. I think this is one that we should come together
21 on and -- and is an easier lift than anything we've
22 seen in recent memory.
23 **MR. GREENBERG:** And as we do move
24 forward on this, and Dr. Walters, we would offer our
25 support from the bureau side to make, you know, kind

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2 of final training or final sign off on Vital Signs
3 Academy so it is all centralized in one place.
4 And then for any research or things
5 like that, you know, all the providers around the
6 state have gone through, you know, final thing and
7 have a list of all them accounted for.
8 **CHAIR WALTERS:** I think that makes
9 sense. Any other comments or discussion?
10 **MR. WINSLOW:** So to summarize, the
11 motion would be to accept the B.L.S. I.M. glucagon as
12 a regional pilot program Statewide.
13 **MR. GREENBERG:** It sounded like they
14 wanted Statewide.
15 **MR. WINSLOW:** They want Statewide? To
16 summarize, the motion will be to accept the B.L.S.
17 I.M. glucagon project Statewide. Suffolk County
18 REMAC will be the administrator of it similar to
19 Hudson Valley having done it for the I-gel.
20 We will limit it to intramuscular use
21 in patients twenty kilograms or greater, all.
22 **MR. GREENBERG:** The only modifications
23 to the motion I would ask is that to recommend to the
24 commissioner to approve the pilot or not to approve
25 it.

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2 **MR. WINSLOW:** Got it. We will
3 recommend that this be brought to the commissioner
4 for approval. Sorry, Theresa. Can I have a second?
5 **MS. ALLEN:** Second.
6 **MR. FORNESS:** Second.
7 **MR. WINSLOW:** Thank you.
8 **CHAIR WALTERS:** Any further discussion
9 then? No? Then if there's no further discussion,
10 all those in favor aye? Any opposed? I see one
11 opposition. Any abstain? And the motion carries and
12 will be forwarded to SEMAC. Thank you.
13 And then, Director Greenberg, I think
14 -- were you suggesting that we do make a change or --
15 or a motion about key points consideration in
16 neonates in the protocols?
17 **MR. GREENBERG:** Yeah, I think that
18 would even maybe just a modification to the approval
19 of the motion that was made before would be
20 sufficient. And then I'll work with Dr. Dailey to
21 get that in the appropriate place. Or Dr. Clemency,
22 either one who wants to tell us where you want it.
23 **CHAIR WALTERS:** So I think in -- in
24 the -- I'm just reading the protocol right now, it --
25 it does say under key points and considerations, just

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2 so everyone is aware.
3 Preschool aged children and infants
4 may have limited response to glucagon. Maybe we want
5 to add something specifically regarding neonates
6 after -- in that sentence or after that sentence.
7 **MR. CLEMENCY:** Yeah, I think that'd be
8 perfect.
9 **CHAIR WALTERS:** Maia -- Dr. Dorsett,
10 that capture what you're looking for?
11 **MS. DORSETT:** Yeah, I mean -- and I
12 think further considerations and meetings you should
13 think about patients with, like alcohol use disorder
14 and liver disease.
15 Those actually are the adverse events
16 that I see clinically as somebody should be getting
17 an I.O. in dextrose and they're getting glucagon when
18 there isn't -- there's like one molecule of glycogen
19 in their liver.
20 And so they have delayed treatment of
21 hypoglycemia. But I think for the purposes of today,
22 I think adding neonate is a simple thing because
23 that's a more complex discussion of how you identify
24 those patient populations.
25 **CHAIR WALTERS:** So I guess my question

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2 is, do we want to -- does saying preschool aged
3 children and infants may have limited response to
4 glucagon, is that sufficient or do we want to add
5 something more specific regarding neonates into that
6 key point that already exists in the protocol?

7 **MR. DAILEY:** I think I would look to
8 see if we have a problem before we try to find a
9 solution. I don't think that there are a whole lot
10 of cases where we're trying to sign off hypoglycemic
11 neonates after giving them a shot of glucagon that
12 didn't work.

13 So I think while it's extremely
14 medically important, I -- I'm not sure that that's
15 something where we need to -- need to change right
16 now, but I think it's something for us all to look at
17 on a regional basis, make sure that that's not
18 actually a concern.

19 **CHAIR WALTERS:** And I guess that while
20 it may not be effective, there probably isn't much
21 harm from that, right? And -- and again, the numbers
22 that -- where that may happen would be extremely
23 small. So maybe that's just something we look at
24 with the data.

25 All right. Very good. And then

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2 that's all the items that were listed on the agenda.
3 There was one item forwarded from Innovations
4 yesterday, regarding some lab testing and Mike
5 McEvoy, if you wouldn't mind bringing that up?
6 **MR. MCEVOY:** So Dr. Redlener's
7 Innovations and Research Committee had a meeting with
8 Wadsworth Lab based on our last SEMSCO meeting when
9 there was a discussion about clinical laboratory
10 testing and expanding the scope of that.

11 Given that we have some community
12 paramedicine legislation in process and some things
13 already going on as well as the administration of
14 blood in the field.

15 So the outcome of that meeting was
16 that Wadsworth is willing to work with us on what the
17 regulatory landscape would look like for doing
18 different levels of testing, but they also felt as
19 though while moderately complex tests are very
20 difficult to license, that many of the things that we
21 would like to see may not even be in that category.

22 They may be wave tests and would have
23 a much simpler process. So the ask from the
24 Innovations group, which they're putting a TAG
25 together to work on this is to list for them tests

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2 that you would like to see so that they can then go
3 back to Wadsworth and have a discussion about how we
4 could make that happen.

5 So I would say, if people want to
6 shoot a list to myself or to Dr. Redlener and anyone
7 who's interested in working with that TAG, let us
8 know and we'll -- Lauren from Stony Brook is going to
9 head that up and we'll let them know about that.
10 That's the request.

11 **CHAIR WALTERS:** All right. And so if
12 anybody is interested, then please reach out to Mike
13 McEvoy or myself or Dr. Redlener and we'll make sure
14 you're on that TAG.

15 And that I think is everything that's
16 on the agenda. I will just open it up if there are
17 any other issues that -- to bring before the
18 committee, Dr. Dailey.

19 **MR. DAILEY:** So while we're talking
20 about our friends at Wadsworth, I opened up the blood
21 glucose P.S. draft final 10/29/2024, P.D.F. that's in
22 our Boardable packet and was fascinated as I read
23 through this.

24 The process of getting our E.M.S.
25 agencies enrolled in the Wadsworth program, sending

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2 them their two hundred dollar checks, unless you fall
3 into the correct categories, is something that is a
4 constant concern brought to me by agencies, for what
5 basically is an administrative process.

6 They're being charged an additional
7 fee without good reason. But one of the things that
8 -- that appears buried deep in this -- in this draft,
9 and I'm not sure who the draft is written by or for,
10 is that B.L.S.F.R. agencies will not be eligible for
11 fee waiver.

12 Most of the B.L.S.F.R. agencies we
13 have are actually municipal or governmental agencies.
14 And I'm really confused as to why they would not be
15 available for a fee waiver on this document that I'm
16 not sure where it comes from and how we can pursue
17 that.

18 **MR. MCEVOY:** That actually came up in
19 our discussion with -- with Wadsworth and Steve
20 Dziura has the actual citation of legislation and he
21 could probably explain it more articulately than I.

22 **MR. DZIURA:** Bear with me. Let me
23 just find the file. I feel like I'm good, but not
24 this good. I am going to keep looking, but I'll
25 paraphrase as I'm -- I'm looking for the actual

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2 language.
3 So the -- the law requires that a fee
4 be assessed to -- for this limited lab license for
5 any agency that is not one of two things. So it's a
6 two-part test that's spelled out in the law.
7 And essentially, it says that you're a
8 volunteer or a voluntary ambulance, so not volunteer
9 voluntary as defined in 3001, which is any not-for-
10 profit corporation ambulance.
11 And that you are operating under
12 contract with a municipality or a couple other
13 things. And so what was happening is, the test was
14 only being evaluated based on the first part, and it
15 was being looked at as are you a voluntary ambulance.
16 And so during an internal control
17 review, it was identified that this wasn't being
18 applied correctly and that it -- it required the two-
19 part test that you have to be a voluntary, not-for-
20 profit corporation and you have to be meeting one of
21 these classifications.
22 So you are a municipality, you're
23 operating under contract with the municipality. And
24 there was one other one, if I can find the memo, I'll
25 pull it up.

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2 But -- so we did that review and
3 that's how we've been evaluating those for probably,
4 I want to say it's since June or July, is after our
5 last internal controls review.
6 So if it doesn't meet that two-part
7 test, then Wadsworth has to assess the two hundred
8 dollar fee for the limited lab license.
9 Unfortunately, that's written right into the law.
10 If it was a regulation, it -- I'll be
11 honest, the -- the two hundred dollars, it's -- it's
12 not as though us or Wadsworth has any interest in
13 assessing that fee.
14 It's the way it's written into law.
15 So the law would have to be changed in order for that
16 fee to go away.
17 **MR. GREENBERG:** And it's not written
18 in -- written into our law, so just a reminder.
19 **MR. DZIURA:** Mike is trying to Google
20 testing law over here and it's not working. I'll
21 follow up with you. Let me just find this memo.
22 **MR. DAILEY:** Thanks.
23 **MR. DZIURA:** It's buried in a file
24 somewhere.
25 **CHAIR WALTERS:** And so Steve is it --

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2 is the issue that they could be a volunteer B.L.S.
3 first response agency, but because they're not an
4 ambulance agency, is that why they get assessed the
5 fee? Is that what distinguishes the -- a first
6 response?
7 **MR. DZIURA:** Say that one more time.
8 So if they're a first response agency --
9 **CHAIR WALTERS:** So because Dr. Dailey
10 asked specifically about a B.L.S.F.R., right?
11 **MR. DZIURA:** Uh-huh.
12 **CHAIR WALTERS:** So a volunteer
13 B.L.S.F.R. does not qualify the way that the
14 regulation is written, even if they're --?
15 **MR. DZIURA:** I finally found the memo.
16 **CHAIR WALTERS:** Okay.
17 **MR. DZIURA:** So -- so it's Public
18 Health Law Section 579.3 -- 579.3. It says when
19 provided -- when provided by a voluntary ambulance
20 service as defined in Public Health Law 30013, so
21 that answers the first part of the question.
22 It -- it is limited to voluntary
23 ambulance services in the law. And then, it -- this
24 is the -- the second part. And when services
25 provided under one of the provisions of General

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2 Municipal Law 209 B, which is the ambulance provided
3 under a contractual agreement to a city, town,
4 village, or fire district who does not operate an
5 ambulance service.
6 Ambulance service furnished by a city,
7 town, with a fire department, village, or fire
8 district when authorized by the governing body of the
9 city, ambulance service furnished by the fire
10 corporation located outside of a village fire
11 district, or fire alarm or protection district, when
12 authorized by the town board, and ambulance service
13 provided under any fire protection contract to a
14 city, village, or fire district authorized by law.
15 So that comes right directly out of
16 Public Health Law Section 579.3.
17 **CHAIR WALTERS:** Does that answer your
18 question, Dr. Dailey?
19 **MR. GREENBERG:** Answer, yes. Like,
20 no.
21 **CHAIR WALTERS:** While they're
22 reviewing that regulation, are there any other
23 comments or issues to be brought before the Medical
24 Standards Committee?
25 **MR. KUGLER:** Is the attendance sheet

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2 somewhere?
3 **CHAIR WALTERS:** Yeah, please make sure
4 if you haven't already, that you signed the
5 attendance sheet to get credit for coming today.
6 **MR. GREENBERG:** Dr. Walters, I don't
7 know if it's a medical or a standard thing, but I
8 will tell you, medically I feel happier and healthier
9 because Hope is here. So I just want that to be on
10 record.
11 **CHAIR WALTERS:** We'll reflect that in
12 the minutes. Thank you. Then if there's no other
13 items to come before the committee, I'll entertain a
14 motion to adjourn. All right. Thank you very much,
15 everyone.
16 (The meeting concluded at 9:22 a.m.)
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2 STATE OF NEW YORK
3 I, DANIELLE CHRISTIAN, do hereby certify that the
4 foregoing was reported by me, in the cause, at the time
5 and place, as stated in the caption hereto, at Page
6 hereof; that the foregoing typewritten transcription
7 consisting of pages 1 through 69, is a true record of all
8 proceedings had at the hearing.
9 IN WITNESS WHEREOF, I have hereunto subscribed
10 my name, this the 16th day of December, 2024.
11
12 DANIELLE CHRISTIAN, Reporter
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