

2/27/2025 - Medical Standards - Troy, New York
NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS

DATE: February 27, 2025

TIME: 8:05 a.m. to 8:41 a.m.

CHAIR: JEFFERY RABRICH

LOCATION: Hilton Garden Inn
Ferris Ballroom
235 Hoosick Street
Troy, New York 12180

Reported by Danielle Christian

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2-27-2025, Medical Standards Meeting

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2 **APPEARANCES:**
3 **ALBERT SHIH** ®öŹ B
4 ART COOPER
5 BRIAN CLEMENCY
6 BRIAN WALTERS
7 DANIEL OLSSON
8 DAVID KUGLER
9 DAVID VIOLANTE
10 DONALD HUDSON
11 DOUG ISAACS
12 EDWARD MAGER
13 GINA WIERZBOWSKI
14
15 JARED KUTZIN
16 JASON WINSLOW
17
18 MAIA DORSETT
19 MICHAEL DAILEY
20 MICHELE FORNESS
21 NAREEN SETH
22 PAMELA MURPHY
23 TERESA HAMILTON
24 THERESA ALLEN
25 TIFFANY BOMBARD
YEDIDYAH LANGSAM

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

CHAIR RABRICH: Start the meeting now.

I'd like to call to order the Med Standards meeting
for February. For those who don't know me, I'm Dr.
Jeff Rabrich, Chair of the committee.

I ask that when you speak, if you
would please -- meeting's being recorded. If you
would please state your name for the stenographer
before you speak and then use the microphone when you
speak so that everyone can hear you.

All right. We're going to record
attendance. The attendance list is being passed
around, please sign in. And we will start with old
business, and our clinical data integrity TAG, is
there an update that you'd like to give?

MS. DORSETT: Sure. Maia Dorsett for
the stenographer. So for the clinical data integrity
TAG, just to give everybody an idea of the scope of
what we're trying to work on.

Our primary focus initially is
improving the quality and accessibility of the data
in the State data bridge so that we can do some
initial quality improvement across regions and the
State.

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2 The process of when data is entered at
3 a local agency to when it goes to the State site, and
4 then our ability to mine that data from the State
5 site is what we're trying to improve.
6 We've decided to focus initially on
7 sort of a few -- thank you. A few -- I would say
8 case studies. One of which would be invasive
9 airways, because when we looked at a regional level
10 within Monroe Livingston, we weren't able to sort of
11 pull all that data from the State site.
12 I think we've had actually a pretty
13 productive meeting even while we were here. We were
14 able to meet with Peter Brody, George Statitis
15 (phonetic spelling), who has joined the division, as
16 well as Ty Cobb, who's the image trend -- I don't
17 know what his technical title is, but he manages our
18 account to actually start looking at that process.
19 And we are able to already identify
20 some of the problems around our lack of accessibility
21 of that data. Some of that data is there, it's just
22 that the way that the report writer works, you can
23 actually pull it by looking at like defining
24 procedures or procedure codes.
25 Our plan, and Peter can feel free to

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1 (Pages 1 to 4)

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 2 add to this, is still to sort of move forward. He's
 3 already reached out to several of the vendors and
 4 have essentially a root cause analysis using a few
 5 different case studies from two different regions to
 6 look at from an agency level.
 7 What -- what is the actual number of
 8 charts or procedures being done, versus looking at
 9 the State site and seeing what are we able to measure
 10 when we try and write reports following, like, the
 11 NEMSQA technical documents.
 12 And then map all the failures in
 13 between so that we can say what are the low hanging
 14 fruit to improve the quality of that data.
 15 **CHAIR RABRICH:** Thank you, great
 16 report. Are there questions for the Clinical
 17 Integrity Data Group, anyone have questions or
 18 comments or feedback for them? I see thumbs up,
 19 that's -- that's it. All right.
 20 Next is our blood implementation
 21 working group. I don't know, is there an update on
 22 that, or -- so nothing currently to report. It's
 23 working its way through the regulatory process still,
 24 is that correct?
 25 Yes, and the group is working on --

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 2 just for everyone's just to refresh your memory, the
 3 group is working on best practices and -- and setting
 4 up your program and implementing and helping to
 5 devise a regional blood plan is the -- the approach
 6 they're taking, but no -- no official update today.
 7 The -- the last order of old business
 8 we have is, just want to -- where did Mr. Violante
 9 go? All right. We will come back to that. The i-
 10 gel project, we had made a change to the i-gel
 11 regarding whether the wording was i-gel or
 12 supraglottic in the advisory, so I don't -- Mr.
 13 Violante or Gina, does someone want to speak to this
 14 just so we can -- just want to clear up any confusion
 15 so that we get the wording correct in the -- in the
 16 policy.
 17 **MR. VIOLANTE:** Great, thanks, Jeff
 18 sorry about that, Dave Violante. Just talking with
 19 Gina. We were looking at some of the wording of the
 20 continuation of the i-gel project.
 21 It's going to move forward as an
 22 S.G.A. project, but we wanted to make sure that we
 23 didn't encumber any issues calling it an i-gel
 24 project initially when this group had moved it
 25 forward.

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 2 It's still an i-gel project at the
 3 H.V. REMSCO because that's the way the pilot was
 4 completely laid out. It'll be an S.G.A. moving
 5 forward as it goes into D.O.H. policy and out through
 6 the protocols and all of that.
 7 So I don't think we're actually going
 8 to need to -- to worry about that moving forward as
 9 we previously had thought.
 10 **CHAIR RABRICH:** Thank you. Does
 11 anyone have any questions or concerns around this,
 12 the i-gel project? Dr. Cooper?
 13 **MR. COOPER:** What does S.G.A. stands
 14 for?
 15 **CHAIR RABRICH:** Supraglottic Airway,
 16 it's more -- instead of a product name, it's just a
 17 more generic.
 18 **MR. WINSLOW:** Dr. Rabrich?
 19 **CHAIR RABRICH:** Yes. I'm sorry, go
 20 ahead.
 21 **MR. WINSLOW:** Jason Winslow. Does
 22 that mean you cannot use any other brand?
 23 **MR. VIOLANTE:** No, we were just trying
 24 to differentiate the i-gel project was the Hudson
 25 Valley's i-gel project full stop period. And so

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 2 moving forward as the State moves with the protocols
 3 and the policy, it'll be an S.G.A., not i-gel --
 4 **CHAIR RABRICH:** Meaning --
 5 **MR. VIOLANTE:** -- specifically.
 6 **CHAIR RABRICH:** -- it's not product
 7 specific, it -- it started as i-gel just because that
 8 was the project, but yeah, just to clarify.
 9 **MR. VIOLANTE:** Correct.
 10 **CHAIR RABRICH:** Dr. Clemency, did you
 11 have a comment?
 12 **MR. CLEMENCY:** So -- yeah, to follow
 13 up. So can -- does that mean any supraglottic airway
 14 under the sun is permissible then?
 15 **CHAIR RABRICH:** I believe if the
 16 wording is S.G.A. it would mean any supraglottic
 17 airway product that that agency medical director
 18 approves that agency to use. Is that correct?
 19 **MR. VIOLANTE:** It's F.D.A. --.
 20 **CHAIR RABRICH:** Well, yes, it has to
 21 be F.D.A. approved, but yeah. But it would be agency
 22 and agency medical director choice of supraglottic
 23 airway.
 24 **MR. CLEMENCY:** I defer to Dr. Dailey.
 25 **CHAIR RABRICH:** Dr. Dailey.

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 2 **MR. DAILEY:** So we've gone down
 3 similar pathways to this before, and while I
 4 recognize the department can endorse a specific
 5 device, I have significant concerns of allowing any
 6 agency to choose any device.
 7 Which we've already seen one agency
 8 who will probably place four devices a year, send us
 9 a letter saying that they wanted to use something
 10 else because they found the, you know, latest
 11 greatest widget.
 12 For which there is no approved
 13 training. My suggestion would be, if it's still
 14 possible that the approval of specific devices remain
 15 at the level of the regions where it traditionally
 16 has been in order to make sure that the training
 17 exists and that the quality is maintained.
 18 **CHAIR RABRICH:** So refresh my memory,
 19 but I believe there was a SEMAC advisory that talked
 20 about products in general, and how they got approved.
 21 I -- I like what you're saying, I just want to make
 22 sure it doesn't conflict with that policy statement.
 23 But you're saying S.G.A. the agency
 24 medical director's choice, but approved by the region
 25 is what you're -- I'm hearing from you.

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 2 **MR. VIOLANTE:** The way that the
 3 protocol reads is that if equipped and trained and
 4 regionally approved.
 5 **CHAIR RABRICH:** There you go.
 6 **MS. WIERZBOWSKI:** Dr. Rabrich?
 7 **CHAIR RABRICH:** Yes.
 8 **MS. WIERZBOWSKI:** Down here.
 9 **CHAIR RABRICH:** Sorry.
 10 **MS. WIERZBOWSKI:** Gina Wierzbowski
 11 from the Division. I have a couple of questions and
 12 I would like to thank the group for clarifying some
 13 of these things because I've been the one trying to
 14 draft the S.G.A. policy.
 15 So yes, it is in there that the -- it
 16 will be regionally approved. There -- in review
 17 there's been a couple of questions raised in terms of
 18 education.
 19 We do have the education that's
 20 available for i-gel training that we had considered
 21 including in the policy as something that is
 22 standardized.
 23 And if the group was okay with that,
 24 then we would -- we would do that, which might help
 25 steer towards where you want them to be. And also,

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 2 there was a question with regard to continued data
 3 collection for the -- for that.
 4 In the policy we're putting -- we're
 5 going to have obviously medical director review for
 6 any occurrence, and we have some parameters set forth
 7 in terms of like information on things that they need
 8 to include in their charting, you know, the different
 9 -- the different things that we want to make sure
 10 that we capture.
 11 But do -- does the group want to see
 12 specific reporting, do you want them to maybe
 13 continue to use the portal that was set up for
 14 collection of that specific data. It's really up to
 15 the group; we'll do whatever you want.
 16 But I want to make sure that we cover
 17 all the bases before we move too much further ahead.
 18 **CHAIR RABRICH:** Thank you. So let --
 19 let's take those two things separately, so first, the
 20 training issue. I'll open that up for discussion,
 21 but I think you -- we're probably thinking about some
 22 sort of, you know, training that's regionally
 23 approved for use.
 24 I don't know how people feel, you
 25 know, about the training, I know we've done for

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 2 protocols kind of, you know, standardized training
 3 that is approved by regions are rolled out, but Dr.
 4 Dorsett.
 5 **MS. DORSETT:** Yeah, like I would not
 6 put into any policy a specific training that people
 7 are to follow. And it could -- you could make it
 8 regional approval, but right, ideally we move a bunch
 9 of this, if your region is doing it as part of your
 10 initial E.M.T. education class.
 11 So I think there -- I think if you say
 12 that there has to be education and training that
 13 encompasses x curriculum, right? So, like, proper
 14 placement candidate, confirmation with waveform
 15 capnography, as well as interpretation of those
 16 capnography waveforms for successful versus not.
 17 I think in terms of reporting, the
 18 thing that makes the most sense is, it's all good
 19 that somebody reviews every single chart, but you
 20 should be reporting your performance on Airway 18,
 21 which is confirmation with waveform capnography when
 22 you say it's successful.
 23 There's a national quality measure
 24 that says what is your performance for correct use --
 25 **CHAIR RABRICH:** Uh-huh.

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 2 **MS. DORSETT:** -- we should just be
 3 using the national performance measure.
 4 **CHAIR RABRICH:** Okay. Thank you.
 5 Other thoughts on this? So if it -- if it read
 6 something like a regionally approved training and
 7 education plan, that could be whatever, it could be
 8 in their E.M.T. class, it could just -- would just be
 9 regional.
 10 Do we want that layer of the region
 11 saying, yes, this training you're doing is adequate
 12 for this type of device? I don't know what people
 13 think, I don't -- I don't want to -- I don't want to
 14 write it for them, but, you know, I'm happy to hear
 15 other thoughts.
 16 **MS. MURPHY:** Dr. Rabrich?
 17 **CHAIR RABRICH:** Yes.
 18 **MS. MURPHY:** Dr. Murphy.
 19 **CHAIR RABRICH:** Dr. Murphy.
 20 **MS. MURPHY:** So I think, you know,
 21 what Dr. Dailey brought up is very important because
 22 there are some entities out there that want to use
 23 equipment that we're not sure where the training and
 24 such is applied.
 25 So I think I understand, you know, the

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 2 protocol and I understand the process of putting
 3 something in a protocol about training. But maybe we
 4 could just put a link for our training materials that
 5 people can use if they want.
 6 If that's the, you know, the item
 7 they're going to put forward in their region or in
 8 their agency. But I think, you know, we just have to
 9 be careful that we keep track of what people are
 10 using and what they're doing because of all the
 11 variations out there.
 12 **CHAIR RABRICH:** Thank you. Dr.
 13 Dailey, no. Yeah, so I -- I think what I'm hearing
 14 from the group for feedback for you is that the
 15 regions would like to know what people are using.
 16 They'd like to have some oversight of
 17 that and they'd also like to have some oversight of,
 18 you know, how they're planning to -- what their
 19 implementation plan is and -- and training, et
 20 cetera. Is that fair to say?
 21 **MS. WIERZBOWSKI:** Yes. Yeah, and I --
 22 I think there may be a way for us just to put like
 23 for a reference the training that exists and say you
 24 -- you may use this if you so choose.
 25 But you may also submit your own

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 2 training and education plan to your region for
 3 approval. I agree with Dr. Murphy that, you know,
 4 perhaps just including that for informational
 5 purposes not a requirement.
 6 I think that would be -- as long as
 7 the group is okay with that, that would be fine with
 8 me.
 9 **CHAIR RABRICH:** Yeah, I -- I think
 10 we're hearing consensus around that, that that's
 11 okay. And then as far as the data collection piece,
 12 I'm not even going to look over here for a second
 13 before saying, yes, we want data on people placing
 14 these devices, right.
 15 We want to know -- you know, is what
 16 we're doing successful? Are people able to place
 17 these successfully, or do we have a problem? So
 18 absolutely, I think we'd want to continue to collect
 19 data around this. Yes, Dr. Bombard.
 20 **MS. BOMBARD:** Within that data I just
 21 want to echo Dr. Dorsett that -- and title waveform
 22 and title capnography needs to be within that data
 23 collected.
 24 **CHAIR RABRICH:** Correct --
 25 **MS. BOMBARD:** And I don't know if we

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 2 want to, you know, delineate within the training,
 3 there's really two big points, one is waveform
 4 capnography --
 5 **CHAIR RABRICH:** Uh-huh.
 6 **MS. BOMBARD:** -- the other one is
 7 placement, and placement's pretty general.
 8 **CHAIR RABRICH:** Yeah.
 9 **MS. BOMBARD:** Right?
 10 **CHAIR RABRICH:** Yeah.
 11 **MS. BOMBARD:** But if we want to just
 12 say your -- your training must include --
 13 **CHAIR RABRICH:** Uh-huh.
 14 **MS. BOMBARD:** -- that would be pretty
 15 streamlined, and I think reasonable and would again
 16 bring us back to, you know, capturing waveform, which
 17 we all, I feel, think is really important to every
 18 single airway.
 19 **CHAIR RABRICH:** Yes, I think we all
 20 agree that's the standard. It is mandatory to do
 21 continuous waveform already, so, Dr. Dorsett?
 22 **MS. DORSETT:** I think specifying that
 23 the interpretation of the waveform is an essential
 24 part of the training. One of the things we found
 25 when we looked regionally at all invasive airways

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 2 with capnography training is we had a few where
 3 people connected it, thought they had a number, but
 4 weren't -- they didn't actually interpret the
 5 waveform correctly.
 6 And we had one where I was like, this
 7 isn't -- this is for an intubation, like an
 8 esophageal intubation. This is inadequate
 9 ventilation when you actually look at the waveform.
 10 So I think people think I -- if it's -
 11 - I connect the thing and I got something after two
 12 breaths --
 13 **CHAIR RABRICH:** I see --.
 14 **MS. DORSETT:** -- but it -- but it --
 15 then it disappears and it's less than four, that is
 16 not adequate confirmation so there has to be
 17 interpretation. I would also suggest that there is a
 18 documentation standard around when that is actually
 19 documented as part of the P.C.R.
 20 So what happens is sometimes you have
 21 fallouts when you look at the data which is that you
 22 have to have a capno level after the placement that
 23 is documented in the chart to pull that data.
 24 Sometimes people connect it, but they
 25 never document the capno, or they document the capno

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 2 at the time of placement but then terminate
 3 resuscitation on handoff and don't have another one.
 4 So saying that the -- the ideal
 5 documentation standard is at time of placement, with
 6 patient movement and at termination of resuscitation
 7 or handoff is the recommended documentation standard
 8 for this would allow you to actually use data to say,
 9 are we putting them in place, securing them properly
 10 so that they're not dislodged, and are recognizing
 11 dislodgement if it happens.
 12 **MS. WIERZBOWSKI:** Dr. Dorsett --
 13 **CHAIR RABRICH:** Yes.
 14 **MS. WIERZBOWSKI:** -- you'll be very
 15 happy to -- Gina Wierzbowski, W-I-E-R-Z-B-O-W-S-K-I,
 16 common spelling. It's early. So you'll be happy to
 17 know that all of those points are included in the
 18 policy, specifically for your documentation must
 19 include all of those things, so that should make you
 20 very happy.
 21 **CHAIR RABRICH:** Yes, and so we
 22 appreciate that feedback and then once the document
 23 is complete obviously this body will -- will see it
 24 and review it and, you know, but I -- I -- I
 25 appreciate that and I think all your points are being

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 2 incorporated into that document currently, so.
 3 **MR. VIOLANTE:** Mr. Chair?
 4 **CHAIR RABRICH:** Yes.
 5 **MR. VIOLANTE:** One other thing, Gina,
 6 I think you're also asking about the Drupal whether
 7 that needs to continue or not. We had used the
 8 Drupal as a form of cross checking when an i-gel was
 9 used against documentation actually coming in.
 10 So if that is something that the State
 11 or regions would like to continue doing, I imagine
 12 that's possible. I don't think we need that at the
 13 Hudson Valley though for everything around the State
 14 since it's going to be going to individual regions.
 15 **CHAIR RABRICH:** Thank you. Any other
 16 comments on the S.G.A. policy?
 17 **MR. HUDSON:** Just one, Dr. Rabrich.
 18 **CHAIR RABRICH:** Yes.
 19 **MR. HUDSON:** Don Hudson. Do we have
 20 an E.T.A. on when that policy will come out to
 21 essentially terminate the pilot and make it a
 22 Statewide standard?
 23 **CHAIR RABRICH:** Good question. Gina,
 24 any thoughts?
 25 **MS. WIERZBOWSKI:** Well, considering I

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 2 have answers to my questions it should be sooner
 3 rather than later, probably sometime within the next
 4 thirty days.
 5 **CHAIR RABRICH:** Excellent, thank you.
 6 Any other questions on this issue or -- or comments?
 7 All right. We will move on to new business. So we
 8 have a New York City protocol to review which is the
 9 altered mental status protocol.
 10 And basically in this protocol it was
 11 changed to put the -- for C.F.R. a bullet point six,
 12 if patient's blood glucose level is suspected to be
 13 low and the patient is conscious and able to drink
 14 without assistance, administer a glucose solution or
 15 other sugar containing beverage.
 16 That's really essentially the only
 17 substantive change to this protocol, which had
 18 previously been in this protocol in New York City.
 19 In updates it inadvertently got removed, its back in.
 20 The rest of it under E.M.T. is just re
 21 numbering to make everything consistent after that.
 22 So I don't know if there's any discussion on this
 23 protocol, or questions, or comments, or anyone else
 24 from New York City wants to add anything? Dr.
 25 Isaacs?

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 2 **MR. ISAACS:** Yeah, just -- Isaacs,
 3 just to reiterate what Dr. Rabrich said, this is --
 4 we had this in previous 2019, it was edited out by
 5 mistake.
 6 We're not adding glucometers for
 7 C.F.R., it's just if someone has a-- a mental status,
 8 suspected of being hypoglycemic assistance may give
 9 them some oral glucose, so.
 10 **CHAIR RABRICH:** Thank you. Other
 11 discussion? All right. So we'll take a vote on this
 12 protocol. Does this have to be roll call or just --
 13 yeah, I don't -- do I need a roll call vote or no?
 14 We never do, okay. At SEMAC we do.
 15 Yeah, okay. So all in favor of this
 16 protocol, raise your hand please. Any opposed? Any
 17 abstentions? All right. It passes unanimously.
 18 The next two items, the general
 19 operating procedure for Haz-Tac and the alternative
 20 treatment destination. These are not -- there's no
 21 change in these protocols at all. These are all
 22 language cleanup for various reasons.
 23 So if we take Haz-Tac first. It
 24 really was just language changes and cleanup to make
 25 it more consistent and more aligned with the

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 2 collaborative protocol, I believe, in certain cases
 3 and more of a standard.
 4 I don't know, Dr. Isaacs, do you want
 5 to add anything to this, I know there's no medicine
 6 changed in here.
 7 **MR. ISAACS:** Yes, there's no medicine
 8 changes. It was actually consistent with our unified
 9 protocols. There was certain things, like, removed
 10 because they're in our unified protocols already or,
 11 like, paromomycin was added, just because it's a
 12 unified protocol, it borders the Haz-Tac protocol.
 13 But essentially, there's no
 14 substantial changes, just editing and clarification.
 15 **CHAIR RABRICH:** Does anyone have any
 16 questions about this protocol? All right. Because
 17 there's no medicine change, there's just language
 18 cleanup, I believe it's informational. Do we need to
 19 vote on this or not?
 20 **MR. LANGSAM:** Are you asking me?
 21 **CHAIR RABRICH:** I'm asking you, your
 22 opinion, yeah.
 23 **MR. LANGSAM:** No, I'm not going to --
 24 **CHAIR RABRICH:** Okay. All right. I
 25 appreciate that. The -- the second item is the

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 2 Alternative Treatment and Destination Decision one,
 3 and that one was changed, again, a language change to
 4 make it consistent with the recently passed laws
 5 regarding treatment in place and alternate
 6 destination.
 7 And basically the only thing that was
 8 added here is that if a patient refuses treatment
 9 after E.M.S. assessment and treatment, the patient
 10 shall be considered as treat in place in accordance
 11 with New York State Law, all required R.M.A.
 12 procedures will still be followed. That's it, that's
 13 basically the change that was put in this document.
 14 So I don't know if people have
 15 questions on this one, or comments? All right. You
 16 know what, we will -- we'll take both of these
 17 informational changes together and we'll just --
 18 we'll just take a roll call vote.
 19 Everyone in favor of these, raise your
 20 hand. So that there's no questions later on and we
 21 don't have to redo anything, good. Anyone opposed?
 22 Any abstentions?
 23 Okay. These pass unanimously as well.
 24 Is there any other new business for the committee or
 25 discussion items anyone would like to bring up? Dr.

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 2 Dailey.
 3 **MR. DAILEY:** So one discussion item
 4 that I think is relatively important, the military
 5 and the majority of the trauma community has moved
 6 from dosing T.X.A. as one gram to dosing T.X.A. as
 7 two grams.
 8 We have an update coming, I think the
 9 suggestion of the small group of physicians that I've
 10 discussed this with already is that we just move this
 11 forward at this point now, make that change, allow
 12 agencies to adapt to it and then move forward because
 13 it's the medicine that's being practiced in our
 14 trauma centers.
 15 **CHAIR RABRICH:** Thank you. Yes, I
 16 forgot that, thank you. The -- there was discussion
 17 of this in the collaborative working group, however,
 18 when the protocols got finalized it was never put in
 19 there.
 20 And then in proofreading them for, you
 21 know, to go out for the -- the upcoming protocol
 22 update, it was recognized that we did not change the
 23 one gram to two grams.
 24 So I don't think we want to wait a
 25 whole another year to do that, I think we probably

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 2 should -- should put that in there now. But are
 3 there -- is there other discussions or thoughts on
 4 making this change to T.X.A.?
 5 I see a lot of thumbs ups, and any
 6 other commentary? So would you like to make a
 7 motion?
 8 **MR. DAILEY:** I will make such motion,
 9 please change the dosing of T.X.A. and the protocols
 10 from one gram to two grams.
 11 **CHAIR RABRICH:** To be effective --
 12 **MR. DAILEY:** To be effective in July.
 13 **CHAIR RABRICH:** To be in July,
 14 seconded by Dr. Cooper. Any further discussion on
 15 this motion? Dr. Isaacs, did you want to add
 16 anything? Dr. Winslow?
 17 **MR. WINSLOW:** Winslow, yeah. Can we
 18 just get a general census of -- of where this is
 19 being used. I know Suffolk and Nassau don't use
 20 T.X.A., and I wasn't sure if there is great use of
 21 it, and I think that would be a great thing to put on
 22 the record just so that if there are regions that
 23 aren't using it that they could look to the other
 24 regions.
 25 **MR. DAILEY:** I can just speak to the

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 2 discussions from -- from the STAC and it really does
 3 appear that there's an Upstate, Downstate
 4 differentiation here, kind of like treating
 5 hypoglycemia with maple syrup, we do that up here.
 6 Yeah.
 7 **MR. WINSLOW:** Do they use it in -- do
 8 they use it in New York City?
 9 **MR. DAILEY:** New York City --
 10 **CHAIR RABRICH:** No.
 11 **MR. DAILEY:** -- they're actually seems
 12 to be at -- at the centers themselves, there seems to
 13 be some discretion.
 14 **MR. WINSLOW:** No -- no, I meant by
 15 E.M.S.
 16 **MR. DAILEY:** Yeah.
 17 **CHAIR RABRICH:** Dr. Isaacs, your
 18 microphone, please, yeah.
 19 **MR. ISAACS:** Sorry, are we still
 20 talking about maple syrup or T.X.A.? Okay. No,
 21 T.X.A., we're -- right now we're just using it in
 22 special operations, so we've had it for a long time,
 23 and I think it was like a year, two years ago, we did
 24 change the two grams, so just supportive with Dr.
 25 Dailey on that.

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 2 **CHAIR RABRICH:** And what's the
 3 dividing line, Dr. Dailey, is it the Tappan Zee
 4 Bridge, or what's the --
 5 **MR. DAILEY:** I believe it is the
 6 bridge over the Tappan Zee.
 7 **CHAIR RABRICH:** One mile north?
 8 **MR. DAILEY:** Yeah.
 9 **CHAIR RABRICH:** Okay.
 10 **MR. DAILEY:** Yeah.
 11 **CHAIR RABRICH:** But -- yeah, so --.
 12 **MR. WINSLOW:** But just to that point,
 13 Mike --
 14 **MR. DAILEY:** Yeah.
 15 **MR. WINSLOW:** -- if this -- sorry,
 16 Winslow. If this is really a good thing, maybe the
 17 STAC should make recommendation to that. I can tell
 18 you is, I know two of the staff members who both said
 19 they don't use it in their own hospitals, so why
 20 would we want to put out an advisory that we would
 21 recommend it?
 22 And so now we have this disparity and
 23 these are from our trauma colleagues who we -- we
 24 look to for guidance on this exact subject matter.
 25 **CHAIR RABRICH:** Your microphone's not

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 2 on.
 3 **MR. DAILEY:** Thank you. One -- one of
 4 the things that -- that when we origin -- originally
 5 did this, we had said that it was going to be if the
 6 RTAC and the region's approved.
 7 And that was because there is that
 8 discrepancy in the trauma community, you know, that -
 9 - that is an ongoing discussion at the STAC. That's
 10 why it says if equipped and trained within the
 11 protocol, and in some cases it may be E.M.S.
 12 constantly asking the trauma community.
 13 You know, here's the literature, this
 14 is what we're reading, explain why you're not using
 15 this and that may ultimately end up driving some --
 16 some change, but that's where it is right now.
 17 **CHAIR RABRICH:** Dr. Isaacs?
 18 **MR. ISAACS:** I know there was some
 19 pushback initially from the trauma community, at
 20 least in the New York City, but they are supportive
 21 of how we use in terms of delayed transport, so
 22 specifically on delayed transport.
 23 But I think with the literature coming
 24 out from the military and then their strong support
 25 from it, it's -- they've been supportive of now in

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 2 New York City with it.
 3 **MR. WINSLOW:** And more than that, I
 4 think it's a great option for an agency that as we
 5 move towards changing the hemorrhagic shock protocol
 6 to be administer T.X.A. or administer blood, it's a
 7 great option for an agency that doesn't have access
 8 to blood to be least to do something for that patient
 9 who is critically ill.
 10 So I -- I kind of think that we do
 11 need to get a little bit of maybe a request from the
 12 STAC, if you will, to kind of be a little bit more
 13 formative and guidance.
 14 **CHAIR RABRICH:** Sure. Maybe our STAC
 15 representative can --
 16 **MR. WINSLOW:** That's --
 17 **CHAIR RABRICH:** -- yeah --
 18 **MR. WINSLOW:** Yeah, thanks.
 19 **CHAIR RABRICH:** -- can relay that
 20 message.
 21 **MR. HUDSON:** I have a couple of
 22 things, but just on T.X.A.
 23 **CHAIR RABRICH:** Yeah.
 24 **MR. HUDSON:** So just to give some
 25 additional color, so --

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 2 **CHAIR RABRICH:** Who are you?
 3 **MR. HUDSON:** I'm sorry, Donald Hudson.
 4 **CHAIR RABRICH:** Thank you.
 5 **MR. HUDSON:** I thought we were just
 6 doing that once, but okay. Gina, you can probably
 7 get away with it just once, but. So the
 8 conversations as the Nassau RTAC is up and running
 9 again and, you know, I would suggest to the group
 10 that the process of regionalization is working.
 11 The discussions at our regional RTAC
 12 have been, you know, one of -- is there a
 13 demonstrated need, do we see those types of patients,
 14 is there entrapment, you know, without proximity to
 15 trauma centers and what not.
 16 So, you know, they're mindful, it's
 17 almost a -- a ongoing conversation at every meeting,
 18 just like, you know, hey, where are we at, anything
 19 change, and so, you know, I would say, I don't know
 20 what STAC's feeling is, but, you know, let the RTAC
 21 sort of do their thing.
 22 **CHAIR RABRICH:** Thank you. Dr.
 23 Winslow, you had more?
 24 **MR. WINSLOW:** Yeah, one thing --
 25 sorry, Winslow. One thing I -- I found, we had a

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 2 question from an agency about the croup protocol and
 3 the use of nebulized epinephrine and or racemic epi.
 4 Neither nebulized epinephrine nor racemic epi are
 5 currently in the medication formulary --

CHAIR RABRICH: On -- on this topic
 because we have a motion that we're discussing --

MR. WINSLOW: I'm sorry.

CHAIR RABRICH: -- so we'll get back
 to that in a minute. Do you have anything else on
 T.X.A.?

MR. WINSLOW: No.

CHAIR RABRICH: Okay. We'll come back
 to you in a second. All right. So any other
 discussion on the T.X.A. -- Dr. Walters?

MR. WALTERS: My only other suggestion
 would be that, I think, I agree with the two gram
 change. I think we should just maybe specify two
 grams of T.X.A., slow I.V. or I.V. -- I.O. push just
 so we specify how it's given, as opposed to now where
 it's given one gram over ten minutes.

That dosing change, that's consistent
 with T TRIPLE C guidelines, what the military is
 doing and data published by the Army Rangers.

CHAIR RABRICH: Correct, good point.

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 2 All right. Any other discussion on this, Dr. Dailey?
 3 **MR. DAILEY:** Friendly amendment
 4 accepted.

CHAIR RABRICH: Yeah. So the motion
 is to change the protocol to two grams of T.X.A.,
 slow I.V. push via I.O. or I.V. And that that change
 will be effective in July with the protocol rollout.

All in favor of that motion? Opposed?
 Any abstentions? Okay. Motion unanimously carries.
 Dr. Winslow, your next topic.

MR. WINSLOW: Thanks Jeff. We had a
 question on the croup protocol, it is an option for
 racemic or nebulized to traditional epinephrine.

Could we add to the medication
 formulary, which is currently not there, nebulized
 epinephrine and or racemic, which is currently
 missing.

CHAIR RABRICH: Okay. Good question.
 Discussion on this? Do you want to make that in the
 form of a motion?

MR. WINSLOW: Motion to add those two
 changes to the medication formulary.

CHAIR RABRICH: So --.

MR. WINSLOW: To clarify for agencies,

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 2 because currently it's not in the approved formula.
 3 **CHAIR RABRICH:** So just so we're
 4 clear, your motion is to add racemic epinephrine,
 5 right, and nebulized epinephrine, is that right?
 6 **MR. WINSLOW:** Yeah, under the epi it
 7 just says I.V., I.M., I.O. we would just also add
 8 nebulized.
 9 **CHAIR RABRICH:** So you're adding the -
 10 - the route for epi and then racemic epi to the
 11 formulary?
 12 **MR. WINSLOW:** Yes.
 13 **CHAIR RABRICH:** Okay. Is there a
 14 second for that motion? I see a second, Dr. Kugler.
 15 Discussion on the motion.
 16 **MR. WINSLOW:** I think it probably was
 17 just an oversight in the most recent updates, quite
 18 honestly. I -- I don't have the older versions to --
 19 to attest to that.
 20 **CHAIR RABRICH:** Uh-huh.
 21 **MR. WINSLOW:** But I think they were --
 22 they're supposed to be there.
 23 **CHAIR RABRICH:** Okay. Thank you. Is
 24 there any other discussion on that motion? Seeing
 25 none, all in favor of that motion, please raise your

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 2 hand. Anyone opposed? Any abstentions?
 3 Okay. This motion also passes
 4 unanimously. Anything else, Dr. Winslow?
 5 **MR. WINSLOW:** Yeah, I just -- just had
 6 one last thing. I had a lot of questions from E.M.S.
 7 providers and agency medical directors about the
 8 Opioid Withdrawal Pilot Program protocol.
 9 Is it possible, since it is an
 10 optional protocol, that that'd be put in like big red
 11 letters above the protocol that this is optional
 12 because it does State in the bottom under key points
 13 and considerations, that only -- only enrolled and
 14 trained agencies may participate, but it's buried so
 15 far down there, I have a lot of questions from
 16 providers saying, do I have to do this?
 17 So I just bring it up for discussion,
 18 but if it's going to be an optional protocol, maybe
 19 it could be in big bold red letters, optional.
 20 **CHAIR RABRICH:** Thank you. Dr.
 21 Dailey.
 22 **MR. DAILEY:** So we've got a lot of
 23 things in the protocols that are optional by being
 24 equipped and trained. So can it be, I -- I suppose
 25 we could start changing the wording around somewhere.

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 2 The reality is that we still can't do
 3 it because of the nature of the legislation around
 4 buprenorphine. So I would take that out to a vote on
 5 -- at this table now as to whether or not it's
 6 reasonable to have one protocol out of many that
 7 would then say optional, right?
 8 We don't say optional at the top of a
 9 new protocol that we would create for T.X.A. So I
 10 would say that the consideration for treating these
 11 patients is not optional.
 12 The -- the decision on whether or not
 13 to equip and train your agency that then becomes
 14 optional at the agency level and then approval at the
 15 regional level.
 16 **MR. WINSLOW:** Yeah -- yeah, I agree
 17 with you. The -- the problem is that a lot of agency
 18 medical directors have told me they don't plan to add
 19 Suboxone to their controlled substance plans.
 20 So I think that that is really the
 21 optional for each agency medical director to decide.
 22 However, when you leave the protocol as a pilot
 23 program, so therefore, when you want to apply to the
 24 pilot program you have to go through that policy as
 25 well, adds another layer.

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 2 I think it would be just simpler to
 3 make it an optional protocol, that way you don't have
 4 to apply if you wish to participate, was the whole
 5 point.
 6 **CHAIR RABRICH:** That's a good point.
 7 I mean, I -- I understand Dr. Dailey's point too, is
 8 like we don't -- other things that are optional, we
 9 don't specify it that way.
 10 I'm just wondering if there's another
 11 way to get it, you know, like, a REMAC advisor or
 12 letter to agencies that says, you know, this protocol
 13 is -- as opposed to changing that one specific
 14 protocol. I think it's more of a -- I think it's
 15 more of a how, not a what, but --
 16 **MR. WINSLOW:** Yeah, I mean I don't
 17 really need to make a motion or ask --
 18 **CHAIR RABRICH:** Yeah -- yeah --
 19 **MR. WINSLOW:** -- for there to be a
 20 change, I can just tell you as July 1 is coming and
 21 we meet again before then. But a lot of questions at
 22 my -- in my region on are they going to be required
 23 to do this and how so?
 24 And if they wanted to apply, what is
 25 the process to apply and how do we make sure that

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 2 it's done safely and appropriately?
 3 **CHAIR RABRICH:** Right. So it sounds
 4 like there's need for some information clarifying
 5 that protocol and how to use it if you want to use it
 6 and that you don't have to use it.
 7 Which I -- I think could be handled in
 8 a different way than actually putting something on
 9 the protocol, right? Like maybe we need to send
 10 something out to agencies explaining that. Other
 11 thoughts on this?
 12 **MS. BOMBARD:** Yes.
 13 **CHAIR RABRICH:** Dr. Bombard.
 14 **MS. BOMBARD:** Should we put pilot next
 15 to the pilot ones, would that be helpful rather than
 16 optional?
 17 **CHAIR RABRICH:** We could do that; we
 18 could put a nice big airplane on the top or --.
 19 **MS. BOMBARD:** Yeah, I like that.
 20 **MR. WINSLOW:** Currently it's in small
 21 print underneath it --
 22 **MS. BOMBARD:** Sorry, take it back.
 23 **MR. WINSLOW:** Currently the pilot
 24 program only is in small print underneath it --
 25 **CHAIR RABRICH:** Okay.

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 2 **MR. WINSLOW:** -- and I get it, I don't
 3 want to make a big deal out of it.
 4 **CHAIR RABRICH:** Yeah.
 5 **MR. WINSLOW:** But it -- it becomes a
 6 big deal in July, so we need to --
 7 **CHAIR RABRICH:** Yes.
 8 **MR. WINSLOW:** -- get ahead of that --
 9 **CHAIR RABRICH:** Yeah.
 10 **MR. WINSLOW:** -- curve.
 11 **CHAIR RABRICH:** I think your points
 12 are well heard. I think we can go back and take a
 13 look at, you know, maybe the font for that needs to
 14 be changed, made bigger or something, but I -- I
 15 think that yes.
 16 That in combination with, I still do
 17 think there should be some information clarifying the
 18 intent of that protocol and how it will be used that
 19 could be sent out to agencies as well. So I'm going
 20 to do that.
 21 Any other comments on this? All
 22 right. I'm told that we have some blood regulation
 23 update information available from the Bureau, so
 24 Gina, I don't think you need to spell your last name
 25 again, but if you could give us any --

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 2 **MS. WIERZBOWSKI:** Yes, Gina
 3 Wierzbowski, good morning again. I just wanted to
 4 give the group a quick update. We had one final
 5 meeting with Wadsworth to go over the latest draft of
 6 the regulatory package and we are ready to submit it.
 7 Initially, we were going to wait for
 8 A.A.B.B. to come out with their standards, but we
 9 have been told they're not coming out somewhere
 10 towards -- until somewhere towards the end of March
 11 perhaps, and that isn't even necessarily set in
 12 stone.
 13 So -- and that will take us some time
 14 to go through and review and make sure and all of
 15 that, so in -- in the spirit of moving things along,
 16 we're going to submit the package as it is now and
 17 we're going to submit it as an emergency package,
 18 which means it will work its way through the regular
 19 process.
 20 But when it gets to a certain point it
 21 will be enacted at the same time as it goes out for
 22 public comment, as long as it's approved. So that
 23 means it's a little bit shorter in terms of when we
 24 get to enactment, hopefully by several, several
 25 months.

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 2 So we're going to submit that and then
 3 when the standards come out, we will take a look at
 4 them, we'll make sure that there is -- that we didn't
 5 miss anything glaring, that they recommend we do and
 6 -- and perhaps have another meeting of this group --
 7 of the subgroup that we had that was advising us from
 8 members of SEMSCO, et cetera.
 9 Just to make sure we don't miss
 10 anything, but we feel that at this time we're in good
 11 shape to just start moving forward. And I just
 12 wanted to let the group know that because I know
 13 everybody is anxiously awaiting.
 14 **CHAIR RABRICH:** Thank you.
 15 **MS. WIERZBOWSKI:** You're welcome.
 16 **CHAIR RABRICH:** Are there questions
 17 around the regs or the process for Gina, anyone? All
 18 right, thank you.
 19 **MS. WIERZBOWSKI:** You're welcome.
 20 **CHAIR RABRICH:** Is there any other new
 21 business or discussion items people would like to
 22 bring up? All right. Well, it's going to be a short
 23 meeting then.
 24 I will entertain a motion for
 25 adjournment if no one has anything else. So moved.

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2 All right. We are adjourned, thank you very much.
3 (The meeting concluded at 8:41 a.m.)
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