

9/18/2024 - Medical Standards - Saratoga Springs
NEW YORK STATE
DEPARTMENT OF HEALTH

MEDICAL STANDARDS

DATE: September 18, 2024

TIME: 8:07 a.m. to 9:44 a.m.

CHAIR: JEFFERY RABRICH

LOCATION: Embassy Suites
86 Congress Street
Saratoga Springs, New York

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2 (The meeting commenced at 8:07 a.m.)
3 (The hearing commenced at 08:07 a.m.)
4 **CHAIR RABRICH:** Good morning,
5 everyone. This is the meeting of the Med Standards
6 Committee. For those that don't know me, I'm Jeff
7 Rabrich, Chair of the Committee. And the attendance
8 will be going around for your signature. Okay. And
9 then yes, Dr. McEvoy.
10 **DR. MCEVOY:** One quick comment for
11 those who weren't here yesterday. Because of the
12 size of this room, there are two satellite rooms
13 upstairs. So, please make sure that you're using a
14 microphone when you speak.
15 And even if you're coming forward from
16 behind us, come up to a microphone because otherwise
17 no one upstairs will know what you're saying. Thank
18 you.
19 **CHAIR RABRICH:** Thank you. And for
20 those people who are upstairs in the other rooms, if
21 you wish to speak at this meeting, I'm told you need
22 to come down here, so bear that travel time in mind,
23 if you have something you want to comment on, make
24 your way down to this room, so you can comment as
25 well.

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2 **APPEARANCES:**
3 **ALBERT SHIN**
4 **ARTHUR COOPER**
5 **BRIAN CLEMENCY**
6 **BRIAN WALTERS**
7 **DAVID KUGLER**
8 **DAVID VIOLANTE**
9 **DONALD DOYNOW**
10 **DONALD DUVAL, JR.**
11 **DONALD HUDSON**
12 **DOUGLAS ISAACS**
13 **JASON WINSLOW**
14
15 **JEREMY CUSHMAN**
16 **MAIA DORSETT**
17
18 **MICHAEL DAILEY**
19 **MICHAEL MCEVOY**
20 **MICHELE FORENESS**
21 **PAMELA MURPHY**
22 **RYAN GREENBERG**
23 **TERESA HAMILTON**
24 **THERESA ALLEN**
25 **TIFFANY BOMBARD**

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2 All right. So -- are you ready, Dave?
3 **MR. VIOLANTE:** Yes, I am.
4 **CHAIR RABRICH:** Okay. So, we are
5 going to start with -- with old business. And the
6 first item is, we're -- we're going to have a
7 presentation on the i-Gel project. So, we'll turn it
8 over to Mr. Violante and Dr. Murphy and for -- and
9 first, thank you for all your hard work on the
10 project and we look forward to hearing your report.
11 **MR. VIOLANTE:** All right. Thank you
12 everybody. I appreciate your -- your time with this.
13 Certainly, feel free to stop me if you have any
14 questions. And if we could just go to the next slide
15 here. Thank you, Teresa. I appreciate that.
16 All right. So, first of all, a very
17 special thanks to everybody involved. There was a
18 lot of people that did just a ton of work on this
19 project. And so, everybody from the Hudson Valley,
20 REMAC and Regional E.M.S. Council, the executive
21 leadership and the -- all the folks here that were a
22 part of this as well.
23 So, the SEMAC, certainly everyone here
24 from Med Standards, the Bureau of E.M.S. for all of
25 their countless hours of -- of help and work with

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 2 this. Really in looking at data, scrubbing data,
 3 getting data, validating data, and working through
 4 the different components of this with the agencies as
 5 well.
 6 So, there is just a ton of work by
 7 everybody. And you can see the -- the group on here
 8 that was the i-Gel committee from the HVREMSCO. Next
 9 slide.
 10 So, just to recap what this actually
 11 is. We looked at a demonstration project for the
 12 feasibility of E.M.T.s to successfully utilize an i-
 13 Gel S.G.A. during the treatment of adult patients in
 14 cardiac arrest.
 15 And we did this for a couple of
 16 reasons. And Greenville brought this forward to us,
 17 and we thought, yeah, this is a super -- this is a
 18 super fantastic idea. So, better airway management
 19 and oxygenation as related to difficulties in B.V.M.
 20 seal as -- as one piece, reduced availability, and
 21 access to A.L.S. as another reason. And we have a
 22 lot of other states already doing this.
 23 Currently, there are somewhere around
 24 thirteen or fifteen other states that are utilizing
 25 this at the B.L.S. level in conjunction with

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 2 capnography. And so, these are the three main
 3 reasons for doing this. Next slide.
 4 Here's our timeline. It seems like it
 5 was so long ago, and it was, when we first started in
 6 2020 from the concept brought to the HVREMSCO, coming
 7 up to the D.O.H. for approval, developing the
 8 project, modifying it a little bit here and there,
 9 getting approval from SEMAC, SEMSCO, starting it,
 10 getting all of the folks doing the training, going
 11 through collecting data.
 12 And then finally here we are reporting
 13 to the state, and this is a -- a wonderful day to be
 14 able to do this. So, here's our timeline. Next
 15 slide. So, here's what we ended up with. A hundred
 16 and seventy-three agencies applied to the program.
 17 We have a hundred and twenty-four that completed the
 18 approval process, went through all of the training,
 19 the didactic training, the -- all the other pieces to
 20 what they needed to do in terms of getting this
 21 project up in running.
 22 And we ended up with almost two
 23 thousand E.M.T.s across the state that were trained
 24 to insert i-Gel's, which is fantastic. We ended up
 25 having agencies submitting a Drupal survey in

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 2 addition to getting weekly reports from the Bureau of
 3 E.M.S. to the HVREMSCO of the study.
 4 And the reason for this was to ensure
 5 data, so that we knew a Drupal that came from an
 6 agency that inserted an i-Gel was one facet of this
 7 happened, and then getting the report from the state
 8 with all the remaining data was the next piece.
 9 And so, we were able to see what
 10 agencies weren't sending data to the state through
 11 this mechanism where we said, hey, we've got a
 12 Drupal, but we don't see their report at the state
 13 level, where is that?
 14 And that prompted us to be able to go
 15 to the agency and fix any transmission issues,
 16 anything like that -- that -- that came across. And
 17 so, that was very helpful not only for the i-Gel
 18 program, but then for any other data that needed to
 19 get to the state, and then, also get out to hospitals
 20 and other -- and other groups involved.
 21 Next slide. So first, so our outcomes
 22 here. When we looked at primary feasibility
 23 outcomes: successful insertion, maintenance of the
 24 S.G.A.s reported by the crew, confirmed by a hell of
 25 a provider is the next step of this. And then,

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 2 verified by Waveform Capnography, all the components
 3 that we wanted to see.
 4 Next slide. Field terminations was a
 5 little bit of a different issue in this case. And
 6 so, in these cases, we didn't always have an A.L.S.
 7 provider be able to come to and see the S.G.A. and
 8 the insertion. They didn't always go to the hospital
 9 to have that verification, and they had a termination
 10 in the field. So, what we looked at in terms of this
 11 data was their idea of success of a successful
 12 insertion and in addition, capnography. And so, in
 13 the absence of capnography, we didn't count that one
 14 into the data. Next slide.
 15 So, here's the actual numbers here for
 16 i-Gel cases, and I'm sitting here down by this thing
 17 and still can't see it. Sorry about that. Okay.
 18 So, i-Gel cases from '23 to '24, total of four
 19 hundred and nineteen, three hundred and twenty-seven
 20 successful, fifty-nine not in the repository. And
 21 then we have failures that are not on the list that
 22 were -- were considered. So, people that did
 23 failures, when we say failure, we counted failures as
 24 those that, they couldn't do it for some reason.
 25 We'll look at what those slides are next.

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 2 Go ahead. Next slide. Here's our --
 3 our ages, weights, genders. Next slide. So, we
 4 typically had about a seven to eight minute dispatch
 5 to patient time as a median. And then at patient to
 6 first attempt, another somewhere around seven
 7 minutes, just below seven minutes as well. So, these
 8 were -- were fairly timely.
 9 Go ahead. Next, i-Gel sizes and then
 10 ETCO2 values. So, something that we didn't initially
 11 think about in terms of what we had wanted and sent
 12 out to folks was looking at a pre i-Gel end tidal
 13 value and then an insertion i-Gel value and then a
 14 post insertion somewhere down the road value.
 15 And so, we got values that were a
 16 little bit over the place in terms of end tidal CO2.
 17 Some folks just placed the i-Gel and didn't do an end
 18 tidal until after insertion. And so, you'll see
 19 where some of these values are in there with the
 20 highest ones. Lowest ones or the final ones that are
 21 there. But they all seem to be in a general pretty
 22 median area of -- of around just above twenties.
 23 Next. And so, are success rates. So,
 24 we've got reporter success all the way on the left,
 25 B.L.S. basic provider reported success. Capnography

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 2 reported in eighty-six percent is the next column.
 3 Next to the right, placement confirmed by higher
 4 level provider, eighty-three percent. And then
 5 finally, placement confirmed by higher level provider
 6 and or capnography ninety-six percent of -- of those
 7 placed. Next slide.
 8 So, here's some interesting
 9 information we pulled out of this. Patient responses
 10 either unchanged or improved. There are a number of
 11 different areas that are non-recorded. And so, in
 12 those cases we just could not find the data on what
 13 that was, and so we left it at not recorded for what
 14 it was.
 15 So, unchanged or improved adverse
 16 events, three hundred and five had none. Other
 17 adverse events were vomiting, apnea, combinations of
 18 those and nausea. Reason discontinued, med control
 19 field order for a field termination, eighty-nine.
 20 Other reasons not recorded, we just
 21 couldn't find what those reasons were as to why it
 22 was discontinued. Protocol completed, return of
 23 spontaneous circulation fifty-six, D.N.R. emulsed.
 24 You can -- you can see what these are. I -- I will
 25 happily read them to you, but I think you can see

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 2 them.
 3 Airway failure reasons, none, two
 4 hundred and eighty-five. And then we have a
 5 smattering below there, difficult anatomy,
 6 secretions, blood vomit, jaw clench, patient access.
 7 Inability to expose vocal cords, again, some of the
 8 data that comes through, we did our best to try and
 9 make sure the data was completely aligned, but some
 10 of the data that came through showed things like
 11 this, and so we didn't want to report that.
 12 Outcomes, a hundred and twenty-one
 13 expired in the field, seventy-two in the E.D., forty
 14 were ongoing resuscitations in the E.D., thirty-one
 15 ROSC, thirty ROSC in the E.D. and then some others
 16 not recorded. Next slide.
 17 Here are the i-Gels by region, just
 18 from an informational perspective of where these were
 19 done all around the state. Next slide. So, we ran
 20 into some challenges with this and -- and aside from
 21 really demonstrating that E.M.T.s could insert i-Gel
 22 successfully. One of the other side benefits of this
 23 is that we believe that some of the data moving
 24 around the state was dramatically improved. And this
 25 was one of the most difficult pieces of the study

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 2 initially. So reasons for that, documentation of
 3 data was sometimes in a narrative area, which could
 4 not be captured.
 5 And so, we changed that and tried to
 6 move agencies into getting the data into a tabulated
 7 field. And so, the spin off was that not just data
 8 for i-Gels went in that area, but other data also
 9 then went into those areas, making that data
 10 capturable and able to be looked at.
 11 Vendors using NEMSIS data
 12 configurations were some of the challenges. And so,
 13 working with the number of -- of vendors to ensure
 14 that an i-Gel was an i-Gel and not an intubation or
 15 something otherwise, was -- was one of the components
 16 that was a challenge. And in -- in some of the
 17 vendors, agencies themselves could change some of
 18 these data fields. And so, it went away from NEMSIS.
 19 And -- and we were able to get them back into what
 20 the right field reporting values were supposed to be.
 21 And again, not just for i-Gel, but then for some
 22 other things as well.
 23 We had issues with data flow from
 24 agencies to either the regional repository or the
 25 state repository. And so, we worked a lot with the

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 2 data informatics team and agencies to fix that.
 3 Especially, when we saw Drupal come in, but we didn't
 4 see the report in the state report. And also, from
 5 regional sites, the state repositories, we had a
 6 number of regional sites that had gotten the data,
 7 but it hadn't been moved up to the state yet.
 8 And so, this ended up allowing for
 9 better data flow once we realized what those problems
 10 were and then worked with the agencies and the
 11 regions to get that data flow happening. Mapping,
 12 which we talked about. And then ability to report
 13 the data in the state repository. We went through a
 14 number of iterations of a report out of the state to
 15 finally get the things that we needed, and there was
 16 a lot of work by the data informatics team with us to
 17 -- to get exactly what that was supposed to be.
 18 And fall -- finally there was just a
 19 ton of follow up among agencies to get complete data
 20 sets for things that were missing. And so, we would
 21 give quarterly reports, reach out to agencies
 22 individually once we had a weekly report from the
 23 state to say, hey, this is what we got, is that true?
 24 Is that not true? And to make sure that the data was
 25 clean and good.

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 2 Next slide. So, some of the solutions
 3 to data collection challenges got us a lot of things,
 4 and it really progressed data movement from agencies
 5 to the state. And then out also to regions and then
 6 down to hospitals. And so, that positively really
 7 impacted data collection not only for this, but for
 8 other areas of P.C.R.s and whatever data people
 9 needed as well. Next slide.
 10 So, we really believe that this works.
 11 And so, the data strongly suggests E.M.T.s can
 12 utilize an i-Gel, S.J. in adult patient and out of
 13 hospital cardiac arrest. Next slide.
 14 So, here's our recommendations. That
 15 the bureau develop an i-Gel B.L.S. adjunct policy
 16 that allows current certified E.M.T.s to utilize and
 17 maintain it in an instance of cardiac arrest if
 18 trained and equipped with regional authorization and
 19 oversight, and that Waveform Capnography is mandatory
 20 in all uses.
 21 That's our first recommendation out of
 22 this. The second one is that, the i-Gel for the love
 23 of God, demonstration project include. I say that in
 24 jest only because this was just a ton of work, and
 25 we're absolutely happy to do this, but we really

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 2 believe it needs to move to the next step and that is
 3 to the state as an adjunct.
 4 But we don't want the folks to not be
 5 able to continue to use this. And so, we want to be
 6 able to continue this project until the state has the
 7 policy and things in place to be able to do it, so it
 8 doesn't stop.
 9 And finally, we want to advocate, of
 10 course, that -- that B.L.S. providers can use an i-
 11 Gel and capnography and Waveform Interpretation in
 12 the B.L.S. scope of practice not only for New York
 13 State, but to advocate that nationally. And so,
 14 those are our -- our -- our three recommendations out
 15 of this.
 16 Next slide, please. For future
 17 demonstration projects, we do have some suggestions,
 18 and a lot of this is happening now, especially with
 19 the research project flow sheet that's -- that we've
 20 all been talking about, which is fantastic to have
 21 that in place.
 22 But for folks to develop a set of
 23 expectations that are smart in -- in action, right.
 24 So specific, measurable, achievable, relevant, time
 25 bound, clearly communicate all the information,

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 2 develop a good data set and test it -- test it
 3 accurately, get good data to have something come
 4 through efficiently, effectively from every vendor
 5 that's involved, and every agency involved with this.
 6 Validate the data for accuracy,
 7 include documentation expectations of what we want,
 8 specifically in P.C.R.s and how folks are to do that.
 9 Whatever training needs to be updated, reinforced,
 10 re-evaluated, and modified. And then absolutely
 11 confer on a very regular basis with all those
 12 agencies involved, regions, the state, et cetera.
 13 And these are recommendations also from this as well.
 14 Next slide, please. And there's our -- our
 15 bibliography for information.
 16 So, that is a wrap-up of the i-Gel
 17 program. I believe that it's been pretty successful.
 18 Again, huge thanks and shout out to all of the folks
 19 here that made it possible, all of the agencies that
 20 participated, all of the E.M.T.s that were a part of
 21 this and you know, the folks that helped them get
 22 through this and do this.
 23 And of course, to the state data
 24 informatics team for all of their work, and the
 25 thousands of emails back and forth among all of us to

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 2 -- to get this to happen. We think it's very
 3 positive. Anecdotally hearing from E.M.T.s. This
 4 was a very huge success for them, and they feel that
 5 really their patient care was impacted positively
 6 from this, and they really look forward to doing
 7 something like this. So, again, thank you and -- and
 8 I'll take any questions.

9 **CHAIR RABRICH:** Thank you. So first,
 10 I want to say thank you to you and the team. And I
 11 realize this was a tremendous amount of work to put
 12 this together and then to get all that data and go
 13 through it and -- and make the recommendations you
 14 did.

15 So, thank you very much. It's greatly
 16 appreciated, and I'll open it up to questions or
 17 comments from the group.

18 **MR. VIOLANTE:** You all need more
 19 coffee this morning, I'm sorry.

20 **DR. MURPHY:** So, I think one of the
 21 things also that it proved, Dr. Rabrich, is the
 22 B.L.S. community is starving for new adjuncts and
 23 ways to help their patients, and I think this showed.
 24 I mean, we started with Greenville. I thought it was
 25 going to be like a little Hudson Valley kind of thing

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 2 and look at how it exploded across the state.
 3 You know, so I think it just shows
 4 that they really thrive on having this next step in
 5 their adjunct process, and so I just think it's -- we
 6 should move it forward.

7 **MR. VIOLANTE:** Thank you.

8 **DR. MURPHY:** Make it real.

9 **MR. VIOLANTE:** Yup.

10 **MR. HUDSON:** So, David I see these are
 11 up on Boardable; is it something we can present or
 12 share with our REMACs and such?

13 **MR. VIOLANTE:** Absolutely.

14 **MR. HUDSON:** Cool.

15 **DR. MURPHY:** Yeah.

16 **MR. HUDSON:** All right. Thank you.

17 And then I guess, to the leadership. So, on the
 18 national level, how do we move this forward? And I
 19 know, you know, Ryan and your compatriots around the
 20 country are, you know, have a collaborative group
 21 that you work with.

22 I -- I think that is not just to throw
 23 the final kudos to these guys and the closure of
 24 their project on the state level, but you know, to
 25 bring New York to the forefront, a look -- like a

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 2 look at what we did moment. I think, it'd be a big
 3 shot in the arm to not only our providers, but our
 4 state.

5 **DIRECTOR GREENBERG:** I couldn't agree
 6 more. And so, I'm actually, I'll have two different
 7 meetings in October and November with NASEMSO. I can
 8 bring this to them, find out what that pathway is on
 9 what the next steps are for, you know, kind of those
 10 models and what they work on. And I agree with you.

11 I mean, Dave, obviously tremendous
 12 work to -- to you and your team and -- and you know,
 13 from going through this from the beginning and
 14 figuring it out to, you know, some of the trials and
 15 tribulations that happened along the way.

16 I did have one question for you, but I
 17 think Doug wanted to go first and then I'll go after
 18 Doug. But we'll -- we'll take it to NASEMSO and
 19 bring it back. So, by the December meeting, I should
 20 at least have a little bit of a framework on what
 21 that looks like.

22 **CHAIR RABRICH:** Thanks. Dr. Isaacs.

23 **DR. ISAACS:** Okay. Again, great job,
 24 really outstanding. The only question I'd bring up
 25 instead of being device specific, if it were to

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 2 become a part of the protocols, just supraglottic
 3 airway.

4 I understand, like, our agency uses i-
 5 Gel, but just to, as long as something is F.D.A.
 6 approved and agencies are using various supraglottic
 7 airways, I understand the ease of -- of its use and
 8 simplicity, but just using generic language, so.

9 **CHAIR RABRICH:** Yeah. So, that's an
 10 interesting question. I do think we're going to need
 11 to discuss, so. Dr. Murphy.

12 **DR. MURPHY:** No, go ahead.

13 **MR. VIOLANTE:** Great. Okay. So, when
 14 we initially did this study, it was very specific to
 15 i-Gels, and so this is the data that I'm able to
 16 present specifically with this -- this one particular
 17 thing. If the group wants to move something else
 18 forward, that's a good discussion point.

19 This is where we stood with this
 20 project from the beginning of it as a way to do it
 21 and not a variety of them. And so, this is -- I
 22 don't have data on those other things. It's a good
 23 talking point, though. And also, something that's
 24 important to know is I have -- this whole team has
 25 zero affiliations with anybody else with -- with

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 2 related to i-Gels, Intersurgical or anything like
 3 that. So, I just want to make sure I make that very
 4 clear.
 5 **DR. MURPHY:** And we really wanted, you
 6 know, if you remember, our first conversations talked
 7 about this that, you know, you don't want to be just
 8 naming one product and have some kind of, you know,
 9 problem there. But we didn't want it to be confused
 10 with the king airway. We didn't want it to be
 11 confused with the other supraglottic airways.
 12 This has been shown to work in other
 13 states, and so we wanted to bring it forward in just
 14 this fashion. And the i-Gel as, you know, everyone
 15 alludes to, it's ease to placement and really, as you
 16 can see even in our data, it proves it works. And
 17 so, that's why it wasn't that we were getting any
 18 money from them. We weren't.
 19 **DIRECTOR GREENBERG:** Dave, two
 20 questions. So one, are there other similar, kind of
 21 to Doug's comment, but are there other similar
 22 devices, and maybe not the king. I think king is,
 23 yes, it's another supraglottic airway, but it takes a
 24 little different path.
 25 But, you know, Dr. Isaacs brought up

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 2 related to, you know, not sticking to one, but, you
 3 know, have we seen now that the i-Gel has come out,
 4 have we seen other similar devices from other
 5 companies come out during this project?
 6 **MR. VIOLANTE:** So, there are a number
 7 of devices that are -- that are out there. I don't
 8 know if there are any that act immediately as similar
 9 to the i-Gel from a branding perspective, but there
 10 are other S.G.A.s that are out there, yes.
 11 **CHAIR RABRICH:** Dr. McEvoy?
 12 **DR. MCEVOY:** I would say too, there
 13 are about fifteen states that allow E.M.T.s to use i-
 14 Gel specifically. There are also some major E.M.S.
 15 systems, Fort Worth, Texas, Louisville, Kentucky, who
 16 specify i-Gel in their protocols because it is so
 17 different in -- in the insertion and the use than
 18 other supraglottic airways.
 19 **CHAIR RABRICH:** Dr. Winslow, and then
 20 --
 21 **MR. VIOLANTE:** Yeah.
 22 **DR. WINSLOW:** Oh, sorry. Yeah, we --
 23 we looked at this. There's two other manufacturers
 24 that make a supraglottic airway that does not require
 25 balloon insertion, and so the language should really

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 2 be generic. I -- I do think you'd need to not
 3 promote a product, but what the product stands for
 4 and why the success of the program is that the ease
 5 of the insertion and the lack of having to insufflate
 6 a balloon.
 7 **CHAIR RABRICH:** Thank you. Dr.
 8 Dailey, were --
 9 **DR. WINSLOW:** Another comment David.
 10 As -- as you move this towards publication, which I'm
 11 sure you will, you're going to want to report the
 12 survival data.
 13 **CHAIR RABRICH:** I think, Dr. Dailey,
 14 did you want to say something?
 15 **DR. DAILEY:** I was actually going to
 16 take that in a slightly different direction. I mean,
 17 we've only -- David -- David's work is -- is
 18 excellent, but only refers to the i-Gel. I don't
 19 think we can make it more generic because this is
 20 very device specific in terms of what -- what he
 21 learned, and I think as such we should do that.
 22 The other thing I think that's really
 23 important here is that, David's work went a lot
 24 farther than just i-Gel, right? I mean, we moved the
 25 needle with --

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 2 **CHAIR RABRICH:** The amount of data.
 3 **DR. DAILEY:** -- data and informatics
 4 in terms of how they could work with that data,
 5 manipulate the data work with -- work with this
 6 project. That was an extremely important learning
 7 opportunity for us. We certainly saw some of the
 8 challenges they were all facing together at a prior
 9 meeting. It sounds like many of those were resolved,
 10 and that's just exciting as part of the process.
 11 And the other thing he gives us is a
 12 list of recommendations for how we should approach
 13 future projects. I think we need to memorialize that
 14 and make sure that we follow some of those
 15 recommendations anytime we do our next move to
 16 improve E.M.S. in New York. So, a lot of great
 17 learning. Thank you to Hudson Valley.
 18 **CHAIR RABRICH:** Thank you. Don, will
 19 you?
 20 **MR. HUDSON:** Yes, we, you know, pushed
 21 the -- pushed the ball forward. I think we have past
 22 practice here that worked for this body and for the
 23 state in playing off the successes that was initially
 24 check and inject. You know, not to advocate for a
 25 singular device or manufacturer, but to clearly, you

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 2 know, within the constraints of a study, focus on the
 3 skill itself utilizing a singular device.
 4 I think I would suggest or ask the
 5 Body if that's the path forward that if a region or
 6 an agency wants to use a different blind insertion
 7 device, that they should then apply or, you know, to
 8 bring that to the region who then would come before
 9 Med Standards of SEMAC with that, and that would then
 10 open up that device as did check and inject, which is
 11 now as we know, utilizing a standard syringe, which
 12 was nowhere is on the radar in that initial study.
 13 So, I think this is as -- as everyone's saying, a
 14 tremendous first step, and there's certainly room for
 15 growth in the future.
 16 **CHAIR RABRICH:** So, you'll be
 17 launching a pilot of another supraglottic device, is
 18 that what you're saying?
 19 **MR. HUDSON:** I'll -- I'll --
 20 **DIRECTOR GREENBERG:** Dr. Kugler, I
 21 think he just volunteered, yeah.
 22 **CHAIR RABRICH:** Go ahead.
 23 **DIRECTOR GREENBERG:** Two questions for
 24 you, sir. And you might have said it, and I
 25 apologize if you did. How many of the cases that the

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 2 Can you talk for a minute about what
 3 that was like, maybe the learning curve of getting
 4 agencies to understand what the quality assurance was
 5 and are there some takeaways or things that -- that
 6 we can learn from this project focusing on -- on the
 7 quality assurance?
 8 **MR. VIOLANTE:** Right. So, every one
 9 of the insertions had to go through the quality
 10 assurance process at the agency level and we did
 11 follow up with agencies. They also reached out to us
 12 about the quality assurance of it.
 13 And in some cases, in a number of
 14 cases that we were unsure of the data and reached out
 15 to the agency and then received corrected data. And
 16 the agency followed up to say, yup, we did Q.A. with
 17 the crew. We talked to them. This is what it was.
 18 It was actually an i-Gel, not an
 19 endotracheal tube. It was an i-Gel number six, not
 20 a, you know, something else that was a data issue.
 21 But it seemed by and large that good quality
 22 assurance was happening at the agency level and then
 23 at the variety of regional levels as well.
 24 **DIRECTOR GREENBERG:** Thanks.
 25 **MR. VIOLANTE:** Uh-huh.

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 2 i-Gel was used, was this an A.L.S. provider not
 3 available or not? Like, the patient was transported
 4 all the way to hospital only with B.L.S. Did we --
 5 were we able to capture that?
 6 **MR. VIOLANTE:** I am -- I'm looking at
 7 the moments about that what we might have. We -- we
 8 may have that, but it may not be right up here. I
 9 can look for that and get back to you on that.
 10 **DIRECTOR GREENBERG:** That'd be great.
 11 And on that same line and I, again, I don't know if
 12 you'll be able to tell or not. But is there any
 13 identification of how far ahead of time? So, in
 14 other words, maybe a paramedic was able to get there,
 15 but the paramedic still took twenty or, you know,
 16 twenty minutes to get there and the B.L.S. was there
 17 and like I think you said the average time was seven
 18 minutes, five to seven minutes. What that time
 19 difference was?
 20 And then the other question I had for
 21 you was, the quality assurance. So, this program
 22 required a lot more quality assurance than, I don't
 23 want to say what many agencies would do, but probably
 24 much more specific than a lot of other agencies would
 25 do.

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 2 **CHAIR RABRICH:** Yes, Dr. Cooper?
 3 **DR. COOPER:** Thank you. Terrific
 4 presentation, great work. You know, I share my, you
 5 know, congratulations on all the great quality
 6 improvement work you did in addition to the actual
 7 study itself. And, you know, tribute to Dr. Dailey
 8 sitting to my right.
 9 I guess, the one concern that I have
 10 in terms of bringing this to the E.M.T. level is not
 11 so much the i-Gel insertion itself, but rather the,
 12 you know, the confirmation process.
 13 You know, it seems to me that -- that
 14 -- that the placement issue is a little bit less
 15 complicated, you know, than using the, you know, the
 16 -- the -- end-tidal capnography that we would, you
 17 know, ideally like to see for, you know, confirmation
 18 -- secondary confirmation of -- of correct placement.
 19 So, how do you foresee that rolling
 20 out? And do you think that presents as much of a
 21 barrier as I'm worried that it might?
 22 **MR. VIOLANTE:** That's a -- a great
 23 question. I appreciate that question. I think that
 24 end-tidal CO2 could -- should go right along with
 25 SpO2 in everybody's bag of what they use. And I

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 2 think it's easy enough to be able to utilize.
 3 E.M.T.s have -- have very clearly demonstrated their
 4 ability to do end-tidal CO2.
 5 And as a confirmation process of
 6 placement. And we had some great educational
 7 presentations. And folks had to go through didactic.
 8 And a practical component of understanding placement
 9 as well as end-tidal CO2 evaluation in all these
 10 cases.
 11 And so, it was, I think, a very good
 12 tool to bring patient care overall forward and having
 13 E.M.T.s realize that they can use end-tidal not only
 14 in a placement of an i-Gel but in any kind of
 15 respiratory case or other scenarios as well.
 16 And so, this provides them with yet
 17 another ability to evaluate and treat patients based
 18 on good clinical data that they get versus only for
 19 an i-Gel case.
 20 **DR. COOPER:** Thank you. And as a
 21 secondary question, not secondary, but a different
 22 question. You know, we all are, I think, well aware
 23 of the data showing that at least in relatively short
 24 transport time systems that effective bag-valve mask
 25 ventilation is equal to or preferable to, you know,

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 2 definitive airway.
 3 How do you see this playing out in --
 4 in that regard? Would you be looking to use the i-
 5 Gel only in environments where, you know, where
 6 B.V.M. is not successful or would you suggest that we
 7 should be altering our approach here?
 8 I realize this is only in cardiac
 9 arrest patients, but -- but still, I think that the
 10 question remains how we foresee this being, you know,
 11 ruled out. Thank you.
 12 **MR. VIOLANTE:** Another great question.
 13 And one of the reasons for doing the study as well,
 14 right? And so, mask seal is one of the conundrums of
 15 all E.M.S. providers, you know, out there in the
 16 moving ambulance and, you know, all kinds of
 17 scenarios that -- that cause issues with -- with a
 18 B.V.M. seal and thereby, relating to poor ventilation
 19 and -- and movement of gases.
 20 So, in this case, having an i-Gel
 21 placed afforded a far better seal and movement of --
 22 of airway volume than -- than a B.V.M. seal did. And
 23 so, I could imagine that people would use this far
 24 more successfully and have greater outcomes than with
 25 just a -- a plain B.V.M. seal.

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 2 **DR. COOPER:** Thank you for your very
 3 thorough answers. Greatly appreciate it.
 4 **MR. VIOLANTE:** Thank you.
 5 **CHAIR RABRICH:** Just so one final
 6 question. I know we have a lot of steps to move on,
 7 but what do you foresee as barriers to agencies kind
 8 of adopting this and using it? I know, for instance,
 9 the cost of end-tidal might be an issue or -- or what
 10 -- what are some of the -- the barriers you see
 11 moving forward for agencies adopting this?
 12 **MR. VIOLANTE:** I think cost is
 13 probably the -- the biggest component of it for the
 14 end-tidal, but there's -- there are a lot of
 15 mechanisms out there that to be able to utilize end-
 16 tidal. Certainly, you don't need a forty thousand
 17 dollar monitor where you're only going to use one
 18 facet of it.
 19 There are a number of devices that can
 20 be used such as the EMA or other kinds of things that
 21 are there, not making any particular --
 22 **DR. MURPHY:** Product endorsement.
 23 **MR. VIOLANTE:** Product recommendations
 24 or endorsements, so that these are the things that
 25 are there. So, I think that's probably the -- the

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 2 biggest piece of it. I think it's very possible for
 3 folks to do this, to insert it, to utilize it.
 4 And -- and to do the other adjuncts
 5 that -- that should be with it as part of the program
 6 as well.
 7 **DR. MURPHY:** It should be mandatory,
 8 though, Dr. Rabrich. I think, you know, the end-
 9 tidal CO2 is mandatory with this, you know.
 10 **CHAIR RABRICH:** Yes.
 11 **DR. MURPHY:** So, that was one of the
 12 things we pushed, which we did get a little push back
 13 in the very beginning, but then people understood why
 14 we were going down that road.
 15 **CHAIR RABRICH:** Great. Mr. Hudson?
 16 **MR. HUDSON:** So lastly, on the
 17 capnography, is there an opportunity or is it
 18 possibly time to reiterate what we specifically mean?
 19 My -- I'll make the statement of it's not just yes,
 20 no, in or out at the time of insertion. It's
 21 continuous --
 22 **CHAIR RABRICH:** No, it's continuous
 23 waveform. Yeah.
 24 **DR. MURPHY:** Waveform that's then
 25 recorded and archived. I know that at least in my

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 2 region back home, that seems to be a discussion point
 3 amongst some regions that don't -- some agencies that
 4 don't see it that way.
 5 **DIRECTOR GREENBERG:** You bring up a
 6 point of continuous recorded. And -- and just, I
 7 don't know enough outside of good, better, and
 8 different the LifePak 15 that I use. Dave, on the
 9 devices that you're seeing some of these B.L.S.
 10 agencies use when they're not using a LifePak 15 or
 11 something of that nature.
 12 Does it offer that opportunity to
 13 record it and to upload it to a chart or do something
 14 with it or how -- how does that work?
 15 **MR. VIOLANTE:** Most cardiac monitor
 16 defibrillators such as LifePak, Zoll, et cetera,
 17 whatever, will record it, attach it to a chart and
 18 make it available as -- as a recorded waveform that
 19 can be archived.
 20 Some of the other devices do not have
 21 that ability, but they do have waveform. And you can
 22 record in the chart, what the numbers are, you know,
 23 along the way. I imagine with technology
 24 improvements, some of that will change in the future,
 25 but currently there are some devices that do show

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 2 waveform, but do not record.
 3 **MR. HUDSON:** Yeah. And I think that's
 4 why it -- it might bear some clarification, not just
 5 specific to B.L.S. i-Gel, but maybe as a statewide
 6 re-visitation of the standing SEMAC advisory. Just
 7 to clarify, my impression is, the intent was always
 8 some archived recording that if there's ever a
 9 question, we can have a let's go to the videotape
 10 moment. If that's not the case, then we need to
 11 clarify that also.
 12 **DR. MURPHY:** I think the other thing
 13 this brought up was that providers were quite
 14 impressed with following. And -- and we talked about
 15 the pathophysiology a lot and said, you know, this is
 16 what the waveform loop would look like, this is what
 17 will happen when we lose.
 18 And so, they were really interested in
 19 that. And many of them stepped up to say, gosh, I
 20 never knew this, you know, and that it is, just like
 21 anything we follow and can repeat and to document and
 22 to keep in our records to say this is the progression
 23 of the patient and why it's so important.
 24 **CHAIR RABRICH:** Thanks. Dr. McEvoy?
 25 And then one more comment and then we'll move on to

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 2 the next item.

3 **DR. MCEVOY:** I would just say from
 4 agency perspective, there is a very significant cost
 5 difference between, say the EMA device, which is a
 6 few hundred dollars and something that can actually
 7 record or transmit the data, which adds in a range of
 8 five to eight thousand dollars to each device.

9 So, I'm not sure that we tell our
 10 providers, I want your blood pressure recorded. I
 11 want your heart rate recorded. I think we give
 12 people credit for being able to recognize when the
 13 device is in, when it's not using the tools that we
 14 require.

15 **CHAIR RABRICH:** Thank you.

16 **DR. DUVALL:** I know you said -- I'm
 17 sorry, I know you just said just one more comment,
 18 but requiring continuous recording for a lot of the
 19 agencies in the areas that I'm familiar with, will
 20 take i-Gel back off the table before it even starts.

21 A lot of agencies, B.L.S. agencies, in
 22 particular, can't afford to purchase new LifePaks or
 23 new Zolls for the sake of a recorded strip. I know
 24 there are portable devices, but if we're going to
 25 advance airway tools and provide a better airway and

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 2 then take it back off the table because agencies
 3 can't spend forty thousand dollars on a new cardiac
 4 monitor. It seems like this whole project would be a
 5 waste of time.

6 **CHAIR RABRICH:** Thank you. Final
 7 comment. Go ahead.

8 **MS. BOMBARD:** There are at least two,
 9 maybe three end-tidal devices that do record that run
 10 for about fifteen hundred dollars.

11 **CHAIR RABRICH:** Okay.

12 **MS. BOMBARD:** So, four digits I think
 13 is well within the scope of most of our B.L.S.
 14 agencies, at least in my area. And I think it's a
 15 laudable request whether they're using the i-Gel or
 16 not. They should really be using end-tidal every
 17 time they break out of B.V.M., one hundred percent of
 18 the time.

19 **CHAIR RABRICH:** Yup. Thank you. I
 20 think this issue will come up again later on in this
 21 meeting when we discuss some of the protocols. So, I
 22 think we're -- there's certainly more to discuss on
 23 this. Again, thank you so much for all your work on
 24 this and your really, you know, thoughtful
 25 presentation and answers.

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 2 And, you know, I -- I know it was
 3 meant to start as a small project in the Hudson
 4 Valley with a couple agencies, but, you know, the
 5 interest in it was tremendous and really great work.
 6 **DR. MURPHY:** So, do we make a motion
 7 to move it forward or where do we go from here?
 8 **CHAIR RABRICH:** I think, hold on on
 9 that, because I think when we get to the discussion
 10 of some of the collaborative changes, this is going
 11 to come up again. And then we can decide then what
 12 kind of action we want to take, if any, regarding the
 13 i-Gel. Thank you.
 14 All right. So, our next item to --
 15 did -- did you want to say something?
 16 **DIRECTOR GREENBERG:** Just to confirm.
 17 So, the -- the pilot program will continue the way it
 18 is, though?
 19 **CHAIR RABRICH:** As far as --
 20 **DIRECTOR GREENBERG:** Is there anything
 21 --
 22 **CHAIR RABRICH:** Yeah, until something
 23 changes or we --
 24 **DIRECTOR GREENBERG:** Okay. Just --
 25 **CHAIR RABRICH:** -- move it somewhere

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 2 else or.
 3 **DIRECTOR GREENBERG:** -- just want to
 4 make sure, and that people are clear, it's not
 5 stopping.
 6 **CHAIR RABRICH:** It's not ending, yeah.
 7 **DIRECTOR GREENBERG:** It's not ending
 8 as we work towards what the permanent side. Dr.
 9 Cushman, I think, said he wanted to take on the long-
 10 term analysis of all the data and reporting. So, but
 11 thank you. And -- and to both of you, I just wanted
 12 to say congratulations on -- on this one on, you
 13 know, probably, it's just such a significant thing
 14 for New York State and for the E.M.S. community. So,
 15 thank you.
 16 **CHAIR RABRICH:** Thank you. And
 17 segueing through our -- yeah, go ahead, yes.
 18 **DR. WINSLOW:** There was a piece of
 19 correspondence, though, I believe, messaging went out
 20 that they are currently not accepting more
 21 applications, will that be rescinded after the
 22 meeting?
 23 **MR. VIOLANTE:** Right. So we -- we
 24 will absolutely continue this right after this
 25 meeting, we just wanted to know where --

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 2 **DR. WINSLOW:** Yup.
 3 **MR. VIOLANTE:** -- it was going to go
 4 from here. And if this is the movement forward,
 5 we're delighted to keep doing this --
 6 **DR. WINSLOW:** Yeah.
 7 **MR. VIOLANTE:** until there's something
 8 more permanent that comes out.
 9 **DR. WINSLOW:** Thanks.
 10 **CHAIR RABRICH:** I think -- I think, it
 11 was a pause and then --
 12 **DR. WINSLOW:** Yeah.
 13 **CHAIR RABRICH:** Yeah.
 14 **DR. WINSLOW:** I'm -- I'm just
 15 confirming that. Thank you.
 16 **CHAIR RABRICH:** Yup. Thanks. So, our
 17 next item of old business, so remember at the last
 18 meeting we had talked about putting together a
 19 clinical -- yes, Dr. Cooper?
 20 **DR. COOPER:** Is there any action
 21 needed to keep it going on our part?
 22 **CHAIR RABRICH:** As far as the pilot
 23 goes, no, I don't believe any action is needed. It
 24 just continues as is --
 25 **DR. COOPER:** Thank you.

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 2 **CHAIR RABRICH:** -- until we take some
 3 other action.
 4 **DR. COOPER:** Thank you.
 5 **CHAIR RABRICH:** Sure. We had talked
 6 about a clinical data integrity tag and as part of,
 7 you know, some of the information we receive from the
 8 i-Gel working group, we realized that, you know,
 9 there were issues around data and could we do a
 10 better job with data and for clinical uses.
 11 So, clinical data integrity tag was
 12 developed. Dr. Dorsett, would you like to give a
 13 brief update of what the tag is working on? Not to -
 14 - to call you out, but. So, they -- there has been a
 15 couple meetings of this tag. Just very briefly
 16 wanted to update the group on kind of the -- some of
 17 the discussion the tag has had and what they're
 18 working on currently.
 19 Thank you. Sorry to put you on the
 20 spot.
 21 **MS. DORSETT:** So the first order of
 22 business of the tag was actually to define what is
 23 data integrity because there's a lot of definitions
 24 out there. Using work from other areas, really the
 25 idea is that data integrity is both data quality as

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 2 well as data accessibility because I think people
 3 focus a lot on what is the data that's going in and -
 4 - and thinking about that as quality.
 5 But also, if there is lack of
 6 accessibility of the data to the things that you need
 7 to use it for to improve care, that is also an issue
 8 of the -- of the data. We had -- I don't have my
 9 notes in front of me because I didn't know I was
 10 going to be up here. But we decided that the first
 11 order of business was actually to identify the scope
 12 of the problem.
 13 And so, if our goal is really to make
 14 data high quality and accessible predominantly for
 15 the uses that we have in E.M.S., there's lots of
 16 other stakeholders who are interested in that. So,
 17 we came up with multiple pillars of what data is used
 18 for. There is, the first one, which is patient care
 19 and all the stakeholders in patient care.
 20 The second one is quality improvement.
 21 And there's public health research. And then last
 22 night we added reimbursement because I was reminded
 23 that if we can't bill, we also can't operate, which
 24 was a good reminder. So, those were the five
 25 pillars.

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 2 And we've then brainstormed sort of
 3 what are the different stakeholders in all those five
 4 pillars of data. And we're currently developing a
 5 survey to engage different stakeholders on how
 6 they're using E.M.S. data and what the barriers are.
 7 So, we have a draft survey, that we're
 8 going to put together. We're going to pilot with a
 9 few smaller stakeholders to make sure that we're
 10 gathering the information that we want. And then in
 11 the future, we will enlist you to look at the
 12 stakeholders in your community that fit into those
 13 different groups to give us input.
 14 Really, we want to say like, what is
 15 the problem, not just from our perspective, because
 16 we're not the only ones who use E.M.S. data. And
 17 then also the second half is, we've been sort of
 18 doing investigations or what areas are really high
 19 performing and areas of data integrity and
 20 accessibility.
 21 And so, we're -- the idea is that,
 22 eventually we'll come up with a white paper that
 23 defines the scope of the -- the problem, identifies
 24 really what are the -- the big things that we need to
 25 work on that have the potential to have the greatest

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 2 positive impact and then what are some places that we
 3 can learn from for the change theories that we'll
 4 realize that. Does that work?
 5 **CHAIR RABRICH:** Yes.
 6 **MS. DORSETT:** Okay.
 7 **CHAIR RABRICH:** Thank you very much.
 8 Did you -- Dr. Walters, it looks like you want to say
 9 something?
 10 **DR. WALTERS:** Thank you, Dr. Rabrich.
 11 And so, I guess, just in listening to some of the
 12 committee meetings yesterday and some of the reports
 13 on the i-Gel and things, discussions we've had in the
 14 past makes me think about some of the issues we have
 15 in getting quality data, how it's inputted, is
 16 everybody inputting it the same, and then where it's
 17 getting filtered along the way or not getting
 18 complete data.
 19 And this is not a knock or criticism
 20 of anyone, but it's one of the things I think we need
 21 to look at is, not just getting the data, but getting
 22 good quality data, right? That's the whole -- whole
 23 point of it.
 24 When I heard some of the discussions
 25 yesterday and we're talking about, you know, how at

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 2 the state level, the regional level, how we get data,
 3 whether it's from bio-spatial or from image trend or
 4 how and the barriers or the issues that we're running
 5 into there, it -- it does make me concerned a little
 6 bit.
 7 And let -- let me just say this. I
 8 firmly believe all agencies should be doing some form
 9 of C.Q.I. And we should be improving and looking at
 10 what we're doing and -- and measure our performance.
 11 So, I'm not saying we shouldn't be doing this.
 12 But one of my concerns as we move to
 13 the new regulations and agencies having to implement
 14 some form of C.Q.I. and be looking at some of these
 15 measures is, are they actually getting good data
 16 that's correct, accurate and useful or are we acting
 17 on faulty data, number one.
 18 And number two, if we have a data
 19 informatics department here at the state working full
 20 time and we still have some of these struggles for a
 21 long period of time, how do we expect B.L.S.
 22 volunteer agencies, for example, to be able to get
 23 good data in their department, right, who have less
 24 understanding of the process, how data gets inputted,
 25 how to use that data.

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 2 And I think Dr. Dorsett talked a
 3 little bit about, you know, mining that data and
 4 stuff yesterday. And so, again, firmly believe we
 5 should be doing this, and agencies should be required
 6 to do it, but I think that this is a huge issue we
 7 need to look at it and make sure, like, I don't care
 8 if an agency has numbers, I care that they have
 9 meaningful numbers that they can act upon
 10 appropriately.
 11 **MR. VIOLANTE:** If I may, Mr. Chair?
 12 **CHAIR RABRICH:** Yes.
 13 **MR. VIOLANTE:** So, something that's a
 14 little bit different with data is that, the agencies
 15 can see really good, clean, unadulterated data that's
 16 their own because they house it, they see it, it's
 17 their program. Some of the -- the challenges occur
 18 after that.
 19 And so, agencies have that ability for
 20 one. And one of the things that the Quality Metrics
 21 Committee is really working on is, bringing out a
 22 good quality improvement program at the agency level
 23 and being able to discern that data against national
 24 -- nationally recognized standards for processes from
 25 NASEMSO, which are on the website, the state website

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 2 with a good improvement manual and -- and ways to do
 3 that.
 4 And one of our next goals is to go out
 5 and provide that education for agencies and be
 6 supportive for them and regions to be able to do
 7 exactly what you're talking about.
 8 **MS. DORSETT:** I also want to make the
 9 comment that I think we have to be really careful
 10 about saying we're going to wait to do quality
 11 improvement till we have perfect data, because
 12 quality improvement accepts that the data is
 13 imperfect and it's the direction that your data moves
 14 rather than the actual number.
 15 And that's one of the things that
 16 makes it fundamentally different than research. In
 17 research, I want to know what's the exact number, the
 18 percentage of the time it's done right. But in
 19 quality improvement, I want to know that tomorrow I'm
 20 doing better than I am doing today.
 21 And very often we spend a lot of time
 22 focusing on these documentation problems and these
 23 data problems, but once you actually start doing the
 24 quality improvement work, those things start to fix
 25 themselves, but that work never gets done. Nobody

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 2 recognizes the problem. Nobody starts documenting
 3 correctly until they actually see in some sort of
 4 near objective format what their performance looks
 5 like.
 6 And I think there's a lot of quality
 7 improvement activity that's hindered because
 8 everybody's obsessed with getting perfect data rather
 9 than just starting to look to see like, where are we
 10 now. And you start working on that.
 11 And then a lot of the documentation
 12 stuff sorts itself out as part of the process of
 13 improving the clinical process of work.
 14 **CHAIR RABRICH:** Thank you. All right.
 15 The next old business item was, we had talked also
 16 with implementation of ground use of blood coming up
 17 soon, and my understanding is that bill's going to be
 18 signed today. So, we had talked about putting
 19 together -- yes.
 20 We had talked about putting together a
 21 working group about not so much regulations, but kind
 22 of best practices and implement, like how to
 23 implement a blood program at your agency and
 24 guidelines and discussion on that.
 25 So, I know both Dr. Dailey and Dr.

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 2 Isaacs had some comments and interests on it. I
 3 don't know if there's anything you want to discuss
 4 right now or.
 5 **DR. DAILEY:** No, I think the only --
 6 the only thing I would say is, this is going to be a
 7 huge move forward. However, it also has the
 8 potential to create a significant amount of waste,
 9 which we would never want to see happen.
 10 And of complexity, that would be
 11 unnecessary for the few blood vendors there are in
 12 New York. The program that Air Methods has been
 13 using at the very least, like that of New York has
 14 been extremely efficient and has not wasted any
 15 blood. We need to emulate that model, learn from
 16 them.
 17 And what I would caution and hope that
 18 we can put in place is, a system where all blood
 19 programs that are initiated in the state are done so
 20 on a regional basis and the region actually maintains
 21 the conversation that moves forward to those blood
 22 banks.
 23 We can't have every agency reaching
 24 out independently to these blood banks in the hopes
 25 of starting a program. And the regions need to --

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 2 need to guide the counties here and really use that
 3 opportunity that is memorialized and regulated
 4 through Article 30 in order to develop that system of
 5 care.
 6 **CHAIR RABRICH:** Thank you. Go ahead.
 7 **DIRECTOR GREENBERG:** So, I'll also
 8 just, you know, put out there that the blood regs are
 9 in development right now. They're actually pretty
 10 far along in that drafting portion. So soon,
 11 shortly, probably next couple months, it will start
 12 to go up to the next process, which will then put it
 13 out for public comment and then come here for final
 14 approval and things of that nature.
 15 And that the -- the regs did take a
 16 little bit of a shift in the middle of the working
 17 group that was working on it. Essentially, just to
 18 take out the word air and be available for either or
 19 Dr. Isaacs, I don't know if it includes drones yet,
 20 but, you know, it's okay, I have something for the
 21 next level.
 22 **CHAIR RABRICH:** Well, that's errors
 23 included, yeah.
 24 **DIRECTOR GREENBERG:** Yeah. But I do
 25 think it's important to when you talk about that re -

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 2 - regional component to it and -- and something that
 3 the department has been working with or the bureau
 4 has been working with Wadsworth on, is, you know,
 5 recognition of the amount of additional regulatory
 6 oversight that this will have.
 7 And, you know, if you do have a ground
 8 blood program and you're used to only seeing us once
 9 every two years for a full-service inspection, that
 10 probably won't be the case. When you're carrying
 11 blood, you'll see us more often, not from any other
 12 thing, but to, you know, to ensure the compliance of
 13 it because of the severity of what it is and -- and
 14 everything else.
 15 So, I think that's important too and
 16 not that, you know, people just jump into, hey, I
 17 want to carry blood, and this sounds great, I'm going
 18 to do it.
 19 **CHAIR RABRICH:** Thanks. Dr. Isaacs.
 20 **DR. ISAACS:** Yeah, I just want to
 21 share the -- the same concerns about wasting a
 22 precious resource and so on. But hopefully, the
 23 regulations will help prevent that, but also working
 24 as a region, as Dr. Dailey said. And I'm hoping that
 25 we can now start the coalition or at least once --

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 2 once the bill is signed.
 3 Because I really believe it will bring
 4 our community together in terms of the state of
 5 sharing best practices, training, so we're -- it's
 6 very hard for individual agency and I'm kind of
 7 learning that going through the process right now.
 8 But I think together we all kind of bring some to the
 9 table, we can share what we've learned as a -- as a
 10 community. But definitely, as Dr. Dailey's said,
 11 working within the community, your region is really
 12 critical because it's just going to be duplicating
 13 and -- and making a lot of challenges, especially for
 14 the few blood banks that would be supporting this
 15 endeavor, so.
 16 **CHAIR RABRICH:** Thank you. All right.
 17 We'll move on to our new business items. So, Dr.
 18 Daley, I know you had included a ranger austere
 19 guidelines for field treatment. I believe everyone,
 20 it's been posted to boardable. People should have
 21 had a chance to review this.
 22 I don't know if you want to make some
 23 comments about it and then we can open it for
 24 discussion.
 25 **DR. DAILEY:** Sure. So, the -- the

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 2 brief idea here is on the Division of Forest
 3 Protection of the Forest Rangers through the
 4 Department of Environmental Conservation do extremely
 5 important, rare and -- and complex field rescues
 6 across the high peaks, across the rest of the --
 7 across the rest of the state.
 8 And over the course of the last twenty
 9 years, they really have developed an extremely good
 10 program of providing care. Goal here is to move the
 11 forest rangers from their current training and
 12 certification, which is done through the Wilderness
 13 Medicine -- Medical Associates and it's extremely
 14 good training.
 15 And integrate that into the C.F.R. --
 16 C.F.R. program we have here in New York, while still
 17 allowing them the ability to practice at that high
 18 level. This includes things like, field clearance of
 19 spinal injuries, which is extremely important for
 20 long extrications from -- from the field and really
 21 offers no risk because it's extremely well science
 22 based.
 23 And also, things like, reductions of
 24 shoulder dislocations. As you'll remember, we moved
 25 reduction of patella dislocations into the B.L.S.

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 2 scope a long time ago, here in New York that worked
 3 extremely successfully.
 4 But allowing the rangers to continue
 5 to function at the high level A.R. to protect the
 6 people that are enjoying the backcountry in New York,
 7 protect the rangers and the other providers are
 8 assisting with extrications from the wilderness and
 9 making sure that we have all of this data then
 10 integrated into the trauma system and E.M.S.
 11 databases across -- across the state. So, I think
 12 this is a win-win-win.
 13 And the department has been extremely
 14 helpful in working with the Department of
 15 Environmental Conservation moving this forward.
 16 **CHAIR RABRICH:** Thank you. Do people
 17 have comments or questions on this protocol
 18 guideline?
 19 **DIRECTOR GREENBERG:** (unintelligible).
 20 **CHAIR RABRICH:** (unintelligible),
 21 yeah.
 22 **DIRECTOR GREENBERG:** So, I think it,
 23 you know, just kind of be clear on it, you know,
 24 looking at this and -- and Dr. Dailey and I have had
 25 a number of conversations as well as with the rangers

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 2 and understanding where the gaps are the challenges
 3 and overcoming them.
 4 And looking at this, you know,
 5 essentially based on -- on their specialized training
 6 and their specialized response areas, you know, and
 7 unique response areas, lack of self-service in their
 8 response areas, driving some of this, you know, at
 9 the C.F.R. level that, you know, some things that
 10 otherwise wouldn't normally be done at that level.
 11 And looking at similar to New York
 12 City and HASTAC protocols or specialized teams that
 13 are, you know, it's not a set of protocols for
 14 everyone. It's a set of protocols for a very
 15 specific group who have additional training who are
 16 very unique in -- in the work that they're doing,
 17 and, you know, looking at it from that avenue.
 18 So, I think, you know, just as we look
 19 at this and -- and the understanding of it is that,
 20 it wouldn't just be something that, you know,
 21 expanding, you know, for all C.F.R.s that are out
 22 there, but specifically for these who are specially
 23 trained in a unique environment that need these
 24 extra, kind of, resources in order to be able to best
 25 care for their patients who, sometimes they literally

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 2 are sleeping on the side of a mountain with until
 3 they can take them out the next day. Yeah.
 4 **CHAIR RABRICH:** Yeah. And I believe
 5 that was the intent, right? It's a specialized
 6 protocol for a specialized group of people like
 7 rescue medics, tactical, E.S.U. medics, that kind of
 8 thing. So, I don't know if there's other comment or
 9 if someone wants to make a motion about this
 10 protocol. Dr. Isaacs?
 11 **DR. ISAACS:** Make a motion to approve
 12 these protocols.
 13 **CHAIR RABRICH:** So, to move it to
 14 SEMAC for discussion and approval there.
 15 **DR. ISAACS:** Okay.
 16 **CHAIR RABRICH:** Is there a second?
 17 **DR. CUSHMAN:** Second.
 18 **CHAIR RABRICH:** Okay. Discussion on
 19 the motion?
 20 **DIRECTOR GREENBERG:** Just note that it
 21 was Dr. Cushman for the second.
 22 **CHAIR RABRICH:** All those in favor of
 23 this motion which would move it to SEMAC. Any
 24 opposed? Any abstentions? All right. Motion
 25 carries unanimously. Thank you, Dr. Dailey.

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 2 Next, we'll move on to the -- the
 3 collaborative protocol change discussion. So, thank
 4 you to Dr. Cushman for again putting together the --
 5 the change log, which is very helpful to track these
 6 changes and understand those.
 7 So, I don't know if you want to
 8 basically do a brief overview of the change log and
 9 the changes. And then we can discuss it as a -- as a
 10 group and not go through it individually.
 11 **DR. CUSHMAN:** Kind of.
 12 **CHAIR RABRICH:** Yeah.
 13 **DR. CUSHMAN:** Thank you, Dr. Rabrich.
 14 **CHAIR RABRICH:** Take it away. Yup.
 15 **DR. CUSHMAN:** The first is,
 16 anaphylaxis and allergic reaction, specifically the
 17 addition of ipratropium to be mixed with albuterol to
 18 the E.M.T. and higher level, assuring that -- that is
 19 reasonable within our educational standards and
 20 otherwise.
 21 One subsequent change that I would
 22 suggest is for us to -- des -- despite the evidence
 23 that, you know, frankly, there's probably not much
 24 additional benefit by additional doses of
 25 ipratropium. There's also no known harm to it.

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 2 So, in order to align the
 3 collaborative, Dr. Isaacs, with the unified that --
 4 that actually we -- we not -- I removed it once. So,
 5 that, basically, if you want to mix them together,
 6 have added up to three doses on the house which will
 7 also make things nicer when we're doing the doing up
 8 and so forth, do that would -- unless there are
 9 objections to that, the -- the addition of
 10 ipratropium to be mixed with albuterol if -- if
 11 equipped and trained. That is that item.
 12 Any concerns with that if you're okay
 13 with me, just --
 14 **CHAIR RABRICH:** Thanks. Any questions
 15 or concerns on that change? Not seeing any.
 16 **DR. CUSHMAN:** Cool. Under the
 17 behavioral emergencies protocols, specifically both
 18 adolescent and adult, some excellent conversation
 19 amongst both D.N.S. physicians and our representative
 20 from the Office of Mental Health and I very much
 21 appreciate her wisdom and guidance as well, is really
 22 looking for other agents to be used for the agitated
 23 individual requiring some type of medication.
 24 And so, the recommendation there is
 25 ultimately to add olanzapine as a med control option,

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 2 but also to remove haloperidol. And the reason for
 3 the removal of haloperidol is -- is simply there's
 4 very good evidence that -- that the side effect and
 5 adverse event profile of haloperidol is inferior to
 6 olanzapine and -- and other -- other agents.
 7 So, as we continue to try to move away
 8 from narcotics, if you will. And benzos for those
 9 individuals to add that and make that change. The
 10 other rationale some had asked, you know, well, would
 11 I really give five milligrams sublingual to someone,
 12 and I think the answer is, yeah, it -- it could
 13 actually be.
 14 And we want to enable that now,
 15 particularly with med control options, I think for --
 16 for some of us, in that older adult patient
 17 population, that might actually be the perfect
 18 solution to get them to -- to safely be transported
 19 to the facility.
 20 So, that is the rationale behind those
 21 two changes under ad -- agitated patient, both
 22 adolescent and adult for the removal of haloperidol
 23 and then adding under med control options, again, if
 24 equipped and trained, olanzapine ten milligrams I.M.
 25 once or five milligrams sublingual once.

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 2 And the caution regarding concomitant
 3 midazolam administration. There is some reports of
 4 pretty significant sedation. We don't want to
 5 completely exclude that option, but we need to both
 6 remind providers and emergency clinicians that might
 7 be providing medical oversight for that.
 8 Any questions or concerns on that one?
 9 **DR. CLEMENCY:** Jeremy, could you speak
 10 to the rationale for keeping antipsychotics as a med
 11 control option rather than a standing order?
 12 **DR. CUSHMAN:** Sure, Dr. Clemency.
 13 Honestly, the -- that -- that went back and forth at
 14 least half a dozen times. And the -- the thought was
 15 frankly to ease in.
 16 **DR. COOPER:** Was frankly what, Jeremy?
 17 **DR. CUSHMAN:** To ease -- ease it in.
 18 **DR. COOPER:** Ease in, yeah.
 19 **DR. CUSHMAN:** To ease it in both with
 20 our -- our mental health colleagues with even some of
 21 our emergency department clinicians, some of which
 22 actually have less familiarity with the olanzapine.
 23 Some are still using B-52s, I think. So it -- it --
 24 it runs the gamut. That -- so that was the -- the
 25 non-scientific rationale for easing it in, seeing how

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 2 we have experiences around the state, getting that
 3 feedback, and like many things, perhaps, then moving
 4 that to a -- a more standing order option.
 5 **CHAIR RABRICH:** Which brings up,
 6 right, the -- another, again, data, right? Do we
 7 know, since (unintelligible) has been in the program?
 8 Do we know, are a number of agencies carrying this?
 9 Has there been a lot of use of it? I mean, I -- we
 10 probably don't have a sense of what the usage has
 11 been, but just curiosity everyone has.
 12 **DR. CUSHMAN:** I can't speak for
 13 statewide data. I can speak for my own system's
 14 data, and we don't carry it.
 15 **CHAIR RABRICH:** Okay.
 16 **DR. WINSLOW:** I just have one comment,
 17 I -- I kind of missed it when I was reading through
 18 it the first time, Jeremy. Unless, it being ten
 19 milligrams I.M once or five milligrams sublingual
 20 once, I think that may not be the best option in this
 21 specific population to encourage sublingual use of
 22 medications.
 23 **DR. CUSHMAN:** Again, the -- the -- the
 24 rationale, Dr. Winslow, for that was, that there may
 25 be applications. And so, I -- I agree with you and -

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 2 - and the individual that needs acute intervention
 3 with a medication, going towards their mouth is not
 4 one of my first plans.
 5 Frankly, it's the same reason that
 6 we've had this discussion at this body regarding
 7 intranasal midazolam because it's not always
 8 effective. It doesn't always meet the nose, and they
 9 almost always bite.
 10 So, the -- again, the -- the thought
 11 of the group was that there might be some other use
 12 cases where olanzapine sublingual may be valuable.
 13 And because it's med control, we would have some
 14 constraint over it. It would not require an agency
 15 to use or not to use.
 16 In the end, if this body feels that
 17 it's -- it's more appropriate to keep that off the
 18 table for now, then that's this body's decision.
 19 **CHAIR RABRICH:** Yup. Sorry.
 20 **MS. BOMBARD:** I think it's a fantastic
 21 idea. I've had my share of patients and I'm sure
 22 you've all had your share of patients who have
 23 threatened the -- I'm going to blow soon, right? I'm
 24 going to explode. I am on the verge. I need some
 25 help. And they'll enunciate that to you.

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 2 And you can say, here, would you like
 3 to take this pill that will make you feel more calm?
 4 And I say, yes, I would love to take this pill to
 5 make me feel more calm before I hurt somebody. And
 6 they say these things to me. They must say these
 7 things to you.
 8 So, they must say these things to our
 9 paramedics. I think this is a great idea.
 10 **CHAIR RABRICH:** Thank you. Other
 11 comments on this protocol? Are you thinking or do
 12 you want to speak, Dr. Walters?
 13 **DR. WALTERS:** So, Dr. Winslow, I
 14 guess, were you questioning having the sublingual
 15 option altogether or the dose of it and thinking it
 16 should be ten milligrams?
 17 **DR. WINSLOW:** Just trying to make it
 18 simpler, now you've given them two more options, and
 19 then I also from the safety profile is, yes we've all
 20 had patients say, go ahead, I'm going to be happy to
 21 take this medicine and then they punch you in the
 22 face.
 23 **CHAIR RABRICH:** All right. Other
 24 comments on this?
 25 **DR. CUSHMAN:** All right. The next is

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 2 under -- under pediatric bradycardia. This was
 3 actually brought to me by -- by one of our educators
 4 is, under pediatric bradycardia, it was just an
 5 ordering thing. And although, numerically, we -- we
 6 emphasize that things shouldn't be done in order, we
 7 all read the English language, so we naturally
 8 prioritize one thing over and over there if it's
 9 written before.
 10 So, this is simply flip flopping,
 11 epinephrine and atropine. Dr. Winslow had a good
 12 pickup. Again, you look at these things literally
 13 thousands of times and you -- and you miss them. The
 14 other addition, that is not in the change log that I
 15 have since added to this is just a -- as a reminder
 16 this would be really at the top that if the heart
 17 rate is markedly bradycardia, patient's mental status
 18 or respiratory rate are decreased, ventilate with a
 19 B.V.M. and consider chest compressions essentially,
 20 since that's what they should be doing anyway for
 21 those. Assuming no concerns with that.
 22 All right. Under adult pulmonary
 23 edema another great example of Cushman screwing up, I
 24 inadvertently deleted the nitroglycerin option for an
 25 E.M.T. So, we -- we got to put that back in. That -

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 2 - that was not intentional. My -- my apologies to
 3 all the E.M.T.s listening to me right now.
 4 And then again, I cleaned up some
 5 other language. Under heat emergencies, simply added
 6 palms and soles to locations for cold pack placement.
 7 Another suggestion that was right on. Under
 8 amputation protocol was to, to duplicate our -- our
 9 open fracture because frankly, if it's part of it's
 10 missing, then it's open and -- and that would be a
 11 very appropriate indication that's not necessarily a
 12 fracture, it's just an open amputation. So, that is
 13 simply duplicating that.
 14 Going back to our earlier
 15 conversation, Dr. Rabrich wanted to make sure that I
 16 threw this grenade, is in our trauma associated
 17 shock, the indication for blood has always been in
 18 there. That's not new. What -- what is new and is
 19 consistent with other areas in our protocols where we
 20 have very specifically given a region authority to,
 21 for example, credential R.S.I. providers, allow
 22 certain medications within that region or even define
 23 a stroke severity score within a region, that the
 24 recommendation under the trauma associated shock is,
 25 again, the annotation here that initiation of pre-

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 2 hospital blood products are subject to REMAC endorsed
 3 blood product distribution plan.
 4 Hopefully, that would not conflict
 5 with future reg, but -- but very clearly put whether
 6 the REMAC is deferring to the state or the REMAC is
 7 doing the work as is necessary to coordinate that, so
 8 that really all the points made earlier by Dr. Dailey
 9 are -- are met, that we don't have agencies grabbing
 10 blood and put it on their truck when there's, like a
 11 one percent chance of them using it, and we're
 12 wasting an extraordinarily precious resource related
 13 to that.
 14 **CHAIR RABRICH:** Thank you. Comments
 15 on that protocol? Dr. Winslow.
 16 **DR. WINSLOW:** I -- I think it's
 17 critically important, plus it allows your REMAC to
 18 have involvement of the trauma system. The trauma
 19 surgeons and the trauma centers that are going to be
 20 getting these patients, so they're in agreement.
 21 **CHAIR RABRICH:** Yeah. So, ideally the
 22 REMAC in coordination with the RTACs, right? So, go
 23 ahead, Director.
 24 **DIRECTOR GREENBERG:** And just in
 25 looking into the future and seeing some of the

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 2 complexities that's happened in the past, what do you
 3 think would be the best way in handling that for
 4 agencies that operate over multiple jurisdictions or
 5 multiple regions? Not -- not saying no or anything
 6 else, just trying to --
 7 **DR. CUSHMAN:** Yeah, I mean --
 8 **DIRECTOR GREENBERG:** -- look forward,
 9 yeah.
 10 **DR. CUSHMAN:** I mean, frankly, my
 11 opinion is, at least based on my experience, which is
 12 that agencies that do operate across multiple regions
 13 are engaging those multiple regions to figure out
 14 what makes most sense. Will -- will an R.S.I.
 15 provider that's credentialed in this region, will
 16 that reciprocate when they're operating in the other
 17 region, for example.
 18 Same thing here, I think. Looking
 19 immediately to my right, Dr. Shin is the Regional
 20 Medical Director for the Finger Lakes region. We are
 21 -- probably referred ninety percent of your major
 22 traumas to our trauma center. That's going to have
 23 to be a conversation between the two of us and our
 24 REMACs regarding, it better be a conversation related
 25 to that. My Southern tier folks and even Brian -- to

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 2 my -- to my left, Dr. Clemency in terms of Orleans
 3 County and -- and Genesee County that -- that refer
 4 that.
 5 So, I think organically it can and
 6 should happen, so that we -- we foster these
 7 conversations through the RTACs, through the REMAC's
 8 to figure out what is the most sensible. And then
 9 also, I think we do have to remember that this is
 10 more than just trauma.
 11 I think about all of our inter
 12 facility transfers of extraordinarily sick and most
 13 of them need blood even worse than our trauma
 14 patients, that are G.I. bleeds or obstetric
 15 emergencies that are bleeding out along the way; that
 16 -- that may provide greater access. And at least
 17 that's how we are conceptualizing it within -- within
 18 my region of -- of how do we distribute blood for our
 19 freestanding emergency department, for example, that
 20 is often sending folks that are -- that are bleeding
 21 out. So, you asked, you get.
 22 **DIRECTOR GREENBERG:** And I appreciate
 23 it. And I -- I think this is becoming, you know, a
 24 larger and larger topic as we see more and more
 25 consolidation and -- and services, servicing larger

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 2 areas that -- that didn't exist before.
 3 So again, as we, you know, look into
 4 that future and -- and not making it harder for an
 5 agency to try and manage multiple different ways of
 6 doing something like running a blood program versus
 7 that collaboration, like what you mentioned of, you
 8 know, neighboring systems and things of that nature.
 9 Thanks.
 10 **DR. DAILEY:** I think the other thing
 11 that's important to remember is that the RTACs and
 12 REMACs actually have different territories, right?
 13 And this overlapping situation that we've got in
 14 terms of these regulatory environments really leaves
 15 us in a position where we have to work together
 16 across these regional boundaries. So, it'll give us
 17 lots of opportunity.
 18 **MR. HUDSON:** Not to be reactionary,
 19 but should we just be clear that it should be marked
 20 if equipped and trained, at least somebody take it
 21 and run with it, that this is now an unfunded mandate
 22 from the state that every ambulance carry blood.
 23 It's just adding the asterisks, just to, also for
 24 consistency across all the protocols.
 25 **DIRECTOR GREENBERG:** And -- and

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 2 probably would have to say if equipped, trained, and
 3 approved.
 4 **CHAIR RABRICH:** And approved. Yeah.
 5 **DIRECTOR GREENBERG:** Okay.
 6 **CHAIR RABRICH:** Yeah, this one
 7 requires actual approval, yeah.
 8 **DR. CUSHMAN:** Yeah, it -- it does
 9 actually have the -- the -- the double cross. So, if
 10 -- if equipped and trained for that, but yeah. And
 11 I'm actually going to add the Department of Health
 12 approval to that footnote for --
 13 **CHAIR RABRICH:** All right. Other
 14 comments on that one?
 15 **DIRECTOR GREENBERG:** And just for
 16 understanding. This is a big change too, because
 17 this -- this will also change where ambulance
 18 transfusion services in the future will lie. They'll
 19 sit under this opposed to where they sit today under
 20 Wadsworth. So, there's a pretty significant change
 21 on that front as well.
 22 **CHAIR RABRICH:** All right. And for
 23 the last non-controversial protocol.
 24 **DR. CUSHMAN:** For the -- for the last
 25 one, I ordered these really really well. Under --

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 2 under airway management. So, under -- under oxygen
 3 administration and -- and airway management, again
 4 based on -- on the -- the -- just absolutely
 5 phenomenal work by our Hudson Valley colleagues and -
 6 - and for folks throughout the state that
 7 participated in that -- in that pilot is the addition
 8 within the -- within the protocol for i-Gel
 9 placement, if equipped and trained in the cardiac --
 10 excuse me, in the adult cardiac arrest patient.
 11 And then the -- the key points, we --
 12 we did remove the expectation of a viral filter --
 13 it's viral, not vital. And the recommendation, we
 14 already had this in the protocol. Providers may only
 15 perform endotracheal intubation, used to say, if they
 16 have entitled waveform capnography, the recommended
 17 language is providers may only perform endotracheal
 18 intubation and place supraglottic airways if they
 19 utilize waveform capnography.
 20 To address some of the earlier
 21 questions, it obviously, the -- the intention was not
 22 necessarily to create the requirement to record that
 23 can be an agency or even a regional level should they
 24 -- should they choose to do that.
 25 The key points refers to supraglottic.

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 2 Under the protocol right now, it's just i-Gel, but if
 3 the wisdom of this body is to change that to
 4 supraglottic, it's a replace real quick, so I -- I
 5 defer to other discussion regarding that.
 6 **CHAIR RABRICH:** Thank you.
 7 **DR. CUSHMAN:** Sorry, that's where this
 8 lives, by the way. So, it -- the only place that we
 9 reflect intubation supraglottic airways, anything
 10 else, is under the oxygen administration and airway
 11 management in Section Five of the protocol.
 12 **CHAIR RABRICH:** Thank you. Dr.
 13 Isaacs.
 14 **DR. ISAACS:** Instead of an injured
 15 tracheal tube intubation or using i-Gel, just, what
 16 about the wording just advanced airway.
 17 **DR. CUSHMAN:** I -- I'll be honest.
 18 Everybody interprets that different. In -- in terms
 19 of advanced airway, nowadays, an i-Gel, many would
 20 argue is not an advanced airway. It's -- it's an air
 21 -- so I -- I -- I hear you, Dr. Isaacs, but I
 22 honestly believe that we have to be explicitly
 23 specific in terms of E.T. tube or, in this case, a
 24 supraglottic airway, which I think has always been
 25 our stance.

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 2 I think the other thing that this
 3 would do is this would allow for and would be
 4 consideration should this protocol be approved for
 5 the SEMAC to rescind its previous policy statement on
 6 waveform capnography that is woefully out of date
 7 anyway.
 8 **DR. DAILEY:** If -- if I may just --
 9 **CHAIR RABRICH:** You may.
 10 **DR. DAILEY:** -- piggyback on that. I
 11 think actually the language we probably want to use
 12 is invasive airway, which we can define as
 13 endotracheal or supraglottic airway placement, but
 14 that's a -- a language change.
 15 **CHAIR RABRICH:** Yeah.
 16 **DR. DAILEY:** The other thing I think
 17 we should comment on is just the safety factor here.
 18 And the work of Sal Silvestri down in Orlando, and
 19 actually of Neal Richmond, who's a former New Yorker
 20 at Louisville, demonstrating that actually putting in
 21 a -- a supraglottic airway is not completely simple
 22 and safe, right?
 23 **CHAIR RABRICH:** Yeah.
 24 **DR. DAILEY:** And needs that
 25 supraglottic confirmation with end-tidal CO2. So,

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 2 this is really, you know, purely patient safety
 3 driven and is a -- is a great change.
 4 **CHAIR RABRICH:** So, just to clarify.
 5 So, if we said invasive airway, I think we also need
 6 a note that defines what an invasive airway is, is
 7 that what you're saying? Okay.
 8 **DR. CUSHMAN:** So, as -- as wordsmith
 9 just now, providers may only place an invasive
 10 airway, parentheses endotracheal intubation or
 11 supraglottic airway end parentheses if they utilize
 12 waveform capnography. And this is certainly one of
 13 those that I would actually not move -- that we can
 14 approve in concept.
 15 But I think it's really important that
 16 everybody has some time to look at the language to
 17 make sure that Cushman didn't screw it up again.
 18 **CHAIR RABRICH:** Yup.
 19 **DR. CUSHMAN:** Because it has, frankly
 20 such potential implications for our community that I
 21 don't literally want to a --
 22 **CHAIR RABRICH:** Yeah.
 23 **DR. CUSHMAN:** A parenthesis or a comma
 24 to screw somebody up --
 25 **CHAIR RABRICH:** Yeah.

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 2 **DR. CUSHMAN:** -- unintentionally.
 3 **CHAIR RABRICH:** So, that was the
 4 initial intent, and that's why it's all being
 5 presented today, so people can have time to digest
 6 and discuss it and then, you know, on our -- on our
 7 existing timeline, if we approved it in December,
 8 we'd be on our timeline. And when -- there's -- it's
 9 not an urgent need to approve this right now.
 10 **DR. DUVALL:** Excuse me?
 11 **CHAIR RABRICH:** Yes.
 12 **DR. DUVALL:** As I listen to the term
 13 invasive airway and I realize you're talking about a
 14 parenthesis with a little further description, but
 15 would -- would not a nasopharyngeal or an
 16 oropharyngeal airway be invasive as well? Would that
 17 create even a little more confusion, perhaps to use
 18 the term invasive airway?
 19 **CHAIR RABRICH:** Good question.
 20 **DR. DAILEY:** That's why we define it.
 21 **MR. HUDSON:** In the parentheses, do
 22 you want to put defined as? I hate to be so -- what
 23 I mean, we all know what we say, but not everyone who
 24 reads these gets our intent --
 25 **CHAIR RABRICH:** Well, and then if

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 2 we're going to say defined as, do we just say it, and
 3 not put the parenthesis?
 4 **MR. HUDSON:** Well, then why don't we
 5 staple the textbook to it, and it's a slippery slope.
 6 **CHAIR RABRICH:** Yeah, now I know.
 7 **MR. HUDSON:** I get it, so.
 8 **DR. CUSHMAN:** All right. I -- I hear
 9 that. I'll -- I'll continue to word massage that
 10 unless we all want to keep doing that here. The --
 11 the other that I would -- I -- I -- I don't want my
 12 interpretation of the earlier conversation to -- to
 13 be the rule here.
 14 But is it i-gel placement for adult
 15 cardiac arrest or is it supraglottic airway
 16 placement?
 17 **CHAIR RABRICH:** Yeah. So, this is
 18 another good question, right? So, this is really the
 19 only place where we're referencing a specific
 20 product, so to speak. It was, comes from -- this is
 21 what you studied, right? This is what we have the
 22 data on.
 23 So, it's hard to, I don't think you
 24 can extrapolate that to other supraglottic airways,
 25 but it is pretty specific here. So, is there a

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 2 discussion on whether it should remain as written i-
 3 gel or something else?
 4 **DR. WINSLOW:** There is a AIR Q, is
 5 another similarly looking and functioning
 6 supraglottic airway that is used in the anesthesia
 7 world, and there are actually two published papers
 8 that it is superior to the i-gel in the anesthesia
 9 world.
 10 I would recommend that we be vendor
 11 neutral and just say what the device does. Because
 12 then there's going to be other products in the
 13 future, and we don't have to come back and amend it
 14 and these are the list of approved devices, et
 15 cetera.
 16 **DR. DAILEY:** And I would make the
 17 region -- I would make the language regionally
 18 approved supraglottic device.
 19 **CHAIR RABRICH:** Other comments? So,
 20 we have a suggestion for changing it to regionally
 21 approved supraglottic device, Dr. Cushman?
 22 **DR. CUSHMAN:** Duly noted.
 23 **CHAIR RABRICH:** Okay. Are there other
 24 comments or suggestions on this? Dr. Isaacs.
 25 **DR. ISAACS:** Do regions approve

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 2 equipment, or is it the agency medical director?
 3 **CHAIR RABRICH:** See, I told you
 4 someone would say that.
 5 **DR. ISAACS:** All right, I'm that guy.
 6 I apologize.
 7 **CHAIR RABRICH:** No, it's a good point,
 8 right? Like, it's -- product endorsement is not
 9 something we do. Dr. Cooper was first, and then Dr.
 10 Winslow.
 11 **DR. COOPER:** Thank you. Just for fun,
 12 I quickly googled invasive airway. And there are,
 13 strictly speaking, the majority of responses indicate
 14 that it is either an endotracheal tube or a
 15 tracheostomy tube. There are other definitions and
 16 other devices that are listed as invasive airways.
 17 I leave it for people who are smarter
 18 than I am to figure out what language we should use,
 19 but I think that, you know, it may be the case as Mr.
 20 Duvall's pointed out that -- that use of the term
 21 invasive may cause more confusion than -- than it
 22 alleviates. Thank you.
 23 **CHAIR RABRICH:** It's a good point.
 24 Thank you. Dr. Winslow.
 25 **DR. WINSLOW:** Yeah, you bring up a

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 2 good point about that, Doug. We've had some
 3 discussion at our regional council meetings. You
 4 know, technically an agency approves any device that
 5 can be used for that purpose, but the REMAC's Q.I.
 6 subcommittee has to approve of the training plan and
 7 that it was affected, and that the members were
 8 actually trained to use something they may never have
 9 been trained before.
 10 **CHAIR RABRICH:** Yup, another good
 11 point. And I've also, heard, you know, mostly it's
 12 the agency and the agency medical director who would
 13 approve for that agency what they use, but that's a
 14 good point about the training plan being regionally
 15 approved.
 16 Other comments on this?
 17 **DR. DUVALL:** Our REMAC years ago
 18 developed a policy for approval of new equipment and
 19 new processes that actually comes through our REMAC
 20 and our REMSCO. I'll admit up until two minutes ago,
 21 I thought that all regions did the same thing?
 22 **CHAIR RABRICH:** Yup. There's
 23 variation, so. Other comments, other feedback for
 24 Dr. Cushman as we -- this is -- as the wording of
 25 this is considered? Mr. Hudson.

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 2 **DR. WINSLOW:** Just thank you, Jeremy.
 3 It's a lot of work. Thank you very much.
 4 **MR. HUDSON:** And -- and I don't want
 5 to die on this hill, but I think it's important to
 6 clarify, especially if we're going to rescind the
 7 previous SEMAC advisory for capnography, that we
 8 clarify to some verbiage about continuous ongoing
 9 throughout the entirety of patient care. To clarify,
 10 it is not a snapshot of wear in, take it off.
 11 **CHAIR RABRICH:** Yup. No, I think that
 12 the wording is continuous waveform capnography,
 13 right? Is that -- I think it's what you're saying.
 14 Recording is a separate issue. We could say, you
 15 know, if desired, equipped, or something like that,
 16 but continuous waveform, I think, is what you're
 17 saying that it's -- yeah.
 18 **MR. HUDSON:** Yes, some I'll see the
 19 recording to the regions as, you know, it was
 20 probably pointed out for various different reasons,
 21 but I think it's important for a statewide standard
 22 that we make sure the intent is from the time,
 23 ideally, before insertion but we're not there yet.
 24 At the time of insertion until the
 25 patient care is transitioned or terminated.

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 2 **CHAIR RABRICH:** Thank you. I saw Dr.
 3 Cushman noting your comments very closely, so.
 4 **DR. ISAACS:** For initial and ongoing
 5 monitoring of airway patency.
 6 **CHAIR RABRICH:** Excellent. Are there
 7 other comments about this or any of these
 8 collaborative changes that people want to bring up?
 9 So, Dr. Cushman, what's the -- your recommendation
 10 is, take this information back, and that, or you'll
 11 seek -- are we -- we looking for any action item
 12 today, or kind of incorporate these comments and
 13 suggestions and bring it --
 14 **DR. CUSHMAN:** No. At -- at first, I
 15 was actually hoping that we would be able to slap the
 16 table on a couple of these things and move them
 17 forward, but there are a couple of wording changes
 18 thanks to the feedback from this body that I think
 19 are really important.
 20 So, I will ask that -- that none of
 21 these are brought for action at the SEMAC. I will
 22 repost these -- these updated, so that folks in the
 23 meantime can have the opportunity to look, and again,
 24 make sure that my wordsmithing hasn't been with mis-
 25 intention and then we'll bring it for action in

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 2 December along with likely some more, because
 3 everybody keeps --
 4 **CHAIR RABRICH:** Yes.
 5 **DR. CUSHMAN:** -- filling up the inbox
 6 with suggestions.
 7 **CHAIR RABRICH:** Thank you.
 8 **DR. CUSHMAN:** Some of which are really
 9 good. Some of which are interesting.
 10 **CHAIR RABRICH:** Yeah. And I would --
 11 I would ask that people, as these are posted, that
 12 you review these, so that at the December meeting, we
 13 can have some final discussion on these and then move
 14 this forward.
 15 **DIRECTOR GREENBERG:** Dr. Cushman, is
 16 there any value or need to bring this to the SEMAC or
 17 bring any of these for discussion for today, So, that
 18 you're not in a situation to where, in December other
 19 members of the SEMAC might have other comments,
 20 changes, suggestions that they want to at it?
 21 **DR. CUSHMAN:** I'm open to you and the
 22 chair in that determination, so --
 23 **CHAIR RABRICH:** Yeah. I think I will
 24 present it as discussion that there was good
 25 discussion, and then we can ask for if there's

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 2 additional comments from the SEMAC, from the broader
 3 group and then bring it back in December.
 4 **DR. CUSHMAN:** I think, Director, at
 5 least on -- on the -- on the -- the -- the blood
 6 concept, I think is going to be really important to
 7 make sure that the SEMAC is -- is behind this -- this
 8 idea of, we're all on the same page from a region,
 9 RTAC, STAC, REMAC, whatnot perspective.
 10 And I think certainly the i-gel and
 11 capnography might -- might be worthwhile. But again,
 12 I -- I defer to the snapshot.
 13 **CHAIR RABRICH:** Yes. And I believe
 14 you're going to present the i-gel to the SEMAC as
 15 well, so it'll -- it'll flow in that discussion. All
 16 right. Other items of new business? Any other new
 17 business?
 18 **MR. VIOLANTE:** If I might just --
 19 **CHAIR RABRICH:** You may.
 20 **MR. VIOLANTE:** -- channel my inner Don
 21 Hudson for a moment.
 22 **DIRECTOR GREENBERG:** Are you sure?
 23 **MR. VIOLANTE:** Yes, it's good. So,
 24 just to provide some -- some clarity that since the
 25 i-gel at the B.L.S. level is not in scope of

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 2 practice, and that we want to include it in our
 3 protocols from a clinical perspective, which is
 4 great, that we still need to recommend that it is a
 5 B.L.S. adjunct at the state level with appropriate
 6 policy.
 7 **CHAIR RABRICH:** Okay. Okay. Dr.
 8 Walters, are you --
 9 **DR. WALTERS:** Just -- are we on new
 10 business still?
 11 **CHAIR RABRICH:** Yeah.
 12 **DR. WALTERS:** I saw on Boardable, the
 13 rescue medic protocols from New York City were on
 14 there. Is that a topic for discussion today?
 15 **CHAIR RABRICH:** It's both --
 16 **DR. WALTERS:** I think, can be approved
 17 by the REMAC, correct?
 18 **CHAIR RABRICH:** They were approved by
 19 the REMAC. They were sent up as late after, I think,
 20 the agenda was approved. So, if some -- but if
 21 someone wants to bring up an item of new business and
 22 that's the item of new business, we can discuss it.
 23 **DR. ISAACS:** I'd like you kept
 24 bringing up the topic of the rescue medical protocol
 25 changes.

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 2 **CHAIR RABRICH:** Okay. Would you like
 3 to talk about what the changes are?
 4 **DR. ISAACS:** I would love to. Thank
 5 you. So, we have existing rescue paramedic protocols
 6 for New York City. There were some minor changes,
 7 including to our previously approved blood
 8 transfusion protocol.
 9 So, in terms of the sections in our
 10 G.O.P., we have prolonged field care. We did change.
 11 We had antibiotics as a medical control option, and
 12 we moved that to a standing order. Just given the
 13 timely manner, we've had it out for several years.
 14 And then in terms of blood
 15 transfusion, the main changes were previously we did
 16 not have pediatrics in there, so we added pediatrics
 17 with similar parameters that we had for adults. We
 18 have age-appropriate vital signs.
 19 In addition, we previously had the, in
 20 terms of a medical control option, they had to reach
 21 the field response physician for trauma. We'd have
 22 it as a standing order. We anticipate having blood
 23 in the field twenty-four seven, on our specialty
 24 units.
 25 We also added medical now as a medical

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 2 control option for medical causes of bleeding. Also,
 3 in the blood transfusion protocol, there's a lot of
 4 literature on hypocalcemia during trauma, not just
 5 with -- with in terms of giving blood products, the
 6 citrate as an additive, but really to trauma in
 7 itself.
 8 We had one gram of calcium chloride
 9 and one gram of calcium gluconate. There's a lot of
 10 literature in terms of should it be more than one
 11 gram. It's not. The evidence is not overwhelming,
 12 but we went with in terms of standard practice,
 13 looking at military protocols and other protocols
 14 around the country of using calcium gluconate, so we
 15 changed that from one gram to two grams.
 16 And -- and then in terms of the other
 17 additional protocol changes, we added for our
 18 compressive syndrome protocol. We're removing
 19 mannitol. While academically, there is some evidence
 20 to support, low dose mannitol helping during
 21 prolonged operations, helping asthmatic diuresis, but
 22 the reality, we've never used our protocol. In terms
 23 of FEMA US&R, it's never been used, and I don't
 24 believe has been used on the international level --
 25 as part of the International Search and Rescue Groups

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 2 known as INSARAG. It tends to crystallize, so
 3 operationally, it's been a lot of challenges. So, at
 4 this point we're removing that.
 5 And finally, for pain control
 6 protocol, we had fentanyl lozenge since lollipops is
 7 known. We do not carry it. I've been trying to
 8 apply, was tending to imply to increase the amount of
 9 fentanyl can carry on our units but getting data and
 10 information from the military Special Ops groups,
 11 they've shown to be ineffective due to increase with
 12 the activity, the dry mucosa, you don't get a very
 13 effective absorption.
 14 So, they have fawned out with using
 15 that. So, therefore, since we do not carry it,
 16 hasn't shown to be effective at this point, we want
 17 to remove from our protocol as well.
 18 **MR. HUDSON:** That's only for the
 19 paramedics?
 20 **DR. ISAACS:** Correct. This will only
 21 be for rescue paramedics. And one thing I did fail
 22 to mention, I apologize, is compressed syndrome, for
 23 the same reason, for the calcium gluconate for
 24 hyperkalemia, we're also, changing that dose from one
 25 gram to two grams.

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 2 **CHAIR RABRICH:** Are there comments,
 3 questions, feedback for Dr. Isaacs on this protocol
 4 from anyone?
 5 **DR. WALTERS:** I have two quick things.
 6 Under -- give me one second, sorry. Number seven,
 7 we're going to talk about, it says, field -- field
 8 blood product transfusion for patients with suspected
 9 massive hemorrhage shall be administered by the
 10 O.M.A. response physician and rescue paramedics.
 11 Maybe you want to consider that too.
 12 **DR. ISAACS:** I -- I apologize, that's
 13 a typo -- another version that and removed that.
 14 That was from the -- thank you.
 15 **DR. WALTERS:** Yup. And then the only
 16 other thing is looking at seven point four, it says -
 17 - it looks like you changed transporting to a trauma
 18 center to the nearest appropriate nine one one
 19 receiving facility. Is that just changing the
 20 wording, but still with the intent they go to a
 21 trauma center? Because most of these probably should
 22 be going to trauma centers.
 23 **DR. ISAACS:** Well, the nearest
 24 appropriate. So, if it's a trauma patient, they will
 25 be going to a trauma center. If it's a medical

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 2 etiology for the hemorrhage, then necessarily would
 3 not need to go to a trauma center.
 4 **CHAIR RABRICH:** Any other comments or
 5 feedback? Go ahead.
 6 **DIRECTOR GREENBERG:** So, there's a
 7 process problem with this, which is the document is
 8 not a public document. It needs to be a public
 9 document, which is -- and unfortunately, we only
 10 received this two weeks ago. So, it didn't go
 11 through the -- through the process for the approvals.
 12 It didn't go through the reviews. It's not public
 13 today for anybody who's attending the meetings to be
 14 able to have a copy of it.
 15 So, the discussion is good, and I
 16 think, you know, those are things, but this would
 17 have to come forward at the December meeting because
 18 of it.
 19 **CHAIR RABRICH:** Right. So, we could
 20 possibly, this group could approve it and send it to
 21 SEMAC, but SEMAC wouldn't be able to act on it today.
 22 It would have to wait until December, so that there's
 23 an appropriate public review, period, is what I'm
 24 being told.
 25 Did you, someone want to say --- yeah,

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 2 go ahead.
 3 **DR. WALTERS:** Is that actually a
 4 formal written policy we have about --
 5 **DIRECTOR GREENBERG:** Public documents
 6 for public meetings? Yes.
 7 **DR. WALTERS:** No, I'm not asking about
 8 public documents. Well, I mean any item can be
 9 brought up and discussed in a motion made in a public
 10 meeting, even if it's not on the agenda beforehand.
 11 I'm talking about, does a protocol have to be posted
 12 beforehand before we act on it? I don't know that
 13 that's -- is that what we think and what we've always
 14 done or is that an actually a hard fast rule. That's
 15 what I'm asking.
 16 **DIRECTOR GREENBERG:** You can have a
 17 discussion on anything. You can bring it up and have
 18 the conversation, things that go along with that one.
 19 But if there's a document that's being approved
 20 during a public meeting, the opportunity for the
 21 public to see the document of what's being approved
 22 is part of that process.
 23 **DR. ISAACS:** When we say public
 24 comment, are we, is that defined as in terms of the -
 25 - the SEMSCO the state, or -- the reason being

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 2 because they were put out for our REMAC, it was a
 3 public meeting. And the document was put out, so.
 4 **DIRECTOR GREENBERG:** For the REMAC,
 5 but not for the SEMAC or SEMSCO. So, in other words
 6 if you were to come here, and -- and -- and again,
 7 it's just part of the process that goes through it.
 8 Legal will also be here later if you'd like to take
 9 it up with them.
 10 But, you know, this is the problem
 11 with two weeks ahead of time and not having
 12 something. Now it will say, especially with meetings
 13 and REMAC and REMSCO and things, if there's the
 14 ability to, and -- and Dr. Isaacs, I know that this
 15 is happening in New York City, where things have come
 16 in, you know, not in that six week window, and we've
 17 been able to accommodate it because the documents
 18 haven't gone through the process and they were still
 19 able to be posted and everything else that goes along
 20 with it, then we will make those accommodations.
 21 We're happy to provide that, but it
 22 has to be, you know, in the ability to provide it.
 23 **DR. ISAACS:** Well, I'd like to make a
 24 request to someone else. I'll take a motion.
 25 **DR. WALTERS:** I will make the motion

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 2 that we approve these rescue medic protocols and send
 3 them to the SEMAC for approval.
 4 **CHAIR RABRICH:** Is there a sec --
 5 There's a second. Okay. All in favor? Any opposed?
 6 Any abstentions? So, one opposed, motion passes. It
 7 will go to SEMAC and, you know -- that's -- yes. So,
 8 that -- it moves it forward to them and then what
 9 happens there can be discussed.
 10 **DR. WALTERS:** Thank you.
 11 **CHAIR RABRICH:** Thank you. Is there
 12 any other new business? Seeing none, I will
 13 entertain a motion to adjourn. All right. Thank
 14 you.
 15 (The meeting adjourned at 9:44 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 91, 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 3rd day of October, 2024.
 11 DANIELLE CHRISTIAN, Reporter

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