Suffolk
REMAC
Suffolk Regional Emergency Medical Advisory Committee
360 Yaphank Avenue, Suite 1B • Yaphank, NY 11980
Telephone: 631-852-5080 • Fax: 631-852-5028 • Website: www.suffolkremsco.com

This meeting summary will not be considered final until formally approved at the January 27, 2026 meeting.

Meeting Summary

November 25, 2025

Hospitals / Physician Members-at-Large Represented:	**See Attendance List**
Non-Voting Members Present:	**See Attendance List**
EMS Division Staff Present:	**See Attendance List**
Sub-Committee Meeting Attendance:	**See Attendance List**

Call to Order:

The meeting was called to order at 1903 by Chairman Dr. Marshall, presiding. The pledge was recited and there was a moment of silence. The secretary took roll call of attendees and determined that a quorum was present, and official business could be conducted.

Chairperson's Motions:

- Dr. Marshall asked for a motion to approve the September 30, 2025, minutes as distributed. Dr. Winslow made the motion to approve, seconded by Dr. Acosta. The motion passed without opposition.

Correspondence:

- Secretary Hannigan reported that there was a change in representative for NYU Langone Hospital – Suffolk to Dr. Artale.
- Dr. Glantz resigned his seat on REMAC as a physician at large.

Chairperson's Report:

- Dr. Marshall wished all happy holidays, and thanked Southold Fire Department for hosting the REMSCO Awards and South Country Ambulance for hosting the CPR and Trauma Save Awards. Congratulations to all the recipients.
- Dr. Marshall thanked Dr. Glantz for his many decades of dedicated service to the REMAC. He has been instrumental in many projects, most recently RSI. His dedication to the REMAC, the RSI Subcommittee, and the work that's been done has really helped move this region forward in many ways that have been highly successful. Dr. Winslow made a motion to send Dr. Glantz a plaque. The motion was seconded by Dr. Acosta and passed without opposition.
- Later in the meeting the BLS Igel and membership openings will be discussed. The openings will be announced at this meeting, applications should be sent to the secretary. The vote will happen at the January meeting.
- Secretary Hannigan will be posting an excel template to the website for agencies to use to report their annual active membership.

Vice Chairperson's Report:

- No report.

Second Vice Chair's Report:

- Dr. Guszack stated that his report will be covered under the RSI Subcommittee.

EMS Division Report

Operations Report- Chief Paul Marra excused, report given by Deputy Chief Dan Keegan

- The following updates to the NYS DOH Part 800 regulations are as follows:
  1. 10 NYCRR Part 800, § 800.3 Definitions
     a. Subdivision (m) of this section has been repealed and is replaced with an updated definition of an emergency ambulance service vehicle.
  2. 10 NYCRR Part 800, § 800.23 General requirements related to equipment
     a. This section will be repealed in full on April 22, 2026.
  3. 10 NYCRR Part 800, § 800.24 Equipment requirements for certified ambulance services, basic life support first response vehicles and emergency ambulance service vehicles
     a. These requirements will be effective April 22, 2026, six months from the date of enactment. Until April 21, 2026, the current equipment requirements are still in effect. The NYS State Department of Health, Division of EMS webpage displays the current regulations first and the new requirements below with the effective dates clearly noted. Breaks it down by Ambulance, BLSFR and ALSFR
  4. 10 NYCRR Part 800, § 800.25 General Waiver Requirements- Pertains to specialty use vehicles and how to obtain a waiver.
  5. 10 NYCRR Part 800, § 800.26 Equipment requirements for emergency ambulance services vehicles other than an ambulance
     a. These requirements are effective October 22, 2026, twelve months from the date of enactment. The current equipment requirements remain in effect until October 22, 2026. The Division's webpage displays the current regulations first and the new requirements below with the effective dates clearly noted.
- BLS Igel NYS Policy Statement 25-09, has been posted, agencies that are looking to implement the BLS Igel must become familiar with the requirements. There is a registration component for this program through the state portal. Agencies' policies and procedures need to be created, and they are all outlined in the Policy Statement.
- Indemnity contracts are in the final stages and will be going out shortly.

Education and Training Report – Steve Januszkiewicz excused, report given by Dan Keegan

- Fall Classes are all running smoothly and progressing
- Evaluating course needs and locations for Spring 2026
- Working on a Hybrid CFR course to hopefully begin 1st quarter 2026
- Instructor Update Course (two sessions) to be held at SCEMS in January, either Sunday January 25th or Monday January 26th
- Second round of online BLS Core Content starting beta testing December 1st, expected to be fully up by December 15th, anyone expiring January 31st should contact the division for assistance and to get into the beta testing

- EMS Officer and Leadership Course in conjunction with the SCFA being held at Mastic Ambulance Monday January 26th and Monday February 2nd, must attend both sessions to receive certificate, registration is through SCFA website and opens shortly
- FRES is in the preliminary stages of developing a separate website for the department, website will have sections for all four divisions. Our plan is to use this as an additional resource in tandem with social media outlets and the REMSCO website to showcase the EMS Division and training opportunities
- The Division is working with additional county departments and a couple of outside organizations to develop a first responder centric training in the recognition of human trafficking and the appropriate way to interact and treat possible victims

System Medical Director Report and the State Council Report– Dr. Winslow:

- Dr. Winslow reported:
  - "The next meetings of the State Council are scheduled for December 9 and 10 in Troy, so there will be a report at the upcoming January REMAC meeting on State Council.
  - As a regional QI initiative, I did want to give the REMAC membership a brief summary of this summer's experience with drownings and near-drownings in Suffolk County. The total number of fatal drownings reported by the Medical Examiner's Office was 10 with zero children - 3 in residential pools, 3 from public beaches, 4 from boating accidents in open water. There were over 1000 persons saved from the 3 County beaches by the County Lifeguards this past summer. I want to take a moment to thank all the Lifeguards and their leadership for their skill in assisting bathers in distress. The Suffolk County area hospitals reported 75 patients that EMS transported to their facilities after a submersion injury and there were 18 admissions with 6 total fatalities in the hospitals. Thank you to all the hospital representatives for your assistance. I would like to ask the hospitals to continue to track this information next year and I will be looking for the same information next fall.
  - On October 22, the American Heart Association published the 2025 guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. I encourage all EMS leaders and medical directors, all EMS educators and all EMS providers to read through the new guidelines. I will not take the time here to discuss all the updates but I did want to address two important issues from the new guidelines. First, there is a new recommendation to support ongoing resuscitation at the scene in out-of-hospital cardiac arrest, as opposed to early transport, and a recommendation to train EMS providers on field termination and death notification to families accordingly. I will work on education on field termination and death notification in the upcoming months and I welcome any REMAC physician or paramedic member who would like to assist me.
  - Second, the published guidelines comment that the routine use of mechanical compression devices is not recommended but may be considered in certain circumstances such as during EMS transport. I would like REMAC to look at this issue as a regional QI project for 2026. In my opinion, the use of mechanical compression devices is good EMS medicine, provides compressions at the correct rate and depth as opposed to a human that will likely tire during a long resuscitation. Their use is also important during transport where the safety of the EMS providers would be compromised if manual compressions were being performed. I want to report that so far in 2025, Suffolk County Medical Control reports that there have been 58 patients in out-of-hospital cardiac arrest who have achieved ROSC in the field and who survived to hospital discharge and 34 of these patients had use of mechanical compression devices during the resuscitation. I want to state for the record that the use of mechanical compression devices by EMS during the resuscitation and during transport is good EMS

medicine and the decision to use such a device is at the discretion of the EMS providers and their agency leadership and their medical director.

- Finally, I want to ask all EMS providers to make a post-call notification to Suffolk County Medical Control for just 2 situations in accordance with REMAC policy. (1) use of an advanced airway including endotracheal intubation and supraglottic airways and (2) all cardiac arrest situations – defined as any time chest compressions were performed and/or a defibrillation was delivered to the patient. So please make the post- call notifications and log the cases. This is a important part of the regional quality improvement program and how we identify potential successful saves. Also, all EMS providers should be aware that Suffolk County Medical Control is available at all times as a resource. I want to take a moment to thank Chris Gallway, Steve Slovensky and the leadership of Stony Brook EMS for their service to the REMSCO and the County as Medical Control. They do a great job and thank you."

REMSCO Report- Ed Boyd excused:

- Dr. Winslow reported that the 2026 REMSCO EMS Tom Lateulere Conference is on April 18, 2026. Speaker and vendor flyers are in the room and available to all.

Subcommittee Reports:

RSI (Dr. Guszack)

- Dr. Guszack is appointed by Dr. Marshall as the new chair of the RSI Subcommittee following Dr. Galntz's resignation.
- Dr. Guszack reported that at the meeting on October 14th, there was much discussion on moving forward with policy changes and shifting the responsibility from the RSI Subcommittee to the agencies themselves. The policy is still being worked on, and the final draft will be brought to the REMAC for review when available.
- The minimum standards are being considered, but they have been working thus far, unsure if they should change.
- The policy will help clarify and explain the responsibilities and expectations of the participating agencies, identify the minimum standards for the paramedics, outline the training requirements for the classes, and solidify the QA/QI process. A mechanism for a centralized review process and an "approval certificate" needs to be built if agencies would like that completed. All credentialing remains in the hands of the agency medical directors.
- A question was asked if "no documented unrecognized esophageal intubations" would be part of the minimum standards. Discussion took place, and it was decided that it would be up to the agency medical director.
- Dr. Winslow told the group that medical directors who appoint RSI medics at their agencies make those providers active upon their appointment. Dr. Winslow may not send the information to Medical Control immediately, but it does not affect the provider's ability to practice.
- Dr. Minnerop was looking for the policy and application for RSI. Dr. Marshall reported that the application is down, but the policy is on the website.
- Dr. Winslow reported that Hampton Bays Volunteer Ambulance Company wishes to participate in the RSI program and asks for tentative approval to allow for the budgeting of necessary equipment and medications. Dr. Winslow made a motion to support them as an RSI agency. Dr. Acosta seconded the motion and it passed without opposition.
- The RSI case review process will remain unchanged.

Membership (Dr. Acosta, report given by Dr. Marshall)

- Dr. Marshall reported that there is an open at large position available. Any interested physicians should reach out to the secretary to be considered. The nominees will be discussed, and the vote will be conducted at the January meeting.

QA/QI (Dr. Winslow)

- Dr. Winslow reported that the new registration process continues. He also asks that agencies update their provider list annually in January.
- QA/QI projects are ongoing. One is on cardiac arrest, and the other is on supraglottic airway use. Information on both can be found on the website.

Protocols (Dr. Marshall)

- Dr. Marshall reported that the working protocol group met last month and discussed the 2026 version that will be going live in July.
- Updates include AHA compliance updates, adding PO Tylenol to the EMT level, IV Tylenol to the AEMT level, IV Zofran at the AEMT level, olanzapine will move to standing order for medics, additional OB protocols will be added, specifically for post-partum hemorrhage. Dr. Marshall will have a more detailed report at the January meeting.
- Dr. Marshall clarified that Suffolk REMAC recommends that all providers transition to surgical cricothyroidotomy. The only place where training is required is for RSI providers.
- New York State released an updated policy statement on BLS Igel that covers the transition from pilot program to protocol and outlines what agencies need to do to participate. All agencies that were in the pilot program may continue to participate, but they also need to meet the requirements of the new policy on the protocol change. New participants will have to apply with the state as well as meet the requirements. The policy can be found here as *attachment 2*. As use of the BLS Igel requires REMAC approval, Dr. Marshall made a motion that the chair, vice chair, and second vice chair may review and provide regional approval for an agency if it meets existing standards and devices. The motion was seconded by Dr. Acosta and passed without opposition.
- Mr. Werfel asked for clarification on the transition from needle to surgical cricothyroidotomy, as it was his understanding that the region transitioned all providers and required training for all providers in March of 2025. Dr. Marshall clarified that REMAC does not have the authority to mandate either of these procedures over another. The REMAC can only recommend that surgical cricothyroidotomy be used by all providers, but can mandate training. There was discussion on "if trained and equipped" items in the collaborative protocols and the surgical cricothyroidotomy. Dr. Marshall called for an end to the discussion. Dr. Acosta asked if the aeromedical portion of the RSI Protocol will be changed or updated; unclear, more to come in January.
- Dr. Marshall announced that REMAC credentialing cards will no longer be given out, as REMAC does not credential providers. Dr. Winslow made a motion that REMAC have a policy that they do not provide a credentialing card and these should not be used as a means of employment in Suffolk County EMS agencies. Dr. Marshall asked Dr Winslow amended the motion from policy to notification; Dr. Winslow agreed. Dr. Acosta seconded the motion and it passed without opposition.
- It was discussed about interoperability of providers within different agencies within the system, and Dr. Marshall stated that issue can be discussed at a subcommittee meeting.

Bylaws (Dr. Coyne)

- No report, though updates to come which will be discussed at a subcommittee meeting with a zoom option.

Old Business:

- Nissequogue Fire Department requested that REMAC remove the term "first responder" from it's recommendation letter to become an ALS Agency, based on state requirements. Dr. Marshall made a motion that REMAC send that amended letter to Nissequogue. It was seconded by Dr. Acosta and passed without opposition.
- Blood will be going live on the helicopter prior to the next REMAC meeting, educational materials will be provided by Stony Brook University Hospital. Dr. Winslow stated that he updated the Suffolk County Trauma Triage materials and sent them to membership and relevant organizations for feedback. Any recommendations should be sent to Dr Winslow.
- Mr. Edouard asked that all representatives take back to their departments that one of the requirements for the blood bank is to have a patient MRN for tracking. Please assist EMS in getting these numbers.
- Mr. DiPino asked if system hospitals could provide the system of their internal trauma criteria breakdown; it is not possible as the metrics are all different.
- Dr. Guszack asked for clarification on blood. It was determined that the paramedic supplying the blood would then assume care of the patient.

New Business:

- The 2026 meeting dates for REMAC are January 27, March 24, May 26, July 28 (but may be with REMSCO), September 29, and November 24.
- The next RSI Subcommittee meeting will be on December 18, 2025. Location to be determined, but Middle Island FD offered, pending availability.
- The other subcommittee meetings will be on December 16, 2025 at 5PM at SCEMS with remote options.
- Mr. Darienzo gave a short presentation on a potential pilot program for the paramedic use of Keppra. A summary of the project can be seen here as *attachment 3*. There was some discussion, and there was a motion made by Dr. Marshall to support the pilot to SEMAC. It was seconded by Dr. Acosta and passed without opposition.
- Dr. Winslow's term as the REMAC representative to SEMAC is expiring. A motion was made by Dr. Marshall that Dr. Winslow continue his representation to SEMAC for one more year. It was seconded by Dr. Geffken and passed without opposition.

Motion to adjourn made by Dr. Marshall, seconded by Dr. Acosta. The meeting adjourned at 2115.
Respectfully submitted,

Jennifer Hannigan
Deputy Chief, Education and Training
REMAC Secretary

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Suffolk Regional Emergency Medical Advisory Committee

REGIONAL MEDICAL ADVISORY COMMITTEE (REMAC)

FOR EMERGENCY MEDICAL SERVICES OF SUFFOLK COUNTY
MEMBERSHIP ATTENDANCE LIST

November 25, 2025

Facility	Hospital Delegate/Alternate	SIGNATURE
EMS Medical Director	Jason Winslow, MD	
Eastern Long Island	Lawrence Schiff, MD	
Good Samaritan	Eric Decena, MD / Chris Raio, MD	
Huntington	Devin Howell, DO / Leo Huertas, MD	
J.T. Mather	Eddie Kim, MD / Adam Wos, MD	
NYU Langone Hosp- Suffolk	Joseph Artale, MD / Christine DeSanno-Caridi, DO	Artale-Excused
Peconic Bay	Jeffrey Cangelosi, MD / Nick Palamidissi, MD	
Southampton	Max Minnerop, MD	Excused
South Shore University	Brian Blaustein, MD/ Anthony Urmaza, MD	
St. Catherine's	Paul Taglienti, MD	
St. Charles	Jeffrey Wheeler, MD / Joseph Garber, MD	
Stony Brook University	Joseph Bove, MD	

Physician Members-at-Large:

Juan Acosta, DO		Vacancy	
Lincoln Cox, MD	Excused	Christopher Guszack, MD	
Scott Coyne, MD		Youssef Hassoun, MD	
Caitlin Feeks, DO		Lauren Maloney, MD	Excused
Andrew Flanigan, DO		R. Trevor Marshall, MD	
Gegory Garra, MD		James Vosswinkel, MD	
Jack Geffken, DO		Daryl Williams, MD	

Suffolk REMAC
Suffolk Regional Emergency Medical Advisory Committee

REGIONAL MEDICAL ADVISORY COMMITTEE (REMAC)
FOR EMERGENCY MEDICAL SERVICES OF SUFFOLK COUNTY
MEMBERSHIP ATTENDANCE LIST

November 25, 2025

EMS Division Staff:	**Signature:**
Steven Januszkiewicz, Education and Training Coordinator	
Paul Marra, Chief, EMS Operations	
Jennifer Hannigan, Deputy Chief, Executive Secretary	
Christopher Gallway, University Medical Control	
Edward Boyd, Chair, REMSCO	

Non-Physician Members-at-Large:	**Signature:**
Edward Boyd	
John Boyd	
Jess Boyle	
Robert Cavalieri	
Scott DiPino	Excused
Shawn Edouard	
Thomas Fealey	
Patrick Gugliotta	
Jason Hoffman	
James Jackson	Excused
Michael Presta	
David Roth	
Daniel Siciliano	
Richard Tvelia	
Paul Werfel	

Suffolk REMAC
Suffolk Regional Emergency Medical Advisory Committee

REGIONAL MEDICAL ADVISORY COMMITTEE (REMAC)
FOR EMERGENCY MEDICAL SERVICES OF SUFFOLK COUNTY
MEMBERSHIP ATTENDANCE LIST

November 25, 2025

GUESTS:

Name (Please Print)	Affiliation	Signature
Anthony Schenk	AMR	
Dina Waynch	program PAgency	
David Nesbeur M	Deer Park FD	
Cole Daciento	CVAC	
Anthony Guerne	NFD	
Carl Goodman	RJEMS	
Danny Keegan	SCARES EMS	
Robert Terrell	SBEMS	

(please turn over to add additional names)

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Subcommittee: BSI

Date: 10/14/25

Location: Bay Shore

Chair/Acting Chair: Guszack Quorum reached? Y/N

Present at location:

CAVALIERI, BOB	
WERFEL P.	
Shawn Edwards	
JASON HOFFMAN	
Dina Mangano	
Chris Guszack	
Carl Goodman	
Dan Siciliano	
Jen Hannigan	
Jason Lupia	
Trevor Marshall	

Continue on back if necessary.

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Subcommittee: REMAC (all but RSI)

Date: 10 / 21 / 2025

Location: SCEMS - Yaphank

Chair/Acting Chair: Dr. Marshall Quorum reached? Y / (N)

Present at location:

Mike Pasta	
Paul Marra	
Trevor Marshall	
Dan Siciliano	
Jen Damiano	

Continue on back if necessary.

NEW YORK STATE | Bureau of Emergency Medical Services and Trauma Systems

Policy Statement

Number: 25-09
Date: November 12, 2025
New/Supersedes: New

Supraglottic Airway Implementation for BLS Practitioners

PURPOSE

The purpose of this policy is to provide guidance to certified services wishing to implement the use of a Supraglottic Airway by Basic Life Support (BLS) practitioners for patients in cardiac arrest.

AUTHORITY

Article 30, Section 3002

SCOPE

All certified ambulance services or Advanced Life Support First Response (ALSFR) services with Basic Life Support (BLS) level practitioners.

DEFINITIONS

Certified ambulance service is defined in 800.3 (j) and is applicable to this policy statement.

Advanced Life Support First Response (ALSFR) service is defined in 800.3 (ae) and is applicable to this policy statement.

Supraglottic Airway device (SGA) means a medical device that is inserted into the pharynx to maintain a patent airway and facilitate ventilation without the need for endotracheal intubation. The device must be Food and Drug Administration (FDA) approved.

POLICY

The New York State Emergency Medical Advisory Committee (SEMAC) and the New York State Emergency Medical Service Council (SEMSCO) approved the use of a Supraglottic Airway (SGA) by an Emergency Medical Technician (EMT) at their September 2024 meetings. The Commissioner of Health has approved the addition of Supraglottic Airway (SGA) use by Emergency Medical Technicians (EMTs) as part of their scope of practice in New York State.

The Supraglottic Airway (SGA) has been approved for use in adult and pediatric patients in cardiac arrest by New York State certified Emergency Medical Technicians (EMTs) when trained and equipped, and if regionally approved.

Education

The Regional Emergency Medical Advisory Committee (REMAC) will approve the training programs implementing Supraglottic Airways(SGAs) at the Basic Life Support Level for certified ambulance services and Advanced Life Support First Response (ALSFR) services.

Registration for Implementation

1) A certified ambulance service or Advanced Life Support First Response (ALSFR) service seeking authorization to use Supraglottic Airway (SGA) devices at the Basic Life Support (BLS) level must make a written notification to the appropriate Regional Emergency Medical Advisory Committee (REMAC). The notification shall include, but is not limited to the following:
    a) Application for use of Supraglottic Airway by Basic Life Support (BLS) providers. The application may be found at this link: Supraglottic Airway for BLS Agency Application
    b) Updated Form 4362 Medical Director Verification which by signing, the medical director attests to the following:
        i) Approval of agency training program;
        ii) Capability for continuous waveform capnography monitoring; and
            (1) The device a service implements to monitor waveform capnography is not required to have the capability to record and print the waveform, only to clearly display waveform and end tidal carbon dioxide readings.
        iii) Review of each implementation by the service medical director.
    c) The name / brand / model of the Supraglottic Airway (SGA) device being utilized by the certified service or Advanced Life Support First Response (ALSFR) service.
    d) If the service changes devices, notification must be made to the appropriate Regional Emergency Medical Advisory Committee (REMAC) for re-approval prior to implementing any changes.
    e) Written policies and procedures that include, but are not limited to:
        i) Practitioner training and education, which must include, but is not limited to, the following core components:
            (1) Understanding and monitoring of waveform capnography readings;
            (2) Contraindications for Supraglottic Airway (SGA) implementation; and
            (3) Documentation standards, including the required entries contained within this policy statement.
        ii) A plan for maintenance of competency.
        iii) Continuing education requirements.
        iv) Use of Supraglottic Airway (SGA) devices consistent with Regional and State policies and protocols.
    f) A quality assurance plan that details the process for review of each use by agency medical director.
2) Review and Approvals:

a) Applications will be submitted to the appropriate Regional Emergency Medical Advisory Committee (REMAC) and the Department.
b) The REMAC will review the training plan and submission by the service.
c) If the application is not complete or the training plan not sufficient, the REMAC will notify the service and advise they must resubmit all documents.
d) The REMAC will notify the Department if the training plan is approved and the submission complete at EMS.Licensure@health.ny.gov.

3) The Department will notify the service that they are approved to implement the SGA program. Upon receipt of notification, the service must submit an updated Medical Director Verification form indicating SGA approval. The Medical Director Verification Form may be found at this link: EMS Forms.

Documentation and Patient Care Standard

1) Documentation of Supraglottic Airway (SGA) implementation in a prehospital care report which must include, but is not limited to, the following entries from the National Emergency Medical Services Information System (NEMSIS) fields:
   a) Indications for Invasive Area (eAirway.01)
   b) Date/Time Procedure Performed (eProcedures.01)
   c) Procedure (eProcedures.03)
   d) Size of Procedure Equipment (eProcedures.04)
   e) Number of Procedure Attempts (eProcedures.05)
   f) Procedure Successful (eProcedures.06)
   g) Verification of correct placement with continuous waveform capnography
   h) Procedure Complication (eProcedures.07)
   i) Response to Procedure (eProcedures.08)
   j) Procedure Crew Members ID (eProcedures.09)
   k) Role/Type of Person Performing the Procedure (eProcedures.10)
   l) Procedure Authorization (eProcedures.11)
   m) Procedure Authorizing Physician (eProcedures.12)
   n) Date/Time Airway Device Placement Confirmation (eAirway.02)
   o) Airway Device Being Confirmed (eAirway.03)
   p) Airway Device Placement Confirmed Method (eAirway.04)
   q) Type of Individual Confirming Airway Device Placement (eAirway.06)
   r) Crew Member ID (eAirway.07)
   s) Airway Complications Encountered (eAirway.08) Suspected Reasons for Failed Airway Management (eAirway.09) if appropriate)
   t) Periodic reassessment of Supraglottic Airway (SGA) placement, especially after patient movement.
   u) Serial recording of vital signs, including wave form capnography, at a minimum every five (5) minutes.
2) Patient Care Turnover:
   a) If an Advanced Life Support (ALS) intercept occurs, documentation must include the following:
      i) Time of turnover of patient care to the Advanced Life Support (ALS) provider.
      ii) Advanced Life Support (ALS) confirmation of Supraglottic Airway (SGA) placement.
      iii) Supraglottic Airway (SGA) removal, if performed.

iv) If no Advanced Life Support (ALS) is available, the emergency department Medical Control NP, PA, or Physician (MD/DO) must confirm placement.
(1) Placement confirmation must be documented in the patients care record, regardless of level of practitioner confirming placement.

b) In the event a patient is not transported, and care is not turned over to Advanced Life Support (ALS):
i) Document all confirmation methods used to confirm correct placement.

General Guidelines and Requirements

1) Supraglottic Airway (SGAs) may only be used by certified providers who have been credentialed by their agency medical director. The Regional Emergency Medical Advisory Committee (REMAC) may maintain a registry of providers who have been credentialed by their agency medical director for regional awareness and tracking of the program.
2) A certified ambulance agency or Advanced Life Support First Response (ALSFR) service may only implement the use of Supraglottic Airway (SGAs) by certified Basic Life Support (BLS) providers after they have met the requirements contained in this policy statement.

Any questions regarding this policy statement may be forwarded to the Standards and Licensure Bureau at: EMS.Licensure@health.ny.gov.

Resources:

The following training resources may be found on Vital Signs Academy:

Supraglottic Airway for the Basic Life Support (BLS) Provider

Capnography for the Basic Life Support Provider

Prehospital Levetiracetam (Keppra) as an Anti-Epileptic Drug (AED) for seizures

Background

Benzodiazepines remain as the first line termination therapy for seizures in the pre-hospital setting across the United States. However, there is the chance of recurrence of another seizure after pharmacologic intervention, especially in patients with a known history of or prolonged seizure. In the hospital setting, like in the emergency department, Levatiracetam is administered post seizure prophylactically to prevent recurrence.

Proposal

What is being proposed is a 12 month "pilot" of using Levatiracetam in Suffolk County by paramedics with a select criteria for efficacy in the prehospital setting. Administration of the medication would be via IV or IO and would only be for patients over 14 years of age to start with the following criteria:

- Known history of seizures and currently postictal
- Seizure terminated with a benzodiazepine prior to ems arrival or by ems
- Multiple doses of benzodiazepines administered (bystanders and/or ems)

Proposed protocol (see reverse side)

Rationale

Currently when a patient is encountered and has a seizure, our protocol allows for two (2) doses of a benzodiazepine followed by calling for ketamine orders. With that in mind, there is the associated risk of respiratory depression, synergistic effects, and hypersalvation with ketamine. If the patient loses their airway and the provider is not an RSI paramedic, then it would be considered an MFI. The other ideology is if levetiracetam is being given in the ER to prevent seizures, why not bring this into the field for earlier administration? With Levetiracetam having a safe drug profile and little to no side effects, the benefit outweighs the risk.

Cost

Depending on dosing, a vial of 500mg/5ml of Keppra is approximately $4 and 1500mg/100ml is $22.99. This is an affordable intervention for the prehospital setting, but obtaining it from the hospital can also be considered.

Summary

Levatiracetam (Keppra) is a safe pharmacological adjunct that can lead to better outcomes in the prehospital setting. With a low risk, high yield effect, we can hopefully reduce the recurrence of seizures in the field prior to arrival at the hospital. With the Suffolk REMACs permission we can begin to launch a controlled pilot to assess feasibility, safety, and clinical impact in our EMS system.

Seizures – Adult

For pediatric see, "Seizures – Pediatric"

CFR AND ALL PROVIDER LEVELS

- Airway management and appropriate oxygen therapy
  - Suction the airway as needed
  - Position the patient on the side if vomiting
  - Do not put anything in the patient's mouth when the patient is actively seizing
    - Utilize an appropriate airway adjunct, if needed, after the seizure has ended
- Protect the patient from harm
  - Remove hazards from the patient's immediate area and avoid unnecessary restraint
- Ongoing assessment of the effectiveness of breathing
  - See "Extremis: Respiratory Arrest / Failure – Adult" if necessary
- Assist patient with their own medications
  - See "Resources: Prescribed Medication Assistance"

CFR STOP

EMT

- Check blood glucose level‡, if known or suspected to be below 60 mg/dL, see "General: Hypoglycemia – Adult"

EMT STOP

ADVANCED

- Vascular access

ADVANCED STOP

CC

PARAMEDIC

- Cardiac monitor
- Midazolam (Versed) 10 mg IM or intranasal, 5 mg IV; may repeat once in 5 minutes
- Levetiracetam (Keppra) ⓟ‡ 60mg/kg, IV/IO, once, (Max of 4500mg), over 3-5 minutes for:
  - Seizures refractory to benzodiazapines or more than one dose of benzodiazapine given
  - More than one seizure prior to EMS arrival
  - Postitctal patient with suspected high risk of reoccurence
  - Extended transport times greater than 30 minutes
- Magnesium 4 grams IV over 20 minutes, after Midazolam, if patient is pregnantı

CC AND PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Additional Midazolam (Versed) 2.5 – 5 mg IV, IM, or intranasal
- Additional Levetiracetam (Keppra)ⓟ‡
- Levetiracetam (Keppra) when above criteria is not metⓟ‡
- Ketamine 100 mg after two doses of midazolamⓟ‡