5/10/2023 – SEMAC Meeting – Troy, N.Y.
NEW YORK STATE
DEPARTMENT OF HEALTH
STATE TRAUMA EMERGENCY MEDICAL
ADVISORY COMMITTEE MEETING

DATE: May 10, 2023
TIME: 11:39 a.m. to 1:15 p.m.
CHAIR: Donald Doynow
LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

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2 **APPEARANCES:**
3 RYAN GREENBERG
MICHAEL DAILEY
4 YEDIDYAH LANGSAM
STEPHEN GOMEZ
5 MATTHEW TALBOTT
JOHN WASHKO
6 DOUGLAS ISAACS
DR. KUGLER
7 JEREMY CUSHMAN
BRIAN WALTERS
8
MARYANNE PORTORO
JEFFREY RABRICH
9
DANIEL OLSSON
10 LEWIS MARSHALL
MICHAEL MCEVOY
11 VALARIE OZGA
THERESA ALLEN
12 JONATHAN BERKOWITZ
MARK PHILIPPY
13 DAVID VIOLANTE
PAMELA MURPHY
14 DONALD HUDSON
WAJIHA KZMI
15
STEVEN KROLL
JASON WINSLOW
16
AIDAN O'CONNOR
AMY EISENHAUER
17
RICH BRANDT
18 AL LEWIS
DON TRZEPACZ
19 JOHN MORLEY
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2 (The meeting commenced at 11:39 a.m.)
3 **CHAIR DOYNOW:** Okay, why don't we go
4 ahead and get started. If we could all stand for the
5 Pledge of Allegiance.
6 (Pledge of Allegiance).
7 **CHAIR DOYNOW:** If I could ask
8 everybody just to stand for a moment just for a
9 moment of silence for Dr. Trisha O'Neal who was Vice
10 Chair of STAC, who died in a tragic car accident with
11 her husband in February.
12 Okay. Thank you, everyone. Be
13 seated. Val, if we can have a roll call?
14 **MS. OZGA:** (unintelligible) the mic,
15 please? Okay. Good morning, everyone. Dr. Brandt.
16 **MR. BRANDT:** (No audible response)
17 **MS. OZGA:** Dr. Berkowitz.
18 **MR. BERKOWITZ:** Yeah.
19 **MS. OZGA:** Dr. Barry.
20 **MR. BARRY:** (No response).
21 **MS. OZGA:** Dr. Bombard.
22 **MR. BOMBARD:** (No response).
23 **MS. OZGA:** Dr. Cooper.
24 **MR. COOPER:** (No response).
25 **MS. OZGA:** Dr. Cushman.

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2 **MR. CUSHMAN:** Cushman, here.
3 **MS. OZGA:** Dr. Dailey.
4 **MR. DAILEY:** Dailey, here.
5 **MS. OZGA:** Dr. Doynow.
6 **CHAIR DOYNOW:** Here.
7 **MS. OZGA:** Dr. Gomez.
8 **MR. GOMEZ:** Here.
9 **MS. OZGA:** Dr. Isaacs.
10 **MR. ISAACS:** Isaacs, here.
11 **MS. OZGA:** Dr. Kugler.
12 **MR. KUGLER:** Present.
13 **MS. OZGA:** Dr. Lynch.
14 **MR. LYNCH:** (No response).
15 **MS. OZGA:** Dr. Markowitz.
16 **MR. MARKOWITZ:** (No response).
17 **MS. OZGA:** Dr. Maynard.
18 **MR. MAYNARD:** (No response).
19 **MS. OZGA:** Dr. Marshall.
20 **MR. MARSHALL:** Present.
21 **MS. OZGA:** Dr. Murphy.
22 **MS. MURPHY:** Here.
23 **MS. OZGA:** Dr. Olsson.
24 **MR. OLSSON:** Olsson, here.
25 **MS. OZGA:** Dr. Talbott.

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2 **MR. TALBOTT:** Talbott here?
3 **MS. OZGA:** Dr. Walters.
4 **MR. WALTERS:** Walters, here.
5 **MS. OZGA:** Dr. Wicelinski.
6 **MR. WICELINSKI:** (No response).
7 **MS. OZGA:** And Dr. Winslow.
8 **MR. WINSLOW:** Winslow, here.
9 **MS. OZGA:** Non-voting members. Orrin
10 Barsley (phonetic spelling).
11 **MR. BARLEY:** (No response).
12 **MS. OZGA:** Aidan O'Connor.
13 MR. O'CONNOR: (No response).
14 **MS. OZGA:** Mark Philippy. I know he
15 is here.
16 **MR. PHILIPPY:** (No response).
17 **MS. OZGA:** Maryanne Portoro.
18 **MS. PORTORO:** (No response).
19 **MS. OZGA:** Dr. Rabrich.
20 **MR. RABRICH:** Here.
21 **MS. OZGA:** Michael McEvoy.
22 **MR. MCENVOY:** Here.
23 **MS. OZGA:** Steve Kroll.
24 **MR. KROLL:** Kroll, present.
25 **MS. OZGA:** John Washko.

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2 **MR. WASHKO:** (No verbal response).
3 **MS. OZGA:** We have thirteen vetted
4 members here. We have reached a quorum.
5 **CHAIR DOYNOW:** Okay. Thank you, Val.
6 I may be preaching to the choir here, but we have
7 twenty-three members on SEMAC and we have thirteen
8 people who have showed up. I'll just remind folks,
9 and they probably are in listening, but if you miss
10 three meetings, it's time for you to move on and you
11 will be replaced by someone else. We need to have
12 docs here. That's why you're on the list. So let's
13 hope that next meeting we have a little better
14 attendance. All right. Let's move on here.
15 Approval of the minutes. And I have a -- a motion to
16 approve the last meeting minutes. Okay. Guys,
17 everybody need coffee? Thank you. Do we have a
18 second?
19 **MR. GOMEZ:** Second.
20 **CHAIR DOYNOW:** Thank you. All in
21 favor, please raise your hands. Anybody against?
22 (No response.)
23 **CHAIR DOYNOW:** Any abstentions?
24 (No response.)
25 **CHAIR DOYNOW:** All right. Minutes

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2 have been approved.
3 All right. Moving on. Ryan, on to
4 you.
5 **DIRECTOR GREENBERG:** Thank you very
6 much. Good morning, everyone. Still morning, I
7 think yeah. For another fifth couple of minutes. So
8 good morning on the Bureau report. So at the top of
9 the Bureau report absolutely would be the excitement
10 of Part S and the legislative changes that went
11 through in the governor's budget. And all the
12 feedback and everything that -- that people provided,
13 really appreciate everything. And we're excited to
14 see some really -- you know, things that we hope will
15 help in EMS, sustainability, and response across the
16 state.
17 So with Part S for those of you who
18 are not aware of what made it through and what did
19 not, the parts that did make it through, and you can
20 find this online if you look for it, as well as we'll
21 make sure to share a copy with all the members of
22 just a section of Part S because it's a very long
23 document that's not pertaining to EMS. But it talks
24 about the expansion of SEMSCO and roles and
25 responsibilities and the ability to do more things.

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2 I know over the years, there's been some questions
3 with SEMSCO and -- and things of what can it do? Is
4 it only emergencies? What about disaster
5 preparedness and these things, and so it -- it
6 expands their roles and responsibilities. As well as
7 in the REMCOs, as you know, things expand in the
8 SEMSCOs, the possibility for REMCOs to have
9 additional things that they may be asked to do from
10 the SEMSCO and to work with that one.
11 A big one, which is new, and it showed
12 up last year and this year again, is the system and
13 agency performance standards. And what this does is
14 allows SEMSCO to make recommendations on what should
15 be put into a regulation on a system and agency
16 performance standard. So what is the standard that's
17 out there? What is something a benchmark that an
18 agency should -- you know, be required to -- to live
19 up to. On -- on a pretty regular basis so I'm asked,
20 you know, well, you need to do something about that
21 agency, they only get out twenty percent of the time.
22 And unfortunately, we have to shrug our shoulders and
23 say, well, today there's nothing that requires them
24 to get out more than twenty percent of the time. We
25 appreciate that they get out twenty percent of the

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2 time. The problem is -- is that that creates system
3 instability because when they only get out twenty
4 percent of the time, the agencies around it don't
5 know if it's getting out twenty percent of the time -
6 - you know, that time or if they're not going to get
7 out. And then how do they support? And so it really
8 weakens the overall system.
9 So over the -- the past two days,
10 we've heard on a pretty regular basis, and we brought
11 up at each of the committee meetings about starting
12 to think about what these system and agency
13 performance standards will look like. And we're
14 really excited to have this opportunity to now
15 develop those and -- and to look at the subject
16 matter experts around this table and around this room
17 and within the regional councils to say, "Hey, what
18 do you think are the standards that we should follow?
19 What is it out there that needs to happen in order to
20 have sustainability?" and to kind of work those
21 forward. And hopefully, the first step would be a
22 small amount, right? We want it to be reasonable.
23 We want it to be achievable. We want it to help
24 strengthen a system, not weaken a system, not make it
25 impossible for someone to do, but at the same time,

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2 make it something that is going to grow a system and
3 have people work towards a goal.
4 And so, at each of the committee
5 meetings, we spoke about that. We spoke about it at
6 systems. We spoke about it at the quality assurance.
7 We spoke about it -- you know, at each of these, at
8 education. And so over the next couple of months,
9 we're going to start to see a working group. And
10 there's been -- you know, one person, particularly
11 from systems who's going to be working -- leading the
12 charge on that side to make recommendations and then
13 figure out priority, well, what do we want to start
14 with versus what we want to end with? You know, in
15 the first go around, probably want to end up with
16 maybe five, not a lot. You know, if you start
17 looking at five, maybe one is related to education,
18 one is related to -- you know, response, one is
19 related to -- you know, fill in the blank. But the
20 other great part about the system and agency
21 performance standards is it is -- it's developed
22 today. But the standards of today may be different
23 than the standards of ten, twenty, thirty years from
24 now. And those standards can continue to grow. We
25 know where we are today. We don't know what medicine

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2 will look like in twenty years from now. And the
3 standard today could be different. You know, the
4 standard today must be -- you know, your air
5 ambulance that comes out of every EMS station because
6 now we're all driving in drones could be different
7 than what it is today. Probably cost the same amount
8 of money though.
9 So we're really excited about that
10 part. We think this will be a great one. I really
11 urge all the physicians around the table to play an
12 active role in this, to look at what they think would
13 add to -- you know, to -- to add to the system and
14 agency performance standards, what should be
15 included, what should be considered to put them down
16 on paper. And then we can decide which ones, you
17 know, really are what they should be moving forward,
18 and which ones maybe should move forward versus
19 shouldn't. Remember, these will go into regulation,
20 so there'll be open comment period. There's -- it's
21 not a short process. This isn't going to -- you
22 know, oh, well, in September we're going to institute
23 five new standards. It won't happen that way. But
24 hopefully by September, we'll have an idea of what we
25 want to propose and where we want to go with that.

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2 The -- the other parts are recruitment
3 and retention -- development of recruitment and
4 retention on kind of a two-fold side. So half of
5 that will be -- not half -- you know, two-fold, both
6 being at a state level and a regional level, trying
7 to -- you know, have some regional components to it
8 as well as a state component to it. A mental health
9 and wellbeing program, the E.M.S. Task Force.
10 So, E.M.S Task Force, one of the
11 things that we've learned over the past couple of
12 years -- you know, through COVID and everything else,
13 is that to be able to do things very quickly when the
14 demand is there, and I -- and I don't mean quickly in
15 a sense of necessarily minutes, but maybe hours, we
16 need to be ready and have readiness in order to
17 respond and meet those demands. So we're not talking
18 about that -- you know, kind of where we're talking,
19 you know, that -- that initial response, we're
20 talking about a major incident in something else, a
21 community that's larger.
22 Most recent, you know, not this -- not
23 COVID, would be the Buffalo snowstorms. And we know
24 in the Buffalo snowstorms that -- you know, there was
25 an opportunity to bring more resources into an area

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2 after a certain part. But we also know that that
3 wasn't the easiest thing to do. And what's the
4 system and how do we do it, how do we make sure not
5 to pull from the most local of resources in order to
6 not tax that system? And so that took us a number of
7 days to get there. The EMS Task Force will hopefully
8 have contracts in place with existing EMS agencies to
9 be able to, on a dime in -- in a matter of hours
10 opposed to days, have a response to a need in a
11 community, and to help support them and stabilize
12 them until -- you know, the task force can back out
13 and say, okay, now you're back to, you know, a -- a
14 normal frame set. So, very excited on that one, you
15 know.
16 Some other opportunities within the
17 task force might be specialized equipment. Equipment
18 that a community would say, I can't financially
19 afford to buy an MCI bus or something else that, you
20 know, a -- a larger city like FDNY -- you know, says,
21 oh, we have three because it -- the system needs it
22 there. Well, a region or an area may need it, but
23 financially one agency can't. And so, task force
24 possibly being able to buy resources or do things.
25 And then possibly even to say, hey, we're going to

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2 put this into a region and have the region use it on
3 a regular day-to-day basis. But again, disaster
4 comes, that resource has to be ready to move and --
5 and go to another part of the State. So also -- so,
6 you know, resources aren't just sitting and that
7 they're actually being used and have value on a
8 regular basis.
9 And then the -- the last, you know,
10 big one within that Part S was health insurance
11 eligibility for E.M.S Ambulance agency members.
12 There -- this one, I will tell you, I probably have
13 the least amount of information on there, but we will
14 be working on getting more information for the
15 September meeting. Just some more clarity on -- on
16 what that means. But it essentially gives the
17 opportunity for active members to be a part of the
18 health insurance program. And so when we talk about
19 what are some of those recruitment and retention
20 opportunities, these are things that add to
21 recruitment and retention, that ability to offer more
22 to our members, be volunteer other options.
23 In a few minutes to at -- at the end
24 of my report, OHIP is actually joining us today to
25 talk about a -- I believe it's a thirty-six million -

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2 - thirty-four or thirty-six -- they'll correct it,
3 million dollar investment in the Medicaid program for
4 emergency work.
5 So really just a tremendous year for
6 EMS. A lot of recognition -- you know, from the
7 governor's office and chamber -- you know, to support
8 the functions, to help stabilize the system and to --
9 you know, really progress this into the future and to
10 give us dynamics that allow us to adapt to changes as
11 they move forward and not just a fixed thing that's
12 going to say, well, this will short term, put a band-
13 aid on something.
14 Some additional updates on
15 regulations. So we have two packets of regulations
16 that are -- that are in the process going up. We
17 expect to SEMAC them for public comment this summer.
18 So please keep your eyes out for that. We'll make
19 sure to share it with all the SEMAC members and the
20 SEMSCO members that -- those regulations are for
21 education and for operations. The operations are
22 primarily geared around the equipment standards that
23 the safety committee came up with. The education ones
24 are around the education standards that were created
25 by the education committee. Again, hopefully out for

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2 public comment this summer.
3 One of the things I do want to flag
4 for everybody around this table is there is an
5 executive order that is currently in place that is
6 E04. E04 is related to the staffing crisis. And
7 there are a number of provisions within E04 that are
8 being used today, including the ability to take
9 either the national exam or the state exam. If E04
10 comes to an end, which is expected to come to an end
11 around May 20th or 22nd, that would end some of those
12 provisions. And we'll make sure that everybody is
13 aware that those have come to an end.
14 Many of those provisions that we're
15 using today saying all the regs are passed and put
16 into place that are proposed that are in the
17 pipeline, would be kind of reverted back into place.
18 But there could be a window of whenever that EONs
19 until the new regs are in place for education, that
20 some of those things won't be in place. So just
21 keeping that one in mind.
22 All right. For the rest of your
23 update, investigations continues on investigations,
24 operations is out and seeing a lot of different
25 agencies, we're getting back into places. Please

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2 remind your agencies to -- they know we're coming.
3 These are pre-scheduled no surprises for the most
4 part. Remind them to check their policies, remind
5 them to -- you know, have things accessible to -- to
6 do their rechecks to make sure that equipment isn't
7 expired. You know, we're on a fairly regular basis
8 running into situations to where it's not just
9 equipment that’s expired by a month, but it's a year
10 or two years. So you know, just situational
11 awareness on that one. Please -- you know, do your
12 best to work on that. As medical directors, feel
13 free to reach out to your district chiefs and -- you
14 know, ask them, can you tell me a little bit about --
15 you know, what's going on in my region? They won't
16 tell you specifics about your agencies. You should
17 know your agencies, but they will tell you in
18 general, what's a repetitive you know, thing that
19 we're seeing that -- you know, is a little bit
20 different from region to region.
21 On the administration side, we
22 continue to finalize some of the contracts for the
23 PAs and -- and the REMCOs. We also have a health
24 system specialist position that's posted that's going
25 to be a new position, new district chief position

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2 within the bureau. The bureau is also excited to see
3 a number of new positions coming down the pipe as the
4 Department of Health continues to -- you know, raise
5 the number of -- bring back up the number of staff
6 members within the department. I think, you know,
7 it's a big initiative of theirs to -- to get to their
8 base mark numbers. And so you'll see a number of
9 positions around the State being coming up for the
10 Bureau of EMS. Please feel free to share them.
11 On the education side. We're really
12 excited about this one. So for the first time in
13 many years, we have increased the funding for CFRs
14 and EMT training, at the base rate. It's a fifteen
15 percent increase for those two categories for the
16 original classes.
17 We expect to see a second increase.
18 We are meeting with the finance committee on a
19 regular basis. We did this -- we have met with Steve
20 Kroll and -- and the work that he's doing in the
21 survey that he's working on. So the goal is to
22 determine where -- you know, it is best to allocate
23 some of that funding and those increases. Do we
24 focus just on original classes? Do we focus on
25 original and -- and refresher classes? Whatever that

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2 might look like. So that is a big thing that's
3 happening on the education front. We're really
4 excited about that.
5 In addition, we have four new
6 educational pilot programs. The four new educational
7 pilot programs:
8 The first one is an EMT Academy
9 program. This is now open to every single core
10 sponsor out there. So every single core sponsor
11 would be able to -- be eligible to teach one Academy
12 style class at an increased funding rate for -- in a
13 calendar year.
14 The second program is an EMS
15 internship program. This is designed for EMS
16 agencies to be able to bring a person from the
17 community and do some sort of an eight-to-twelve-hour
18 engagement with them, teach them about EMS, teach
19 them about the agency, whatever that might look like.
20 And then they would be able to sign off on the
21 training fund, essentially sending them to EMT
22 school.
23 So what we've heard in a lot of
24 feedback is it takes two months, three months to get
25 a person into a volunteer agency at times. And the

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2 EMT class started -- you know, two weeks before they
3 would've gotten in. This would give them that
4 opportunity to get in and it would also give them an
5 opportunity to sponsor some people who may or may not
6 join or maybe weren't thinking of joining the agency,
7 but now all of a sudden will. So again, excited to -
8 - to see that internship. By the way, this is all
9 out in policy statements, they're posted online
10 already, so if anybody wants to either follow along
11 or see it, they are up on our website.
12 The second program is Intro to
13 Paramedicine. This is a BLS CME pilot program where
14 they'll get their BLS CME hours, but in addition,
15 have an enhanced program to determine a little bit
16 more about paramedicine, a little bit more about the
17 math, the anatomy and physiology you'll have to know
18 the -- the -- the rigor of the coursework that's
19 there. But given that initial exposure, this is only
20 being able -- as a pilot, this is only eligible for
21 paramedic core sponsors to run with. But it is an
22 exciting program to be able to hopefully do an intro
23 program and see where that leads, how many of those
24 convert to going to become a paramedic.
25 And then the last one is funding

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2 behind the EMS leadership training. This is a
3 program that was developed for the State. It's a
4 two-day training. There is a third-day option on
5 recruitment and retention, but it's a two-day
6 leadership training and funding for that one. In
7 addition, on the education front, we have some new
8 PSI group scheduling that's happening. There's about
9 a dozen agencies around the State that are trialing
10 that out. If it goes well, we will advance that to
11 more of our core sponsors. Essentially, what that
12 means is that the instructor has the capability of
13 scheduling everybody at one time. So they register
14 online, then the instructor schedules them. This is
15 to help in some situations where we're seeing them
16 say, well, the students took two months to -- you
17 know, take their exam. So we're trying to reduce
18 that and see what we can.
19 There is also a new ADA process for
20 readers. So following in the national standards as
21 well, EMT or EMS providers who have an appropriate
22 documented learning disability and meet the
23 requirements of the Department of Health ADA
24 compliance office, could be eligible for a reader for
25 their exam. This is a new thing for us. There was a

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2 lot of back and forth on it. There was a lot of
3 discussion on it. This does not mean anybody who
4 raises their hand and says, I want a reader, would
5 qualify for a reader. It would have to be very clear
6 in their documentation through their testing, through
7 their accommodations, that this is an appropriate
8 accommodation for them, and then they would be
9 eligible for that accommodation.
10 The other big difference in that one
11 is we are asking at this point for all of the
12 students who need an ADA accommodation to submit
13 their own accommodation paperwork through the portal
14 on the EMS forms page. A copy of their submission
15 will go to the instructor. So the instructor will
16 know whether or not they submitted. But we are
17 trying to get this stuff in a timely manner. And
18 some of the paperwork is getting delayed in the
19 process due to submission timelines.
20 Data and informatics met last week.
21 They had a robust conversation on a -- on a committee
22 or a number of days together to try and look at how
23 do we reduce the number of required fields within the
24 EPCR? How do we make it more collaborative for EMS
25 provider to be able to complete their chart with less

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2 validation errors? And so we are working on that
3 one. The goal that was given to branch Chief Brody
4 (phonetic spelling) was reduce it by twenty-five
5 percent, if we can. I am told that we are getting
6 closer, but we might not be there yet. But there's
7 been a -- a number of modifications and things, and
8 again, hopefully, that will work.
9 I know that we also have ESO and Image
10 Trend who joined us here today, talked about some of
11 the issues that are related to charts not getting
12 through. There's obviously a continuation of care
13 issue when charts don't get through because if they
14 don't get through, it's not only them not getting
15 necessarily to an agency level, they're not getting
16 to a regional level or the hospital, which is where
17 we really want them to be. So when the care's being
18 delivered, that it can be there. So we are working
19 on all that as well.
20 Next STAC meeting is tomorrow, May
21 11th, at -- at the Albany Wolf Road Marriott. There
22 are a number of changes to the 405 regs that -- that
23 are also in the pipeline for regulatory changes as
24 well as -- we'll be honoring tonight actually, Dr.
25 Marks and Dr. O'Neill, who were the STAC Chair and

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2 the STAC vice chair who unfortunately both died
3 within about a year of each other. So a big loss to
4 the trauma community.
5 The EMS for Children's Grant was
6 awarded on April 1st. Excited to -- you know, that
7 being awarded to the State. And we'll continue on
8 with a lot of great projects. The EMS for C -- EMSC
9 survey concluded on April 31st and we're waiting to
10 see some of those results. The EMS-MSAC meeting was
11 last week -- sorry. No. That one was off. We have
12 updated the Pediatric Assessment Triangle. That
13 document is available online and printed copies here,
14 Amy.
15 **MS. EISHENHAVER:** Printed copies in my
16 office.
17 **DIRECTOR GREENBERG:** And printed
18 copies in the office, but we'd be happy to mail them
19 out to region -- REMCOs who would like some of those
20 updated ones. As well as we also have badge buddies,
21 so the buddy -- the badge ideas that go on. If any
22 of the regional councils would like to have some of
23 those, please reach out to Amy and we can send those
24 off to the regional councils.
25 Vital signs will be October 17th to

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2 22nd. Excited to have a really nice program this
3 year. Looking forward to seeing everybody. Hoping
4 to see those numbers continue to go up. With the
5 pandemic being over, we know that we went down in
6 numbers for during the pandemic, so hopefully that
7 will continue to go up.
8 In just a couple weeks, we have our
9 EMS memorial on Tuesday, May 23rd, at eleven a.m. at
10 the Plaza. Everybody is welcome and we encourage
11 agencies to come. If you are going to bring a
12 vehicle, please make sure to reach out to Val Ozga
13 ahead of time so that we can get you -- by the way,
14 an ambulance or department-lettered vehicle. Please
15 reach out to Val Ozga so we can get you parking space
16 on the Plaza. Really is a very nice event. It is
17 honoring -- eight honorees this year. And so very
18 excited about that one.
19 We spoke about the executive order
20 coming to an end possibly and what that would mean.
21 The Rural Health Task Force -- so the Rural Health
22 Task Force met last week. Really great progress
23 going on there. Great work of the group and really
24 making some nice progress. Hopefully, in September
25 meeting we'll have additional updates for you. I

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2 know their goal is to complete their report by the
3 end of the year or shortly after that, so that has
4 more looking forward to it.
5 Just a reminder, the EMS forms page is
6 live on our website and it really includes almost
7 everything now, particularly all of our submissions.
8 So please make sure to use that one. One of the new
9 things that we're going to add to the EMS Forms page
10 is a policy suggestion update. So if you see a
11 policy statement on our website and you feel there's
12 a better way of wording it, or something's outdated
13 or something contradicts it, we're going to be
14 putting that up on our website and going through all
15 of our policies and -- and working on updates over
16 the next several months.
17 And that is the end of my report. I
18 am going to ask Rich Brandt -- oh, there he is, to
19 step up and speak about OHIP, if he doesn't mind, and
20 the supplement.
21 **MR. BRANDT:** Good afternoon. I think
22 most of you know me. For those of you who don't, I
23 was involved in the EMS for a couple of years. I now
24 work for the Office of Health Insurance Program and
25 I'm pleased to bring you some really good -- what I

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2 think is some really good news at this meeting. For
3 those of you who don't already know we were able to
4 secure an increase in payments to emergency ambulance
5 claims, which will begin on July 1st of this year.
6 So it'll be three quarters of the current fiscal year
7 -- the current state fiscal year, and then it'll be
8 permanent for all quarters of the following fiscal
9 year ‘25. What we did is we took Medicare for if --
10 if I'm over-explaining something, please let me know
11 and I'll -- I'll stop. But Medicare uses what they
12 call an RVU system, a Relative Value Unit system.
13 Every January 1st, Medicare establishes a base rate
14 for BLS non-emergency, which is considered to be the
15 least expensive type of ambulance trip to provide,
16 puts a dollar value on it, and then multiplies that
17 times the RVU index, which is a number greater than
18 one point zero zero. So I've got some numbers here.
19 Give you some idea. And this -- again, these payment
20 increases apply only to emergency ambulance claims,
21 not to not emergency claims.
22 And so we're starting with a base rate
23 of a hundred and ninety-five dollars, which I realize
24 is less than Medicare pays for a BLS non-emergency
25 trip. But for a BLS emergency trip, we'll be

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2 multiplying that by one point two eight, for advanced
3 life support level one, we'll be multiplying that
4 number by one point five two, for ALS two by two
5 point two, and for SCT by two point six. It comes
6 out to be a thirty-eight point four million dollar
7 annual investment in year two of the budget. Again,
8 because -- we're going to be a quarter late in
9 implementing this. We still have some pencil
10 sharpening to do in-house on our end. I think it's a
11 wonderful thing. There are a few counties that have
12 been fortunate, I guess, everything being relative
13 that already received more than this. Those counties
14 will not be affected. They will not have their
15 payments reduced. So this is good news that the
16 total investment it's with the State, it's fifty-
17 fifty. We pay half the Medicare tab -- Medicaid tab
18 rather and the feds pay the rest, the other half. So
19 the State's investment is eighteen point two million.
20 The total investment is thirty-eight point four
21 million dollars. And I think it'll make a
22 significant difference. Those of you who've been
23 around a long time, remember I worked on a similar
24 package with -- then Deputy Medicaid director Liz
25 Misa (phonetic spelling) probably about seven years

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2 ago, maybe early year(sic), that sound about right.
3 Okay. And we were able to get thirty-one million
4 dollars for the industry over a five-year span back
5 then. So this is a larger investment and it's going
6 to be all -- put in place immediately starting 7/1.
7 And again, it affects emergency claims.
8 Any questions I can answer?
9 **MR. WASHKO:** Yeah. Good morning.
10 First off, congratulations. Thank you. Every dollar
11 we can get is -- is a dollar more that we have that
12 we need. I'm just curious about the downstate
13 hospital-based bundled payment arrangements for EMS
14 and Medicaid transportation. And will there be some
15 form of adjustment there or do we have to go down a
16 different road with that?
17 **MR. BRANDT:** I don't know. Probably
18 we will have to travel. You're talking about the in-
19 patient rate state -- DRG state basically.
20 **MR. WASHKO:** Correct.
21 **MR. BRANDT:** Yeah. For -- yeah. I
22 don't know. We did not address that with this.
23 **MR. WASHKO:** Okay. So that's -- just
24 so everyone is aware, downstate, there's arrangements
25 that have been made between the larger health systems

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2 in the State where ambulance services are not billed
3 to Medicaid, but they're paid out -- paid out of, I
4 guess, the DRG, that's paid to the hospital for the
5 in-patient stay. And that's regardless of where we
6 transport. So if we transport someone to a non --
7 one of -- not one of our hospitals, we still can't
8 bill for that. We -- we bill our own hospital for a
9 transport to not our hospital and that's everyone has
10 to do that. So I don't -- I don't know if everyone
11 is aware of that or not, but that's kind of how the
12 model works.
13 **MR. BRANDT:** Right.
14 **MR. WASHKO:** It's definitely something
15 we need to look at from the hospital side to try to
16 see if there's a way to get the rates increased for
17 the EMS as well.
18 **MR. BRANDT:** We are -- and I -- I
19 don't want to -- wander too far off into the weeds
20 here and take your time, but we are also working on
21 another project. Actually, we could have had several
22 children in the time we've been working on it, almost
23 three years now. For certified public expenditures
24 which you're familiar with. I see you shaking your
25 head. If you're from New York City, you're familiar

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2 with it. If we are able to get that state plan
3 amendment approved by CMS and it's been an arduous,
4 torturous journey, that would do away with what
5 you're referring to and put you on fee for service
6 for everything. But that journey is far from
7 complete, unfortunately. And if you think dealing
8 with the state is fun, deal with the feds. So, I'll
9 leave it at that.
10 **MR. MCEVOY:** A question that came up
11 at systems yesterday was is there any change in the
12 definition of an emergency?
13 **MR. BRANDT:** No. No, there is not.
14 And the easiest way to look at this probably is that
15 if it's not emergency Medicaid trip, you need prior
16 authorization or you don't get paid. You do not need
17 prior authorization for an emergency trip. So if
18 you're moving a patient from a community hospital to
19 a tertiary care center, because the community
20 hospital is unable to provide them with the care that
21 they need, that is an emergency trip. And we will be
22 keying these off your hick pick codes or as we call
23 them, because we have to rename everything something
24 different. We call them procedure codes in Medicaid,
25 but they're the hick pick codes. So if you bill one

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2 of the emergency hick pick codes, it will be treated
3 as an emergency claim that RVU modifier will be
4 applied to the rate.
5 **CHAIR DOYNOW:** Okay. Thank you, Rich.
6 Any other questions for --?
7 **MR. LEWIS:** A question Dr. Doynow?
8 **CHAIR DOYNOW:** Go ahead.
9 **MR. LEWIS:** Thank you, sir, for being
10 here. We've worked with Rich -- Rich for a long time
11 and he's such an asset to us in this new position.
12 Now. It does -- do these rates continue or do they -
13 - do they mature at some point?
14 **MR. BRANDT:** No. They -- they
15 continue.
16 **MR. LEWIS:** Okay.
17 **MR. BRANDT:** At this point in the --
18 in the modifiers continue. Okay. the way it works
19 with Medicare, as you know, is every January 1st they
20 raise that BLS rate, the one point zero zero
21 modifier. I don't know what we will be doing. I was
22 thrilled to get thirty-eight point four million
23 dollars and walk away with that. So I -- I -- I
24 can't tell you what the future will hold.
25 **MR. LEWIS:** I can't tell you how much

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2 our industry appreciates what you're doing. And that
3 money is certainly useful to all of us. Thank you.
4 **MR. BRANDT:** Your -- your work matters
5 and you all know that. Thank you.
6 **CHAIR DOYNOW:** Okay. Just want to
7 remind everyone when you're speaking, please state
8 your name for the stenographer. Moving along --.
9 **DIRECTOR GREENBERG:** Excuse me, can I
10 --?
11 **CHAIR:** What's that?
12 **DIRECTOR GREENBERG:** One last thing --
13 **CHAIR:** Sure.
14 **DIRECTOR GREENBERG:** -- if you don't
15 mind. No. No. Okay. Good. Sorry. I just wanted
16 to take a brief moment to -- oh, this is so sad. In
17 August, so in just a couple months, but before our
18 next meeting, District Chief Ferrell (phonetic
19 spelling) will be retiring from us, who has been with
20 us for the past twenty-five years, and then has been
21 a certified provider for the past forty-nine years.
22 And we just wanted to say congratulations. Thank you
23 for all your service and just -- thank you. So.
24 (Members clapping).
25 **CHAIR DOYNOW:** Anything to say, Joe?

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2 **DIRECTOR GREENBERG:** Joe, do you want
3 to say anything?
4 **MR. MARSHALL:** He did say it's ...
5 **CHAIR DOYNOW:** Okay. Moving to Med
6 standards, Dr. Marshall.
7 **MR. MARSHALL:** Good morning,
8 everybody. Good afternoon, sorry. Med standards met
9 this morning and we have several action items to
10 bring forward. We do have some protocol changes that
11 were submitted by the collaborative and there are
12 three of them, and I would like to bring them all to
13 -- to you and have one roll call boat if that's okay
14 with you Chair.
15 **CHAIR DOYNOW:** Of course.
16 **MR. MARSHALL:** Okay. So -- so the
17 first protocol change is the advance directive DNR
18 MOLST protocol. And the changes there improved
19 simplified the language within the protocol itself
20 and makes it easier to read for providers.
21 **CHAIR DOYNOW:** We're trying to get
22 them up there. They're not quite there yet.
23 **MR. MARSHALL:** Okay. Okay. So this
24 was the first one, and this is the advanced
25 directive's DNR MOLST motion to approve the changes

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2 submitted by the collaborative for this. And there
3 was -- it was a unanimous vote with no discussion.
4 The second one is the adult and
5 pediatric seizure protocols and the changes there are
6 on the adult seizure protocol under paramedic they
7 added ten milligrams of midazolam IMORIN and it
8 remained five milligrams IV and repeat in five
9 minutes. Under key points, they added a bullet point
10 to administer midazolam first followed by magnesium
11 if given -- an additional midazolam may be given per
12 protocol if seizures continue.
13 On the pediatric seizure protocol
14 under cc, the dose of midazolam was changed from zero
15 point one milligram per kilogram to zero point two
16 milligrams per kilogram IMORIN with a maximum dose of
17 ten milligrams, which prior was five milligrams.
18 Under paramedic, if the patient
19 continues to seize, additional doses of midazolam can
20 be given, and those are the changes to the seizure
21 protocol.
22 The third one that comes forward is
23 pediatric and adult pain management. And under the
24 adult pain management protocol -- under advanced
25 provider -- acetaminophen up to a thousand

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2 milligrams, and they removed other dose options. So
3 you can give what's appropriate. The same thing for
4 ibuprofen up to four hundred milligrams.
5 Under paramedic, ketorolac is now
6 available fifteen milligrams IV or IM as well as
7 acetaminophen, one thousand milligrams IV over
8 fifteen minutes. Also, other options include a new
9 option, ketamine twenty-five milligrams IV over five
10 minutes or fifty milligrams IM, and it says can be
11 considered weight-based dosing, not to exceed the
12 previous doses I mentioned. Under key points, there
13 are some clarifications and new section on nitrous
14 oxide contraindications as well.
15 On the pediatrics, changes included
16 acetaminophen fifteen milligrams per kilogram with
17 the concentration added. The same thing for
18 ibuprofen a hundred milligrams per five ml
19 concentration under the cc options including morphine
20 or fentanyl.
21 Under paramedic maximum dose went from
22 five milligrams to ten milligrams for morphine. And
23 then they added whole new section on key points and
24 considerations with multiple bullet points regarding
25 side effects, contraindications of the different

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2 medications. And they added weight -- table with
3 weight in pounds to weight in kilograms. So those
4 three came forward -- that come forward unanimous --
5 voted unanimously at Med Standards and comes forward
6 as seconded motion.
7 **CHAIR DOYNOW:** Thank you, Dr.
8 Marshall. Val, can we have a roll call vote under
9 this?
10 **DIRECTOR GREENBERG:** Before you do the
11 roll call vote, is there anything you want talk about
12 dates of when that would be posted or go into effect,
13 just so it's clear on record?
14 **MR. MARSHALL:** So, as we further
15 discussed this morning, we have the New York State
16 Protocol Development process, so at this meeting
17 these will come forward. They will be approved for
18 implementation January 2024 with final implementation
19 by June 2024 for all agencies. And this is -- goes
20 along with our -- our process to have a one annual
21 rollout of new protocols, barring any exigencies.
22 **CHAIR DOYNOW:** Any questions?
23 **MR. PHILIPPY:** Dr. Doynow -- Dr.
24 Doynow?
25 **CHAIR DOYNOW:** Yes.

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2 **MR. PHILIPPY:** Mark Philippy. Oh,
3 sorry, I'm in my unusual seat. I -- I had meant to
4 mention this during Med Standards. I apologize I
5 didn't get up fast enough for this. But in the adult
6 and pain management the -- the changes there -- there
7 may be a just a minor glitch and I just want to
8 understand what the -- the SEMAC's intention is with
9 this. There is a section that refers to the patient
10 if they're able to tolerate oral fluid, considering
11 giving one of the others. And then down below it
12 does –- it appears to allow for the -- the use of
13 tablet form P.O. So I just wanted to clarify, is it
14 the intention that both P.O. and fluid versions of
15 NSAIDs be available or is it sticking with just
16 liquid form?
17 **MR. MARSHALL:** I would ask Dr. Dailey
18 to comment on that.
19 **MR. DAILEY:** The intention with doing
20 it with the liquid form only was that way you didn't
21 have to carry something separate in order to wash
22 down the tablets. However, if somebody was to plan
23 on doing that one way or the other, from an
24 operational perspective, I can't think of any reason
25 for us to micromanage that.

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2 **MR. PHILIPPY:** Thank you.
3 **CHAIR DOYNOW:** Any other questions
4 before the vote?
5 (No response)
6 **CHAIR DOYNOW:** Okay. Val, if we can
7 have a roll call vote?
8 **MS. OZGA:** Dr. Berkowitz?
9 **MR. BERKOWITZ:** Yes.
10 **MS. OZGA:** Dr. Cushman.
11 **MR. CUSHMAN:** Cushman, yes.
12 **MS. OZGA:** Dr. Dailey.
13 **MR. DAILEY:** Dailey, yes.
14 **MS. OZGA:** Dr. Doynow.
15 **CHAIR DOYNOW:** Doynow, yes.
16 **MS. OZGA:** Dr. Gomez.
17 **MR. GOMEZ:** Gomez, yes.
18 **MS. OZGA:** Dr. Isaacs.
19 **MR. ISAACS:** Isaacs, yes.
20 **MS. OZGA:** Dr. Kugler.
21 **MR. KUGLER:** Kugler, yes.
22 **MS. OZGA:** Dr. Marshall.
23 **MR. MARSHALL:** Dr. Marshall, yes.
24 **MS. OZGA:** Dr. Murphy.
25 **MS. MURPHY:** Murphy, yes.

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2 **MS. OZGA:** Dr. Olsson.
3 **MR. OLSSON:** Olsson, yes.
4 **MS. OZGA:** Dr. Talbott.
5 **MR. TALBOTT:** Talbott, yes.
6 **MS. OZGA:** Dr. Walters.
7 **MR. WALTERS:** Walters, yes.
8 **MS. OZGA:** And Dr. Winslow.
9 **MR. WINSLOW:** Winslow, yes.
10 **MS. OZGA:** Motion passes.
11 **CHAIR DOYNOW:** Thank you. Dr.
12 Marshall.
13 **MR. MARSHALL:** So the next motion to
14 come forward has to do with development of blood
15 administration regulations using a framework
16 developed by the department and stakeholders and we
17 actually have a template. And we as a body are
18 requested to come up with the regulations, if I'm
19 correct, for the blood administration.
20 **DIRECTOR GREENBERG:** So as a body,
21 it's a request to promulgate regulations, so to -- to
22 work through that -- I'm -- I'm happy to have
23 actually Don Treepacz step up and just talk a little
24 bit about what's happened so far, and what the next
25 steps would be. Again, I just want to remind

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2 everybody here. So this is a little bit, you know,
3 we're -- we're moving into now doing a lot of
4 regulatory updates to both of things that are new.
5 Last year, the blood legislation came in for Air
6 Medical. But going forward, we -- with Part S and
7 everything else, there's a number of regulatory
8 things that will come to fruition. And so we are
9 working on that process.
10 We're hoping actually by September to
11 have something on paper too, for everybody to see.
12 This is one of the first, because it came out last
13 year, so we're just getting to this now once we
14 figured out that process. And basically, what we've
15 done similar to education is to come up with a
16 framework and then we would take it to next steps,
17 but we wanted to make sure we were on the right
18 direction and to have this group kind of move forward
19 on that. Chief Treepacz? Make sure you state your
20 name.
21 **MR. TREEPACZ:** Thank you. Don
22 Treepacz from the Bureau of EMS. So good afternoon.
23 As the director stated, 3003 Bravo was passed last
24 year. It was added to the Public Health Law,
25 provided the capability for air ambulance stocking

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2 and use and initiation of blood products in a pre-
3 hospital setting. In the last paragraph of that
4 section of law, it charges this body here to move
5 forward with promulgation of regulations and send
6 them -- and send them forward to the commissioner for
7 approval. At the charge of the director, we put
8 together a committee of stakeholders, many of which
9 are in this room, representing all of the air
10 ambulance transport entities across the state who are
11 already operating with blood products in a -- the
12 pre-hospital environment based on the law change, as
13 well as stakeholders from the ground ambulance side
14 of the environment as well. As we all know, there's
15 a -- a desire for that to potentially be included in
16 future adjustments and such.
17 Through that process, we developed a
18 framework that you have there. We are -- we're glad
19 to have Dr. Dailey and a few other folks that
20 provided some input and guidance as well. And the
21 goal will be is if this body so moves forward with
22 this motion, is to go back to that group of
23 stakeholders and anyone else that is willing to be a
24 part of that or wants to be a part of that. And we
25 will formalize those regulations and hopefully have

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2 them presented for approval at this body in
3 September. Again, that's to -- you know, develop the
4 -- the regulatory portion of how to operationalize
5 the blood products. There is no concern that there
6 is not operationalized properly now but certainly, as
7 part of the law, it creates that opportunity or
8 necessity for the regulations in that circumstance.
9 And just a point of clarity, there is
10 a -- a separation between the pre-hospital blood
11 administration initiation that -- that portion of the
12 law covers and the ambulance transfusion service
13 world. Those are two different environments and
14 operate in two different lanes in that circumstance.
15 That was a question that was asked previously.
16 **MR. DAILEY:** If I can just speak to -
17 - to being a member of that group. That was a
18 multidisciplinary stakeholder group and it was one of
19 the most impressive groups that I've had a chance to
20 -- to work with in a collaborative fashion. Don did
21 a great job of -- of herding the cats. And I look
22 forward to that work product continuing to develop.
23 **MR. TREEPACZ:** And just one additional
24 shout-out. Thank you for the -- the comment, Dr.
25 Dailey. And just one additional shout-out to Gina

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2 from the Bureau. She's our policy fellow. She's the
3 -- the one that keeps it organized. I -- I heard the
4 cats and -- you know, as Dr. Dailey said, but she
5 keeps it all organized and -- and puts it beautifully
6 on paper. So thank you very much. It's a team
7 effort.
8 **DIRECTOR GREENBERG:** For those of you
9 who don't know as well, Chief Treepacz, prior to
10 being with the Bureau, was with an Air Medical and
11 ground service as well, so has kind of a lot of
12 knowledge on that front. Again, this is just for Air
13 Medical. We know the desire is there for ground and
14 I think Al Lewis was talking about it before, but
15 this is particular to Air Medical. Also, if you are
16 wondering how are some agencies doing it today before
17 the regs are promulgated? There was a period of time
18 where when it was enacted where they could start the
19 blood products and -- you know, follow certain set of
20 standards. But it is still the directive to have
21 further codified as regulatory -- you know, different
22 additional regulations that go with it.
23 **CHAIR DOYNOW:** Any more discussion or
24 questions on that motion?
25 **MR. MARSHALL:** I don't know that we

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2 need a --.
3 **CHAIR DOYNOW:** Okay. Can we have a
4 show of hands for members who are in favor of this
5 motion? All in favor? Okay. Anyone against?
6 (No response).
7 **CHAIR DOYNOW:** Any abstentions?
8 (No response).
9 **CHAIR DOYNOW:** Motion passes.
10 **MR. MARSHALL:** Thank you. In the
11 fifth motion is to -- for regional REMAC may require
12 all EMS providers who provide EMS care in their
13 region to complete a credentialing process to be
14 determined by the REMAC. We had quite extensive
15 discussion on terminology, the authority of -- of
16 REMACs and REMSCOs, whether it was credentialing
17 registration or licensure. So this motion after a
18 lot of discussion actually passed with one abstention
19 or one no vote, and it comes forward to this body as
20 the seconded motion.
21 **CHAIR DOYNOW:** Any discussion?
22 (No response)
23 **CHAIR DOYNOW:** All right. We have a
24 show of hands of everyone in favor of this -- sorry,
25 Dr. Berkowitz, go ahead.

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2 **MR. BERKOWITZ:** Yeah. So I very much
3 support this motion. I -- I'm in favor of getting
4 clarity on this issue. And I think that the only
5 active issue regarding this specific that --
6 regarding credentialing between regions right now has
7 been resolved. That being said, I have two concerns
8 that I just wanted to raise. One is that -- you
9 know, it seems that the division of legal affairs
10 have said that this -- that this motion is outside
11 the scope of this body. So I'm not -- you know, I'm
12 not -- I'm not that comfortable with that aspect of
13 it and also -- you know, this will force a -- a -- a
14 form of ruling on this matter, and I don't know what
15 the downstream effect of that on our reasons will be.
16 So those are -- those are -- it's not questions, it's
17 just kind of concerns that -- that -- that I've --
18 that I have on it. But I am supportive. Thank you.
19 **CHAIR DOYNOW:** Okay. Thank you. Any
20 other discussion? Dr. Doynow.
21 **MR. DAILEY:** On the motion of the
22 wording that is there would imply that EMTs, CFRs,
23 EMRs, as well as paramedics, would be subject to this
24 credentialing process, is that the intent?
25 **MR. WINSLOW:** Yes.

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2 **CHAIR DOYNOW:** Dr. Winslow, was --
3 that was your -- your motion?
4 **MR. WINSLOW:** Yes. And also the
5 strain -- the stress should be on the word “may
6 require.” I'm trying to make it as soft as I can,
7 but just realize that this process is being done
8 everywhere in the State and has been for thirty
9 years. So we do need to have a comment on it. Even
10 if it pushes the envelope that it can or cannot be
11 done. It -- it does need to be clarified.
12 **CHAIR DOYNOW:** Any other discussion?
13 (No response).
14 **CHAIR DOYNOW:** Okay. If we can have a
15 show of hands of all in favor of this motion?
16 Okay. Anybody against the motion?
17 (No response).
18 **CHAIR DOYNOW:** Any abstentions? One
19 abstention. My motion passes.
20 **MR. MARSHALL:** Okay. Thank you very
21 much, everybody. There was a lot of other discussion
22 that happened. I just want to bring it to your
23 attention. We had a very nice presentation by the
24 Office of Health Emergency Preparedness regarding the
25 CHEMPACK planning and the CHEMPACK program in the

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2 State of New York and where the -- the hub and spokes
3 are around the State. And I think that one of the
4 takeaways was, is that each region needs to be aware
5 of the CHEMPACK program within your region. And --
6 and actually drill and know who can activate it
7 because it could be any physician, and if I recall
8 many years ago, there was an incident where rural
9 physician activated the CHEMPACK because of an
10 organophosphate overdose, and they needed all the
11 atropine that they could find. So it does work. So
12 please take that back to your regions and -- and talk
13 about it and actually make sure you know who's
14 supposed to have it and who can have access to it.
15 We also talked about the medical
16 device advisory that we approved at the last meeting.
17 And which is fine and we're not going to change that.
18 There is a part of Article 3002-A(2)(c), which
19 requires SEMAC to develop minimum standards for use
20 of regulated medical devices. So, which is separate
21 or different from the medical device advisory that we
22 approved, which was to ensure that agency medical
23 directors were involved in the decision about which
24 medical devices their agency would carry. So that
25 would be a group that will get together and look at

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2 developing a -- a list of maybe not devices, but
3 categories that would be approved by SEMAC.
4 We also talked about the medication
5 substitution policy, which is 1304 and we wanted to
6 go back and take a look at it and revise it if
7 necessary. One of the things that is not in there
8 now is -- is Albuterol, because Albuterol was not
9 short back then, ten years ago. So there may be
10 other medications. So we'd like to get -- we'll get
11 some -- some people voluntold to help work on this
12 and -- and update it. As well as I believe the
13 Department is also in the process of going back and
14 looking at a lot of the advisories and policies and
15 making sure that they're updated and current because
16 a lot of them have been around since before many of
17 us. So I think -- we also had a discussion about i-
18 STAT and use of i-STAT which is currently being used
19 in some specific instances.
20 But maybe agencies might want to
21 expand the use of that. I did look up and see that
22 it looks like it was -- it is -- i-STAT is CLIA-
23 waiver, but I don't know which cartridge. So I would
24 just advise any agency that's going to use that to
25 just double-check on that.

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2 We also had some discussion on wasting
3 of controlled substances and the -- and who witnesses
4 it when EMS arrives at a hospital and needs to waste
5 controlled substances. And one region was having
6 problems with one health system that did not want
7 their nurses, doctors, or anyone else to witness the
8 destruction of controlled substance waste by EMS. So
9 I don't know if any other regions are having that
10 issue, but just to -- so you can be aware of it. And
11 I think that's the end of my report.
12 **CHAIR DOYNOW:** Any questions for Dr.
13 Marshall?
14 (No response).
15 **CHAIR DOYNOW:** So we need to have two
16 committees put together, looking at what medical
17 devices should be essentially FDA-approved that we're
18 going to have a list of.
19 Would I have any volunteers at this
20 point?
21 (No response)
22 **CHAIR DOYNOW:** Okay. If not, what I
23 would say -- I'll be happy to work with him.
24 **MR. WINSLOW:** Dr. Winslow.
25 **CHAIR DOYNOW:** Dr. Winslow. I'll be

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2 happy to work you with you, Dr. Winslow. And Dr.
3 Marshall just volunteered as well and I'm sure Dr.
4 Dailey -- I see his hand up is -- is happy to help.
5 **MR. MARSHALL:** You should talk -- talk
6 to them about participating.
7 **DIRECTOR GREENBERG:** That was
8 voluntold. I believe that. There -- there you go.
9 **CHAIR DOYNOW:** Yes, that'll be fine.
10 Also --
11 **DIRECTOR GREENBERG:** Happy Nurse Week.
12 **CHAIR DOYNOW:** -- med substitution.
13 Does anybody have any specific interest in that?
14 **MR. MARSHALL:** Do we have any
15 pharmacists?
16 **CHAIR DOYNOW:** Substitution.
17 **MR. MARSHALL:** Do you have any
18 pharmacists?
19 **CHAIR DOYNOW:** Okay. Come see me
20 later. And then we'll set up. Anybody else for a
21 substitution? I hate to start appointing people
22 because I know all you guys -- Dr. Murphy.
23 Excellent. Now at least we have two people.
24 **MR. MARSHALL:** Mr. Chair. I'll
25 appoint them for you, don't worry.

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2 **CHAIR DOYNOW:** Okay.
3 **DIRECTOR GREENBERG:** There's also a
4 number of people who aren't here in attendance that
5 might be qualified to help you in -- assist in this
6 matter.
7 **CHAIR DOYNOW:** All right. We'll have
8 -- we'll have those two committees going and
9 hopefully, you have something to report back to the
10 on the next -- on the next meeting. All right.
11 Moving on to education. The report.
12 **MS. OZGA:** I have to change that to
13 Don Hudson --
14 **CHAIR DOYNOW:** Okay. Don, the report,
15 please?
16 **MR. HUDSON:** Thank you. Don Hudson.
17 Good afternoon, everyone. So the education agenda is
18 in the publicly posted minutes and agenda. So we'll
19 just go through it quickly. We had an update on the
20 BLS Practical Skills Revisions that are proposed.
21 That's just to refresh everyone's memory of moving to
22 more of a scenario-based testing. And just to
23 reiterate, that's going to be more of a long-term
24 implementation. There's nothing coming down the pike
25 soon, so we're looking at more months to years. So

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2 if you -- you know, don't need to stress out about
3 that as it's still in the early phases -- planning
4 phases.
5 Also, we had Chief Chesney (phonetic
6 spelling) from state education present on the working
7 pilot, I guess, of group scheduling and how that will
8 be implemented as a -- a pilot to see how that can be
9 implemented statewide if it -- it does work out.
10 We have a joint project that we're
11 working in conjunction with Steve Kroll's Group and
12 Finance. Looking at the core sponsor surveys,
13 particularly the financial aspect of that, and
14 commensurate with Director Greenberg's expansion of
15 available funding for core sponsors to run EMS
16 classes to see and what that looks like moving
17 forward, what monies are also available versus what
18 things actually cost to continue down that road. And
19 the acknowledgment that it's been a long time coming.
20 We're thankful for the fifteen percent, but we still
21 need more.
22 Alternative funding for EMS courses.
23 We've come to be aware through our SUNY CUNY,
24 collegiate-based programs that there's probably other
25 funding streams outside of traditional EMS/health

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2 scholarships and whatnot, grants that might be
3 available to us. So we're waiting on some feedback
4 and ideas from them on that.
5 We also have a joint project going on
6 with our paramedic core-sponsorship partnership,
7 reviewing the current State requirements for EMS
8 instructor, both CLI and CIC, what that looks like
9 with the national level classes available, and how
10 that should be altered, if at all, in New York State.
11 We did have a discussion about Hazmat
12 training. So in the National EMS Education
13 Standards, there is Hazmat awareness training
14 required for all EMS providers. There's a number of
15 different classes out there. The question asked was,
16 which ones meet the requirement, which ones don't?
17 So we have that on the agenda for answers on the next
18 meeting so that we can send out some information and
19 review factual about what meets and what doesn't meet
20 that requirement.
21 We also have a field training officer
22 program being looked at what's out there currently,
23 either locally, nationally, who has a functioning FTO
24 program, what are their success and weaknesses, and
25 if that should be something that the state supports

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2 and rolls out on a more statewide basis in the
3 acknowledgment that -- you know, we have a crisis in
4 getting people into agencies and also in then -–
5 indoctrinating them, training them for longevity and
6 for retention. So hopefully a field training officer
7 can fill some of that void.
8 Lastly, we had a Niagara Community
9 College submitted a request for a EMT practical
10 skills exam modification that was passed to the
11 committee from the Bureau. It seemed as though after
12 a lot of discussion as long as the modification is as
13 stated and nothing further for the time being the
14 committee is supportive of that. So I just -- the
15 Bureau will be responding to them that their
16 modification request should be granted for the one --
17 one time they're looking to do it. And we need some
18 information back. If -- if it worked, maybe that's
19 something we should look at to move forward. That's
20 all I have. I'd be happy to take any questions. We
21 don't have any seconded motions.
22 **CHAIR DOYNOW:** Any questions?
23 (No response)
24 **CHAIR DOYNOW:** Okay. Thank you for
25 your report. EMSC Dr. Cooper is out of the country.

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2 So, Amy, we would --.
3 **MS. EISENHAUER:** Thank you for the
4 record, Amy Eisenhauer. So Ryan took part of my
5 report so I won't rehash. No worries. Rehash the
6 grant specifics. I will say though that the new EMSC
7 grant for the next four years has similar performance
8 measures, which is pediatric recognition programs,
9 pediatric emergency care coordinators, and then
10 disaster preparedness. And as soon as I get the
11 official performance measures I will be happy to
12 share them.
13 **DIRECTOR GREENBERG:** Can you touch
14 briefly, as it probably affects, to a certain extent,
15 everybody on this committee, the -- how the hospitals
16 are going to play in the -- in the new grant?
17 **MS. EISENHAUER:** It's at the bottom.
18 So as Ryan mentioned, we did have our EMS, CAC
19 meeting last week. And we talked about the grants.
20 We talked about EMS for children federal. So the
21 EIIC has a pediatric readiness quality collaborative.
22 And they're currently enrolling for that. So it's a
23 QI program. And they really are helpful. They go
24 through everything. So if you're just starting out
25 and you want to do QI don't worry because they really

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2 do a lot of webinars and preparedness and
3 helpfulness. And so if you are interested and you
4 have questions, please let me know. They're
5 enrolling through June.
6 We discussed safe transport of
7 pediatric patients and what has been ongoing since
8 we've now been released back into the world after
9 COVID. So -- and our last meeting, we had a
10 demonstration. So I discussed safe transport of
11 newly born patients as well as all other children
12 with the group. And also last week I was at the
13 Child Passenger Safety Technician Conference, which
14 is put on by the Governor's Office of Traffic Safety.
15 And there were two classes. So one on Safe Transport
16 of Pediatrics at large, which the room was full. It
17 was very well attended. Lots of really great
18 questions. And then I also talked about safe
19 transport of newly born patients. So what do we do
20 after the baby is born? And also really well
21 received, lots of good feedback and questions. So
22 our next EMSC advisory committee meetings will be
23 September 5th and December 4th. They will both be
24 here at the Hilton Garden Inn and that will be from
25 one p.m. to four p.m.

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2 We did discuss some old business. So
3 pediatric agitation education, we are going to
4 continue that work group. In the interim Sarah
5 Grover, one of our Family Action Network members and
6 a EMS educator and paramedic has a class on
7 therapeutic communication de-escalation and she's
8 going to be teaching that on Vital Signs Academy.
9 And we'll be teaching a component of that at the
10 Vital Science Conference. So we're very excited to
11 bring that education out for providers while we
12 finalize something more concrete.
13 We did discuss pediatric triage, and I
14 know that that's going to be discussed at length
15 tomorrow at STAC. So that work group will continue.
16 We did discuss reviewing the length-
17 based measuring tapes and comparing that with our
18 protocols for pediatric medications. And I would
19 like to say thank you to -- I don't see her, Megan
20 Williams, and her paramedic students for doing some
21 of that heavy sifting, lifting, asking questions. So
22 that work is also ongoing. And we will be addressing
23 that and having a nice report from them at our next
24 meeting -- just trying to get to where I was.
25 And then also as Ryan mentioned, I

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2 think last year the American College of Surgeons made
3 it a requirement for trauma verification that there
4 be a pediatric advocate of some sort. And they use a
5 specific language. However, EMS for Children Federal
6 has worked with ACS ENA, ASA, all of the letter
7 people to encourage having a pediatric representative
8 at all trauma centers, because, as we know, sometimes
9 kids get bought(sic) to adult trauma centers if
10 there's a trauma and they're not close to the
11 pediatric trauma center. So they want to make sure
12 all trauma centers are prepared to take care of
13 children.
14 So they have required having one of
15 those, and in our response and also in collusion with
16 the new grant deliverables, we have developed always
17 ready for children pediatric recognition program for
18 emergency departments. And then in coordination with
19 that, the person -- or people, because it can be a
20 team of people, will be the pediatric emergency care
21 coordinators for the emergency departments. So EMS
22 for children gave their stamp of approval. I will be
23 presenting more on this at STAC tomorrow because they
24 are a large component of that as well. But it's
25 gotten great feedback. A lot of the folks who have

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2 reached out to me from hospitals have been looking
3 for this, are very excited to get enrolled. So my
4 hope is to get everything finalized in the next few
5 weeks. And then visit our tag meetings over the
6 Summer to share more about the program, encourage
7 enrollment, answer any questions, allay any fears
8 that might come up and essentially kind of usher the
9 program in. And I think that is most of what we
10 discussed.
11 **CHAIR DOYNOW:** Okay. Thank you, Amy.
12 Any questions?
13 (No response)
14 **CHAIR DOYNOW:** All right. Thank you.
15 **MS. EISENHAUER:** Awesome. Thank you.
16 **CHAIR DOYNOW:** Moving on to old
17 business. Ryan, our EMS medical director, where are
18 we with that?
19 **DIRECTOR GREENBERG:** So we are going
20 through the process of trying to get that fulfilled.
21 It has not been achieved yet, but it is actively
22 going through the process with our administrative
23 management group.
24 **CHAIR DOYNOW:** Okay. Thank you. EMS
25 hospital wait times, and diversions. I know in this

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2 area it's significantly improved. Does anybody have
3 any comments on their specific areas, how things are
4 going, wait times, the crews(sic) to unload,
5 diversions? Dr. Rabrich?
6 **MR. RABRICH:** Yes, I agree. I think
7 there's been improvement, at least in my regions as
8 well.
9 **CHAIR DOYNOW:** Any other comments on
10 that?
11 (No response).
12 **CHAIR DOYNOW:** Okay.
13 **MR. MARSHALL:** I have a question.
14 **CHAIR DOYNOW:** Go ahead.
15 **MR. MARSHALL:** Sorry, I have a
16 question. So, is any region experiencing behavioral
17 health diversion requests? A lot of them, because we
18 are, like daily, every day.
19 **CHAIR DOYNOW:** Okay.
20 **MR. MARSHALL:** Behavioral health
21 diversion requests.
22 **DIRECTOR GREENBERG:** Yeah, we have
23 them too.
24 **CHAIR DOYNOW:** Yeah. That does seem
25 to be a problem probably as well.

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2 **DIRECTOR GREENBERG:** Mr. Chair?
3 **CHAIR DOYNOW:** Yeah.
4 **DIRECTOR GREENBERG:** Is it possible
5 for a deputy commissioner to maybe talk on that
6 topic? He was going to talk under new business
7 related to some things going on, but I think this
8 might be a relevant time.
9 **MR. MORLEY:** So I think everybody in
10 the room is aware of the -- the activity that's been
11 going on over at the Public Health Council Planning
12 Committee. So the first workgroup of the planning
13 committee, and there's another one that's being
14 planned for a couple of weeks from now, but the first
15 one that took place was focused on behavioral health.
16 You're probably aware that the governor's budget she
17 announced in the State of the State that she's
18 putting one B billion towards mental health. Well,
19 as it turns out, mental health has kind of been
20 priming for this moment I think. There's a lot of
21 things that have been going on in the mental health
22 area. And so we heard about them at the planning
23 committee. Dr. Sullivan, the Commissioner for mental
24 health, did a presentation and it was well received.
25 I would encourage you to contact Steve and Ryan to

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2 get the link to the recording of the presentation.
3 It's a two-hour meeting, so it's lengthy. But Dr.
4 Sullivan's portion begins at around minute twenty-
5 seven, twenty-eight. You might fast forward to that
6 piece.
7 And here's some of the things that
8 they've been working on. And I -- I had hoped to
9 have a presentation by OMH come today -- somebody
10 from OMH come today to do a presentation for you
11 folks to hear about some of the things that they're
12 doing because quite frankly, I'm just not capable of
13 doing it any justice other than to say there's a lot
14 that's been going on. So in September -- we'll see
15 you in September, and at that meeting, somebody from
16 OMH will be doing a presentation on some of the
17 things that they've been doing in that space to help
18 relieve some of the -- the -- the edges. It's --
19 it's not going to cause mental health cases to
20 disappear completely, but there is a lot that's been
21 happening.
22 The only disappointment I have is that
23 there isn't quite enough staffing. Everybody has
24 heard that there's a staffing crisis every place in
25 all of healthcare and beyond healthcare even. So

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2 they have not been able to uniformly create a system
3 across the state. So there'll be some counties that
4 are going to be getting some benefits and some
5 counties that don't, I'm sorry to say. But one of
6 the things that they've got is a crisis -- a home
7 crisis intervention group. And you -- you're all
8 aware of sure -- of the nine eight eight number
9 that's out there. And there's a whole list of other
10 things that they've been working on to provide
11 resources to reduce the number of people going to a
12 regular ER. And you'll hear about them at this
13 September meeting in much more detail than I can go
14 into. But it has been happening, and it is
15 happening, and it's going to continue to happen.
16 And some of that billion dollars we've
17 got in this state about, I think it's twenty-four
18 CPEPs, and they're looking to increase that somewhere
19 in the neighborhood of thirty-six, forty CPEPs.
20 Clearly, there's some facilities that are just too
21 small, but the numbers of CPEPs are going to grow.
22 And that's just one of many different tools that they
23 are looking to apply to this issue.
24 **CHAIR DOYNOW:** What's a CPEP for those
25 who don't?

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2 **MR. MORLEY:** Oh, for those of you who
3 don't know CPEP, Comprehensive Psychiatric Emergency
4 -- something P.
5 **DIRECTOR GREENBERG:** Program.
6 **MR. MORLEY:** Program, thank you.
7 Comprehensive Psychiatric Emergency Program. In case
8 there was somebody that didn't know, like me, I
9 didn't know the last P. Any questions?
10 **MS. MURPHY:** Yes. Dr. Murphy. Are
11 they going to put out a -- a request for proposal for
12 the CPEPs? How are we going to apply?
13 **MR. MORLEY:** Too early to tell. We've
14 been having meetings with the –- 'we' meaning OMH and
15 DOH together. We have a better connection to
16 hospitals than they do. So that's our role in this
17 to bring to convene. And we've been working --
18 working with hospital associations. I think everyone
19 in this room is probably aware of the herds data and
20 the amount of -- the amount of data that we've been
21 requesting through COVID from hospitals. It's pretty
22 impressive. Some of that's going to go away as the -
23 - as the COVID goes away. But unfortunately, we're
24 going to end up having to increase some of the
25 questions or create some questions as it specifically

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2 relates to mental health issues. We need data to
3 decide -- we -- I'm saying we like it's our money,
4 but it's OMH is -- OMH needs good data to determine
5 who and where will CPEPs go? Who can apply? Who
6 cannot apply? So we're too early in the process to
7 figure that out, but that'll be up to them. But we
8 want to know how many behavioral health patients
9 there are in the ED waiting for placement. How many
10 -- how long have they been there waiting for
11 placement? How many are children? How many adults?
12 There's a -- a whole list of things that we're going
13 to -- they will need for decision making. So we're
14 going to be converting some of the herd's information
15 and data into -- from COVID questions over to mental
16 health questions to better drive decision making for
17 things like CPEP. But also the -- the home-based
18 crisis intervention center and some of the other
19 things that they're working on.
20 **MR. PHILIPPY:** Dr. Morley? Good
21 afternoon.
22 **MR. MARLEY:** Good afternoon, sir.
23 **MR. PHILIPPY:** I didn't think I was
24 going to let you get away without saying something.
25 So just because this is something that's kind of been

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2 very near and dear to my heart, and as well as Dr.
3 Cushman we've been working in Monroe County for quite
4 some time with some of our stakeholders. One of them
5 is, of course, the Rochester Regional Health,
6 Behavioral Health, and Access -- Access and Crisis
7 Center, which is one of those pilot projects that Dr.
8 Sullivan was on a -- a conference call with us to
9 discuss back around November. The program has been
10 in use for just a little over eighteen months. The -
11 - the success of the program is hampered by some
12 logistical issues, not the least of which being the
13 staffing that you mentioned, but it offers an
14 opportunity for an alternative destination to the ED.
15 It is a standalone facility. I know that some of our
16 colleagues in the Buffalo region are also using a
17 similar system but in -- in Rochester in particular,
18 the combination of mobile crisis teams regional
19 outreach to both the hospital systems and local
20 government entities, as well as this particular usage
21 of -- of a pilot project is starting to show some --
22 some effort to reduce the ED overcrowding. It's
23 still a huge problem but we're starting to see it. I
24 think our biggest initiative right now is to look at
25 alternative transportation modes. And so that might

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2 be something that we might want to approach back with
3 this coalition between OMH and -- and FIPIC (phonetic
4 spelling) is what alternatives to the ED, but also
5 alternative means of getting people there.
6 Particularly for those people who may have emotional
7 crisis but are not otherwise falling into the mental
8 hygiene law, for example, a detention of some sort.
9 So those are some things that we're doing in Monroe
10 County. Certainly more than happy to share our
11 successes with our partnerships locally.
12 **MR. MORLEY:** Fantastic. Thank you for
13 that. You just reminded me something you said, it
14 wasn't specific about insurance, but something
15 reminded me about payments. So when you're talking
16 about mental health, who's going to pay for this? Is
17 -- is -- is a huge, huge piece to this. And it goes
18 much deeper than that in terms of how much are they
19 going to pay you because it's -- is it going to be
20 sufficient? So when -- when the presentation occurs
21 in September, or should you go watch this video of
22 Dr. Sullivan, there's a point in there where somebody
23 asks the question about payment, and I really, really
24 want you to pay attention to her response. Some of
25 the things that are going on in this space right now

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2 are not insurance dependent, they're insurance
3 agnostic, as in the State is paying for them. So we
4 don't give a damn about whether insurance wants it or
5 not today, but we hope to, it'll be deemed -- it'll
6 be identified as having been successful. And then --
7 you know, we'll be looking for them to pick it up.
8 And there's going to be a lot happening in this area
9 in the coming years. We've got a very aggressive
10 legislature interested in this topic and pouring a
11 billion dollars into what's going to get even more
12 attention for better and for worse. So I think that
13 you -- you know, pay attention to this space.
14 There's going to be a lot happening.
15 **CHAIR DOYNOW:** Any other questions for
16 Dr. Morley? Dr. Dailey?
17 **MR. MORLEY:** I knew I couldn't get by
18 without Steve.
19 **MR. DAILEY:** No, without that.
20 **MR. MORLEY:** Oh, he -- Steve, just put
21 his mic on and stopped.
22 **MR. DAILEY:** After you, sir.
23 **MR. KROLL:** I'll go after.
24 **MR. DAILEY:** Okay. So, Dr. Morley,
25 one of the things you talked about was, was --.

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2 **MR. MARLEY:** Could you speak into the
3 microphone?
4 **MR. DAILEY:** Yes, sir. One of the
5 things you talked about was the Public Health
6 Planning Council. And I know that we've had members
7 from this body go over and speak to the Public Health
8 Planning Council in the past, but this is the
9 advisory board when it comes to the commissioner on
10 emergency departments as well as EMS. And my
11 suggestion would be that if we can carry it back to
12 the Public Health Planning Council and there's room,
13 I would suggest that the -- the Chair of this
14 committee and potentially the Chair from the State
15 council be considered as potential -- or potential
16 members for FIPIC. Particularly around issues like
17 this, where we get the idea that it's ED overcrowding
18 when it really is hospital overcrowding, and
19 ultimately it's a significant component from mental
20 health as well that's impacting our emergency
21 department and emergency services.
22 **MR. MARLEY:** Just so I appreciate the
23 -- the comments very much. I want to highlight that
24 -- that it's statute that determines membership to
25 FIPIC. So it did just increase by two people.

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2 There's another bill being moved forward or being
3 advanced to the legislature at this point to add a
4 third position to the council. So the only way that
5 that -- that you can increase or get membership on
6 the council is -- is through statutory authority. So
7 we hear what you're saying and we have no dog in the
8 -- in the fight, so to speak, but would welcome more
9 input from folks. Professor Kroll.
10 **MR. KROLL:** Good morning. Steve
11 Kroll. I just wanted to respond to the question Dr.
12 Marshall did ask right before you spoke. Behavioral
13 health diversions are a continuing daily occurrence
14 here in the capital region of New York State where
15 hospitals have to close down. They're accepting
16 behavioral health patients especially, and pediatric
17 is, you know, is -- is part of that crisis too.
18 **CHAIR DOYNOW:** Thanks, Steve. Any
19 other questions for Dr. Morley?
20 (No response).
21 **CHAIR DOYNOW:** Okay. Thank you very
22 much for the ppresentation. Dr. Murphy, you wanted
23 to speak about eye gel?
24 **MS. MURPHY:** So I just wanted to give
25 everybody follow-up. You know, we started the pilot

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2 project and we went statewide. We have ninety-five
3 agencies that have applied. Forty have completed
4 their training, and as of this date, we have nineteen
5 insertions. Just to give you an update. There was
6 some issues with the data moving forward. I don't
7 know -- David, did you want to speak to that or -- so
8 we've refined and they worked hard over the last
9 twenty-four hours to work through those lumps and
10 bumps so that hopefully the data will flow much
11 easier.
12 **MR. VIOLANTE:** Right here -- here we
13 go. Thanks. Sorry about that. Huge shout out to
14 the DI team. We worked out a really good process in
15 getting the data to us for all the insertions across
16 all the agencies, across all the vendor platforms,
17 and we're going to be getting weekly updates of that
18 information. We can send out some analyses of that
19 to the group if you so wish. But much thanks to the
20 DI team for all of their work in getting the data to
21 the Hudson Valley region.
22 **MS. MURPHY:** Thank you.
23 **CHAIR DOYNOW:** Any questions for Dr.
24 Murphy?
25 (No response).

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2 **CHAIR DOYNOW:** Great project. I'm
3 glad it's going forward. Any other old business
4 anybody would want to bring up?
5 **DIRECTOR GREENBERG:** I just want to
6 think on the eye gel project. We were able to map
7 they eye gel project on where both applications have
8 been received from, as well as the ones that have
9 completed the application process. And I don't know
10 if that was uploaded into Boardable, but that is
11 something that we've completed and can share with
12 this group as well. If they're interested, you'd be
13 able to see a little bit. It doesn't have names,
14 it's just dots on it, but it is actually pretty
15 nicely spread out around the State, which is exciting
16 to see. So that is something that -- again, the DI
17 team is able to put together and we can share.
18 **CHAIR DOYNOW:** Thank you, Ryan. All
19 right. Moving on to new business. Dr. Dailey, you
20 have some new business I understand.
21 **MR. DAILEY:** So historically, many of
22 you may remember a few years ago Mark Gestring and I
23 from the STAC, University of Rochester Trauma
24 Program, did a lot of work with the Center for School
25 Health around some concerns that the education

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2 department had with the use of hemostatic dressings
3 in schools, Stop the Bleed kits. These kits are
4 being promulgated, as you know, since many of you are
5 instructors across New York State. They're being
6 promulgated in schools. They're being used by our
7 law enforcement officers and quite frankly they're
8 saving lives and they're doing a fantastic job. The
9 education itself is -- is spectacular. The reason
10 that we needed to get involved a few years ago was
11 because of concerns from the education department
12 that indeed hemostatic dressings could not be used
13 without a patient-specific order, and a non-specific
14 order could not be issued for the use of these
15 devices.
16 We had a number of long conversations,
17 worked very well with a group of professionals at the
18 Center for School Health and at -- at education. And
19 in 2018, we thought this was resolved. No good deed
20 goes unpunished. And in 2023, it has resurfaced. It
21 resurfaced in a document released by State ED called
22 Guidelines for Managing Emergency Healthcare and
23 Communicable Diseases in Schools. And it talks about
24 recommended procedures around Stop the Bleed, offers
25 example commentary about training programs, and then

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2 has a footnote at the bottom that says, "All
3 medications administered in school require a patient-
4 specific or non-patient specific order." See, New
5 York State ad guidelines from medication management
6 in school. Hemostatic products are considered over-
7 the-counter medications by the FDA and therefore
8 require a patient-specific order for physicians to
9 order and for nurses to administer.
10 They do not fall under those
11 medications that may be ordered, dispensed, or
12 administered under a non-patient specific order in
13 New York State.
14 Notably, Education Law 6909 says that
15 nurses may receive non-patient specific orders.
16 Education Law Sections 131 and 139 are specific to
17 what patient are -- specific to what non-patient
18 specific orders can be, including things like
19 immunizations, PPD placement, HIV testing, treating
20 opioid overdose, which we worked on again around the
21 same timeframe. And this of course raised lots of
22 concerns through members of the STAC, and we'll be
23 discussing it there tomorrow as well. The
24 Commissioner of Education can issue an order that
25 says that this can change and this can be added to

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2 the list of non-patient specific orders that would be
3 possible. The Commissioner of Health could have a
4 discussion with the Commissioner of Education to
5 promulgate this and may be able to -- to assist us
6 with moving that forward.
7 Dr. Morley, I'm glad you have a chair,
8 at the table right now. Hopefully, you can help us
9 move this forward. But the concern that we have is
10 right now we have well-meaning school nurses who are
11 being told that their licenses are at risk if they
12 use product that we are putting out there for use by
13 the public in the course of providing emergent care
14 to a child in need. And that, to me, is morally
15 reprehensible and something that we need to do
16 everything we can to correct because it just doesn't
17 make sense. The thing that carries this even farther
18 to a level where we can all get really crazy about it
19 is that hemostatic dressings aren't actually
20 considered a medication by the FDA at all. They're a
21 Class II medical control device. Will add that the
22 life fact that we were talking about earlier is also
23 a class two medical device. And another class two
24 medical device that many people are familiar with are
25 tampons. So I think that there's an opportunity here

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2 for us to work with education in order to normalize
3 and more appropriately allow our school nurses to
4 provide, Stop the Bleed care when necessary, use the
5 things that we -- the tools that we have put out
6 there for the public and those nurses to use and make
7 sure that our schools are as safe as possible and our
8 school nurses can feel comfortable with providing the
9 care that they can quite ably provide.
10 **CHAIR DOYNOW:** Would you like to make
11 a motion so this body can vote on that and recommend
12 a commissioner address that with a commissioner of
13 education?
14 **MR. DAILEY:** Yes, please. I would ask
15 that the Commissioner of Health work with the
16 Commissioner of Education in order to assure that
17 indeed our school nurses have non-patient specific
18 order for the use of hemostatic dressings in schools.
19 **CHAIR DOYNOW:** Any second of that
20 motion?
21 **MR. ISAACS:** Second.
22 **CHAIR DOYNOW:** Any discussion on that?
23 **DIRECTOR GREENBERG:** As part of that
24 motion or recommendation, would you be able to put
25 together a one- or two-page document summarizing it

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2 and maybe highlighting some of the things that you
3 spoke about here? I -- I will tell you the
4 Commissioner reads a lot and -- and in detail and
5 normally has many questions. So I think a -- a nice
6 summary of something that puts that together would be
7 extremely helpful. Thank you.
8 **MR. MARSHALL:** I just have a quick
9 question. Maybe you know the answer. So in a
10 lifesaving emergency, we don't need consent for
11 anything, so why would we need a patient-specific
12 order to apply a device during a lifesaving
13 emergency?
14 **MR. DAILEY:** That's a fantastic
15 question.
16 **MR. MARSHALL:** Oh, thank you. Thank
17 you. I ask good questions, sometimes.
18 **MR. CUSHMAN:** Cushman. That -- that's
19 actually, I think my point of this, which is this
20 Body should not be recommending that the Commissioner
21 recommend a non-patient specific order for something
22 that is over the counter, the right thing to do for
23 our patients. Because I'm pretty confident, I know
24 my school nurse hands out tampons. I am not aware
25 that that nurse has a non-patient specific order to

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2 do so. And so my greater concern is that when we
3 start doing that, we continue to set precedent of
4 stupidity that -- that we have to continue to
5 identify something that is the right thing to do.
6 That is within the -- the scope of that licensed
7 practitioner to be able to deliver that. What's
8 next? I -- I don't -- I don't know. So we -- we
9 need our nurses to be able to do this without --
10 without concern. But I'll be honest, I'm not sure
11 having a non-patient specific order for something is
12 the best long-term solution to the current problem.
13 **MR. DAILEY:** So this -- this falls
14 into the -- that interesting area where there's ED
15 law and there's Public Health Law both covering
16 similar interventions. You know, the -- the use of
17 naloxone was actually something that was very
18 interesting to -- to many of us that were -- were
19 moving this forward -- you know, in 2013 through
20 2015, as we had additional opportunities to train the
21 public. And we went and trained people in schools
22 and said, okay, everybody in this school can now use
23 a Narcan except the school nurse. And then ED law
24 changed, and then there was also a section of Article
25 thirty that changed. And keeping these in parallel

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2 becomes extremely -- extremely difficult because
3 there is just so much code. I don't have a good
4 answer for how to make sure that when we have another
5 opportunity that presents itself as a type-two device
6 that we can allow our nurses to use this with -- with
7 impunity. I think we will just continue to have to
8 play almost regulatory whack-a-mole with it.
9 **MR. WINSLOW:** Yeah. It -- it's
10 Winslow. I just wanted to say that you have to give
11 them some kind of guidance if this document is out
12 there saying that there's a concern. I kind of agree
13 with -- with -- with both what Jeremy is saying is
14 what is the right mechanism of granting that nurse
15 that comfort zone to use it if needed. And I'm not
16 sure if it's more of a statement or if it actually
17 has to be a -- a following along the lines of the
18 naloxone where you actually have to have a patient, a
19 non-patient specific prescription, but something
20 needs to be stated so the school nurses feel
21 comfortable and they're not confused with what's
22 going on in the -- in the document that -- that Mike
23 shared with us.
24 **CHAIR DOYNOW:** Any further discussion
25 on the issue?

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2 (No response).
3 **CHAIR DOYNOW:** Okay. It's up for
4 vote. All in favor, please raise your hands. Okay.
5 All against?
6 (No response).
7 **CHAIR DOYNOW:** Any abstentions.
8 (No response).
9 **CHAIR DOYNOW:** Okay. Motion passes.
10 It'll be brought up the SEMSCO as well.
11 And Mike, if you could put together
12 one page that Dr. Morley requested?
13 Okay. moving along. Last on the list
14 here is Assembly Bill A5663. Dr. Winslow, you put
15 together a nice reply to this, if you want to mention
16 anything on that. It's the bill A5663 if all of you
17 are not familiar with it. It was a bill that's up in
18 the assembly, but my understanding hasn't gone any
19 place. And it's regard to criminalizing injecting a
20 person with a substance without their implied,
21 without their consent. So Dr. Winslow --.
22 **MR. WINSLOW:** Yeah. So I -- this
23 granted a lot of discussion. We realize there is
24 also no companion bill. So it will die in committee,
25 but I -- I do think it's going to continue to come

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2 back. This is, what, the third year in a row, this
3 person has brought this forward. So I was thinking
4 that the group should make a statement. Maybe that
5 would prevent it from wasting time next year's
6 assembly. That this is just absolute garbage.
7 That's Winslow. Sorry.
8 **CHAIR DOYNOW:** So I do know FDNY
9 already sent a -- a letter, I believe out opposing
10 it. Since your -- your letter hasn't been vetted, I
11 can't put it up on the screen, but if anyone would
12 like to see it, I'm sure he'd be more than happy to
13 share it with the group and send it to your
14 representatives.
15 **MR. WINSLOW:** Yeah. I crafted like a
16 -- a -- a draft frame of a opposition letter pretty
17 much stating that -- you know, a couple of things
18 were concerning to me. One was that they make it a
19 criminal act. That's the garbage part for
20 clarification for those watching at home. But the
21 other issue is Emergency Medical Care is given every
22 day and what defines lifesaving. You know, many EMS
23 providers give -- give care that is not an immediate
24 threat to life, but that isn't well defined in the
25 statute that they're discussing.

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2 The other issue is one of consent.
3 You know, it -- it states in it -- in the very title
4 of it without consent. We all know how tricky that
5 can be with issues of capacity, which is a medical
6 determination issues of implied consent, et cetera.
7 So there are a couple of things in the letter if
8 you'd like -- I sent -- I think I sent Val a copy.
9 Could we use that mechanism to redistribute it to the
10 members and then they could just review it on their
11 own and share with their own constituents?
12 **CHAIR DOYNOW:** I assume we can
13 probably. Ryan, we could put it up on Boardable,
14 could we not?
15 **DIRECTOR GREENBERG:** Yeah.
16 **CHAIR DOYNOW:** Yeah. So it could go
17 up on Boardable --
18 **MR. WINSLOW:** Sure.
19 **CHAIR DOYNOW:** -- for everyone to see.
20 I mean, unfortunately, I think it was a well-meaning
21 bill that has absolutely no basis in medicine
22 whatsoever. Okay. Any other new business before we
23 adjourn? And I give you back twenty minutes.
24 (No response).
25 **CHAIR DOYNOW:** Okay. Can I have a

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2 motion to adjourn?
3 **MR. PHILIPPY:** Motion to adjourn.
4 **CHAIR DOYNOW:** Any seconds. Okay.
5 All right. All in favor?
6 (Chorus of 'ayes')
7 **CHAIR DOYNOW:** All right. We'll see
8 you folks in September 13th for the next SEMAC
9 meeting.
10
(The meeting concluded at 11:15
11
p.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 1
6 hereof; that the foregoing typewritten transcription
7 consisting of pages 1 through 84, is a true record of all
8 proceedings had at the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 30th day of May, 2023.
11
12
13 DANIELLE CHRISTIAN, Reporter
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