5/8/2024 – SEMAC Meeting – Troy, N.Y.

NEW YORK STATE
DEPARTMENT OF HEALTH
STATE TRAUMA EMERGENCY MEDICAL
ADVISORY COMMITTEE MEETING

DATE: May 8, 2024
TIME: 11:33 a.m. to 1:00 p.m.
CHAIR: Donald Doynow
LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

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APPEARANCES:

AIDAN O'CONNOR
AMY EISENHAUER
ARTHUR COOPER
BRIAN CLEMANCY
BRIAN WALTERS
CHIEF ED MAGER
DANIEL OLSSON
DAVID KUGLER
DAVID MARKOWITZ
DAVID VIOLANTE
DONALD DUVALL
DONALD HUDSON
DOUGLAS ISAACS
DR. MAIA DORSETT
DREW CHESNEY
JASON WINSLOW
JEFFREY RABRICH
JEREMY CUSHMAN
JONATHAN WASHKO
KATIE OLDAKOWSKI
MICHAEL DAILEY
MICHAEL MCEVOY
RYAN GREENBERG
STEVEN KROLL
THERESA ALLEN
TIFFANY BOMBARD

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(The meeting commenced at 11:33 a.m.

CHAIR DOYNOW: Everyone I'd like to welcome everybody to SEMAC. If we could please stand for the ledge -- Pledge of Allegiance.

ALL: I pledge allegiance to the flag of the United States of America and to the Republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

CHAIR DOYNOW: And if I can all have you stand just for a minute longer. I just like to have a moment of silence for Sean Donovan. He's one of ours. He's an E.M.S. physician who died unexpectedly on April 17th.

He was very involved in E.M.S. and urban search and rescue. Okay, if we can all be seated. If we can have a roll call, please.

MS. ALLEN: Surely. Dr. Bart, Dr. Berkowitz, Dr. Berry, Dr. Bombard.

MS. BOMBARD: Dr. Bombard here.

MS. ALLEN: Dr. Cooper.

MR. COOPER: Dr. Cooper, here.

MS. ALLEN: Dr. Cushman.

MR. CUSHMAN: Cushman here.

MS. ALLEN: Dr. Dailey.

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MR. DAILEY: Dailey here.

MS. ALLEN: Dr. Doynow.

MR. DOYNOW: Dr. Doynow here.

MS. ALLEN: Dr. Gomez. Dr. Isaacs.

MR. ISAACS: Present.

MS. ALLEN: Dr. Kugler.

MR. KUGLER: Present.

MS. ALLEN: Dr. Lynch, Dr. Markowitz.

MR. MARKOWITZ: Markowitz here.

MS. ALLEN: Dr. Maynard. Dr. Murphy. Dr. Olsson.

MR. OLSSON: Olsson here.

MS. ALLEN: Dr. Rabrich.

MR. RABRICH: Rabrich here.

MS. ALLEN: Dr. Talbot. Dr. Walters. Dr. Wicelinksi, Dr. Winslow.

MR. WINSLOW: Winslow here.

MS. ALLEN: Oren Barzilary.

MR. BARZILARY: Here.

MS. ALLEN: Aidan O'Connor.

MR. O'CONNOR: Good morning, present.

MS. ALLEN: Mark Philippi, MariAnne Portoro, Mike McEvoy.

MR. MCEVOY: Mike McEvoy here.

MS. ALLEN: Steve Kroll.

MR. KROLL: Steve Kroll present.

MS. ALLEN: And Jon Washko.

MR. WASHKO: Jon Washko present.

MS. ALLEN: We have a quorum.

CHAIR DOYNOW: Excellent, thank you. Can we have someone make a motion to approve the previous minutes?

MR. COOPER: So moved.

CHAIR DOYNOW: Thank you, Dr. Cooper.

MR. RABRICH: Second.

CHAIR DOYNOW: Second by Dr. Rabrich. Anybody against? Okay, we'll assume that was passed. We're going to go a little out of order here. We'll hold Ryan's report to after the standing subcommittees. Medical Standards, Dr. Rabrich.

MR. RABRICH: Yes. Thank you. So medical standards met immediately prior to this meeting. There is one motion coming forward for medical standards and that's on the approval of the New York City Rescue Task Force protocol.

That protocol is specific to FDNY providers who are appropriately trained and acting in a rescue task force capacity in a warm zone. The

biggest change to that protocol really is the addition of the extended care section on the last page.

Other than that, it's mostly just some edits to clean up the protocol.

CHAIR DOYNOW: Okay, any discussion? Anybody have any questions? Okay. Can we have a roll call vote on that?

MS. ALLEN: Dr. Bombard.

MS. BOMBARD: Dr. Bombard, yes.

MS. ALLEN: Dr. Cooper.

MR. COOPER: Yes.

MS. ALLEN: Dr. Cushman.

MR. CUSHMAN: Cushman, yes.

MS. ALLEN: Dr. Dailey.

MR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Doynow.

MR. DOYNOW: Doynow, yes.

MS. ALLEN: Dr. Isaacs.

MR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kugler.

MR. KUGLER: Kugler, yes.

MS. ALLEN: Dr. Markowitz.

MR. MARKOWITZ: Markowitz, yes.

MS. ALLEN: Dr. Olsson.

MR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Rabrich.

MR. RABRICH: Rabrich, yes.

MS. ALLEN: Dr. Walters.

MR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow.

MR. WINSLOW: Yes.

MS. ALLEN: Motion passes.

CHAIR DOYNOW: Excellent. Thank you. Don Hudson, education.

MR. HUDSON: Good afternoon, everyone. Thank you. So quickly, education most pertinent is the setting via this and other committees of the C.C. sunset as we have discussed in numerous meetings in the past, and then, put into action in the previous meetings.

It seems to have its intended effect specifically to bridge enrollment. So just memory serves that previous bridge classes have seen diminishing enrollment, leading to the potential discussion of dropping down to only hosting one bridge a year.

So the sunset date, that now has

turned around. So currently, the bridge class that just started has, let me refer to my notes, how many?

MR. WALDRON: Sixty-three.

MR. HUDSON: Sixty-three. Thank you, Ed Waldron from Northwell. Sixty-three people enrolled in it, which not only secures a robust bridge program this time around. But also assures us that we'll be hosting two bridge programs a year for the duration.

So good news on that front. And thank you to everyone here that was supporting of that.

CHAIR DOYNOW: Okay, thank you, Don. E.M.S.C., Dr. Cooper.

MR. COOPER: Thank you, Dr. Doynow. My report will be brief. We were honored at our meeting this past Monday afternoon to have Maia Dorsett of the University of Rochester present a -- the results of -- of the work in her region on medication errors, particularly in kids.

In terms of, you know, making sure that the right dosing is -- is available. It's my understanding that she will be making that presentation here today. So I will not belabor that at this particular time, except to say that we were

thrilled to have the presentation and represented such an enormous amount of work.

And as you'll see when you hear the presentation later today, I think Dr. Dorsett is going to become an extremely valued member of our community going forward. So thank you, thank you, Maia.

To follow up on that Megan Williams, the -- the Paramedic Program Director at the Borough of Manhattan Community College has been working on the -- the -- if you will, the -- the length-based resuscitation tape issues in terms of ensuring that all of the various tapes and methods that are available, such as Handtevy and so on, are yielding similar results.

More to come on that, I think that the work that Dr. Dorsett did is -- is going to be pivotal in the work that Ms. Williams is doing. And the two of them will be getting together over the summer to put things together.

The next item I wanted to comment on is the Always Ready for Children program. Which is a really vitally important program for those of you who are running emergency departments throughout the

State.

And that includes many of you. It's really important that -- that you participate in this program. It's a way that we can meet our requirements under the -- the National Read -- Readiness Program. And as all of you are aware or most of you are aware, in any event the American College of Surgeons has included participation in the National Readiness Project or program as a requirement for the new gray book.

So participating in the Always Ready for Children program is a very neat and easy way to do it for those of you that who are unfamiliar with this program, please contact Amy Eisenhower, our E.M.S.C. Program Coordinator.

And last but not least, I have to give a huge shout out to Amy Eisenhower. Amy is an amazing human being. She is a force of nature. There is no task that she's asked to undertake that she doesn't carry out promptly and with great aplomb.

I know Director Greenberg will have a few comments on this during his report, but all I want to say is that Amy has recently been honored with a promotion to succeed Professor Valerie Ozga

who is seeking greener pastures, the greener pastures of retirement.

Amy is going to be taking on her role and as the person responsible for keeping the Vital Signs Conference rolling into the future. The Bureau will be identifying an individual to assume Amy's role as the E.M.S.C. program manager that that position has not yet been posted.

I don't believe but will be soon. But I am going to ask all of you to stand and give Amy a huge standing ovation for the incredible work that she has done and will no doubt continue to do. We've been assured by Director Greenberg that Amy will still be involved with the E.M.S.C. program, although at a slightly different level.

And, you know, so we will not have to miss her entirely. But again, thank you, Amy, for a job incredibly well done. And with that, I'll be happy to answer any questions. And if there are none, turn the meeting back to Chair Doynow.

CHAIR DOYNOW: Any questions for Dr. Cooper? Okay, moving along. Ryan, if you'd like to give your report.

MR. GREENBERG: Sure, I'm going to ask

for some help from the team on this one. If Ed Mager, and Drew, and Amy can come up, they're going to give the first three sections, and then, I will handle the rest.

MR. COOPER: Dr. Doynow, if I might, I forgot to mention one short item. The Peds Agitation Work Group continues to do a great deal of work. The scripts for the -- the presentations that -- that they're putting together should be ready by the next meeting in the fall and we're indebted to that group for their participation in the program. Thank you.

CHAIR DOYNOW: Thank you, Dr. Cooper. Chief Mager.

MR. MAGER: Thank you. Good morning, Ed Mager, E.M.S. Operations Western Branch and I'm representing the East too for Rich Robinson Branch Chief. From the operations side, a few things, obviously we've -- we're conducting multiple full-service agency inspections.

One of the things that has sort of surfaced out of the eastern portion of the State is E.M.S. vehicle labeling matching the naming convention that is -- that is required. So that some -- some agencies that we're finding have not labeled

their vehicles in accordance with what is on their E.M.S. operating certificates.

So we remind them that is part of the regulations and should be complied with. Other than that, full-service inspections, we -- we are finding significant operational improvements, good things specifically on expired items.

We're finding less frequent S.O.D. issuance related to expire --expired items, disposable items obviously have significant expiration dates that even suction canisters expire these days. So we -- we do remind agency operations chiefs and directors to confirm their vehicle inspections in accordance with Part 800.

So we are also approaching rapidly Part 18 season. So on the eastern portion of the State, excuse me, District Chief Ricardo takes care of all the Part 18s on the eastern half of the State. District Chief Lockwood takes care of the western portion of the State.

So there's significant requirements if any E.M.S. agency or E.M.S. leader gets involved with the planning efforts of any party team events, those events that are anticipate having five thousand or

more people.

We want those applications in completely thirty to sixty days prior to the event and certainly prior to advertising the event in accordance with the -- the party team regulations. We are in the process of updating our -- our policy statement 1201, which is blood glucometry.

There's been some recent changes and interpretations of Public Health Law 579, specifically 579.3, which defines what entities are eligible for a fee waiver. So we'll come up with a clarification policy statement related to that specific issue that has -- has arisen is there's a bunch of, we've changed based on complying with the regulations and the -- and the law to ensure that we're meeting the -- the statutory requirements.

But we have provided multiple updates at various meetings across the State. We are getting some pushback and we're trying to communicate and over communicate, but the policy statement is being written.

Additionally, we'll be -- we'll be currently, the blood glucose policy 1201 also includes albuterol. Our goal will be to develop a

policy statement that takes all of the adjuncts that are required for approvals and summarize all those adjuncts in one -- one place.

So that policy will be under development and we'll be proceeding with that. It will take some time. I don't want to give a timeline on it, but that is in progress or certainly one of our objectives and goals.

I always like to remind people about the (unintelligible) training. It's an excellent opportunity, phenomenal work went into that program and it is available on Vital Signs Academy. Operationally, we're also reviewing our -- our submission portals for agency renewals and controlled substances and ensuring that we're optimizing and trying to make it less bureaucratic to -- to optimize the renewal process and ensure compliance.

And I think, Director, would you like me to stop and give you -- I won't mention the staffing changes, I'll -- I'll leave that to the director. But other than that, I have nothing further. Amy?

MS. EISENHOWER: Okay, so hey, everybody. So I'll do the report from Coverdell

since that is the shorter version. So the Coverdell grant notice of funding came out. The team is working on putting together future plans based on what C.D.C. has asked for in the NOFO.

I can say that no substantive changes have happened with our work with E.M.S. agencies and regions. So we plan to continue the work that we've been doing specifically in -- in high-need regions right, like pre-notification, working on quality measures, all of that stuff and continuing to be a resource for the E.M.S. community as needed.

So for E.M.S. For Children it is that time of year where I ask you to please do your survey. So the E.M.S. For Children survey has returned. It is three months late because it has been updated. Previously the survey has asked things like, do you have a pediatric emergency care coordinator, are you planning on getting one, what kind of training do you do.

And it was very -- very brief, only really focusing on performance measures of the grant. Some of our noted physicians from the E.I.I.C. and work groups over the past few years have gone through and made the survey more similar to the N.P.R.P., the

hospital survey.

So they are still asking, do you have a PECC, what does that PECC do, what kinds of things do you provide, you know, kind of understanding the foundation of championship education at agencies, like, how -- how many pediatric calls do you go on.

What other kinds of things do you do at your service to be pediatric prepared, because really there is no solid understanding of E.M.S. preparedness for pediatric care across the nation. And so that is really what the updated survey is, is trying to give us an understanding of, what's there, what are people doing, what is working well.

And how can we, E.M.S.C., federally and at the State level support E.M.S. agencies and regions in their care for pediatrics. So please complete your survey and you can find it at emspedsready.org. And just -- just like previously, you go to your county, you pick out your agency.

If it is grayed out, somebody at your agency has already completed your survey, so thank you. I think we are two percent complete in the last week, although a new reminder went out yesterday. So I'm hoping more have gone through because I got some

confirmations.

Also, on Vital Signs Academy, there's a tutorial going through the survey, a brief overview of what's in there, kind of what are they asking, explaining questions and of course, if you have any questions, you can always reach out to me or to Allison Lynch.

She's our student assistant and will be heading the work on the pre-hospital PECC program, right over here. So you can reach out to either of us and we'll be happy to help you with whatever you need related to either of those processes. So please complete your survey.

Also on the E.M.S.C. kind of things that have been in process many months ago I talked about some rural health funding for education at -- from E.M.S.C. around pediatric emergency care coordinators, specifically to pre-hospital and PECC kits.

So these kits will go out to each PECC agency. And if you are -- if you are a PECC agency, come see me later and I will give you your PECC kit, so you don't have to wait for the mail. But it is comprised of a variety of different things, including

our Pediatric Assessment Triangle Card, which has recently been updated in the last two months, so if you haven't gotten an updated one you can order them online on our website as usual.

We also will include our pediatric agitation documents, which is also newly released. So if you don't have any, please order them. Some badge buddies that have been around. But you can also order them on our website separately, if you need more.

We also include a P.D. wheel for dosing measurements, a P.D. tape and a Handtevy tape. And then, some communication cards. So these are also something that has kind of been on our radar and came through with this process.

And much thanks to Florida E.M.S.C., Michigan E.M.S.C. And I want to say Kansas E.M.S.C. So at E.M.S.C. we all help each other so we don't have to create the wheel. So inside there are pictures. It's in English and in Spanish.

And then, in the back, it has a place where you can write on it. These are laminated. And we even give you a branded pen. So you have a dry erase pen. There's also some stim toys because what

kid really wants to be in our ambulance.

And all of this comes in a lovely dry bag because I know how it can be in the ambulance. It's all in here, it won't get wet, it will be safe. The bag might get dirty, but the stuff inside won't. So these will be going out over the next few months to the PECC agencies.

New PECC agencies, if you see this and you're like, oh my gosh, I need that. You just have to sign up to be a pre-hospital PECC agency and you can do that again on our website. All the information is there, the sign-up form is on there. Send it on in, we'll send this out to you, we'll give you, you know, a welcome kit.

And if you have questions, Allison or -- or I will be happy to answer them. And then, I believe the rest of my report was related to staffing. We're in the process of interviewing for -- for our pediatric data coordinator.

Yes, E.M.S. Data Coordinator Pediatric, we went through a bunch of different titles and I -- it's a big soup in my brain. So we're hiring for that. We're doing the interviews this week. I introduced you to Allison. She's

wonderful. I am very thankful that she's here to help with this and -- and do all the minutiae and be dedicated to it because it is a lot.

And then, of course, as you all just heard, we will be putting out the -- the work to H.R. to hire for a new E.M.S. for Children program manager coming out soon.

MR. GREENBERG: Thank you, Amy. Ed, did you want to talk about your two staff positions before we go to Drew?

MR. MAGER: Yeah, director, I'm happy to, we're happy to announce that Vinnie Wiemand (phonetic spelling) will be starting with us actually tomorrow in the Syracuse office. So we're excited about that opportunity and he brings a wealth of knowledge, experience and -- and certainly comes from the Mid-state area.

He'll be primarily focused in the -- the Syracuse Central -- Central New York Office and we'll develop a transitional plan for the district chief assignments going forward. But he'll start his intense training process tomorrow. Welcome him to a staff meeting and we'll go from there.

We've -- we're also out of the western

branch, Don Tripez (phonetic spelling) has actually got a promotional opportunity, he'll be moving to a position in E.M.S. licensure. He'll be the branch chief of E.M.S. licensure.

So we'll hopefully be able to backfill his position, you know, in due -- due time. So we're really excited about those two promotional opportunities and bringing on new staff and --

MR. GREENBERG: And now, one more.

MR. MAGER: Yes, Carol Ackerman will be joining the -- the eastern branch and she'll be starting in -- in early June. So we've got some new district chiefs that'll be coming through to the Bureau and we're excited to have them on boarded and -- and trained and get them working, as it's an important mission. So thank you.

MR. GREENBERG: We'll go to Drew, and then -- no. Go ahead, Ed.

MR. CHESNEY: Good -- yeah, still good morning. Good morning, everyone. Drew Chesney, the Education Unit. Two quick staffing updates for us before going on with the full report. One item is that we are losing one of our longer serving student assistants, Rosalie Garcia who's been working with

Gene and C.M.E. for a few years now.

And she will be graduating and moving on with her life and we wish her nothing but the best. That will be a spot that we fill over the summer. Rosalie has been, again, working with C.M.E., most notably with a lot of the F.D.N.Y. processing.

So we will miss her sorely. But we are excited that we are having an addition to the education team. A name that's not new to anybody, hopefully, in the room. Jenny Solomon will be joining the team as our new eighteen, her first day is tomorrow.

As you all know, Jenny comes with a good foundation of knowledge and experience with the Bureau, as serving with the OASIS grant in the mental health education programs that we've been running over the State over the last year, year-and-a-half.

So we're really excited to join Jenny. She'll be working mostly out of the mayoral office and that will mean there will be a little bit of reshuffling with a couple of the responsibilities of staff. But as that's figured out, we'll of course keep everyone apprised through the education calls at

the next meeting.

Sponsor renewals, it is that time of year for sponsors to renew. That has gone out and those are due back by June 30th. That includes about sixty sponsors who are up for renewal. If you feel that you should have been one of them and you did not receive an email and you're a little bit confused about that, please feel free to reach out to Kevin or I and we can take a look and see what was missed on that.

It is a streamlined process that is completely used in the Drupal this year. So the submission is completely online, adding attachments and whatnot. So it -- we used it a little bit of a hybrid last year.

And we've gone completely to it this year and it makes that process a lot easier. Up-to-date on many processing items, I think if you find that we're putting course application numbers out, rosters out next day, our timelines have been great on that.

So we're very pleased with the team overall. Our C.M.E. processing is still sitting out about six weeks. That's just due to sheer volume.

So and that will probably sit that way as a norm. C.M.E. again is -- it is picking up now that we're starting to see the bulk of this COVID extensions expire.

Processing times may be affected with that, so we do appreciate patience. Things that can help the process along for agencies and -- and leaders is to make sure that you're double checking your applications for errors.

Please read them, read them twice, read them thrice and make sure that, you know, you're -- you're dotting your I's on everything that you possibly can. And also if you have questions, calling Gene with a submission number is important so he can readily look up what your inquiry is about. But we're happy overall with that.

Some changes will be coming with the processing for C.M.E.s. We will announce these gradually as we react to the regulations that are coming up. But one of the big items is we're going to be switching from a bulk submission to individual submissions for the agencies to help with processing.

And also, it will help agencies as we go because entire lots will not have to be rejected

if there's an error in one or two applications. So again, more changes to that as we do react to the regulations as they come through.

We're using Boardable as we increase networking and the ability for sponsors to talk to each other, share best practices and engage each other on different levels. Everybody who is a core sponsor administrator or liaison should have access to that Boardable.

Feel free again to talk to one of us if you do not. New policy statements hit the press yesterday on our website. You will see that there is a new policy statement on instructor processing. It fills in a lot of the most common questions that came up.

I think it addresses advanced standing better when it comes to individuals who have educator credentials in other areas of life. And also expands upon reciprocity. And it builds the instructor process to becoming an instructor more into our portfolio of work rather than just check boxes and dates.

So we're pretty excited about that. I do appreciate the work of the TAG that worked on

that. There's some excellent individuals. It wasn't just a Bureau work. It was educators from across the State that reviewed it and their time is greatly appreciated.

The other education policy that hit was HAZMAT educational requirements for courses. Those are providing a little bit more clarity since the old course is no longer applicable that was provided by NIMS and I.C.S.

So it gives two options, both again, no cost to students or core sponsors, so there's no entrance problems there. And it also provides flexibility for core sponsors who have subject matter experts to do things in-house if they want to.

Some responses on P.S.I., in case you were not aware, P.S.I. does provide end of exam surveys for all test takers and users of the process. And we got some feedback on that over the first over '23 and the first part of '24.

And we just thought it would be nice to highlight them since sometimes when we talk about test taking, it's not entirely positive, but overall experience in '23 by over ten thousand test takers was rated at ninety-seven point three percent as

excellent or good.

So far in '24, it's at ninety-seven point one percent. So again, we hear a lot of noise about individuals that are having problems and they're legit. But it's also good to know that we do this on a grander scale and there's a lot of test takers who do go through the process without having those issues and that's -- that is good to know.

There's about a dozen questions that they're asked to touch upon scheduling, site conditions, staff interactions and the overall registration process and interaction with their system so. The other thing that we're working with P.S.I. on is a mobile testing solution for areas that have low access or to testing sites.

Whether it's a longer drive or whatever it may be or they have a high volume of students that when they all graduate at the same time, it puts real strain on the testing sites that are available. Basically it's a mobile testing site that will set up predetermined dates, we'll go into an area with P.S.I., P.S.I. sets it up with their own equipment and their own staff.

They set up for two or three days,

they test eighty, a hundred plus, whatever it ends up being, and then, they go away. This will be pretty decent solution I think, once it's working, we're testing it out in the Finger Lakes region in June.

And then, hopefully expand it out from there. For the paramedic programs across the State, we're trying to figure out better ways of pointing students from perspective students to them, answer their questions on basic foundations of what the programs are about, when they register, who the good contact is for, some of the highlights in that program.

We surveyed all the programs, we received all that data back, so we appreciate the prompt response from everybody and what we're going to do is we're going to spend a little time collecting that, putting it together in a pretty decent format, posting it on our website so that, again, prospective students can go to the Bureau website, see all the programs in the State that offer an original program, and maybe choose, two or three that they can reach out to and have those contacts readily available. Course access and the promotion of that is an issue and we do realize that. This is

just one step to trying to solve that problem overall.

And just a quick reminder on some of the pilot programs that we have outstanding, when it comes to funding for education back in September '23, you -- on our website, you can see policy 2308B, it was enacted to support the recruitment and retention of career and volunteer providers throughout the State. There were three specific items there that really helped with funding that we really try and keep the word out. And we talked about yesterday a lot. One is the academy programs, which are FAST based programs for certification, about four to eight weeks.

Another one is a community intern program that allows the creation of a ten-hour orientation for people that gets them access to State funding, if they participate that and allows agencies to sign off on the verification of membership for them.

And the last one is a retention and recruitment pilot program that if somebody pays out of pocket, works or volunteers for twelve months, they can have their agency voucher back for their

funds of their course.

We continue to try and put the word out on these as best we possibly can through education calls and here at meetings like this, and then, educator updates. And there are three non-traditional avenues for these programs that we hope that people will take more advantage of, because to date it's been nil or nothing at all and that's unfortunate. So that is the report for the education unit.

MR. GREENBERG: Thank you very much. I'll wrap it up with just a couple of things. One, for many of you have asked about licensure. We -- our -- our R.F.P. is out right now for a new licensure platform. It has been homegrown for the past twenty years.

We're excited about this because we'll be able to do more web based things and be able to fill in some more gaps and things happening with that. So you'll hear more about that over the next probably year to year-and-a-half.

In the data and informatics world, we're moving towards three point five and the bulk of the larger providers will be moving in June of 2024.

Also if you're part of MedStandards, it appears that MedStandards would like to be able to do more work.

But no, related to regulations, related to E.P.C.R.s and information and data. So we're going to take that one up. I think talk more over summer and into September, kind of a more long-term project, not a short-term thing.

But to help with some of our data movement and getting data to the right places at the right time. We are -- we spoke about the data coordinator that's in the process of being hired there, as well as working with quality metrics and Dave and his group and trying to make sure that, you know, good data is flowing in his direction so that he can get what he needs.

Next trauma meeting is here, in Troy, on May 29th. So hopefully we'll see some of you there. E.M.S. for Children was already reported on. Thank you very much for that one. Vital Signs, coming to Rochester in October, October 16th to 20th.

Jeremy said that he'll take everybody out on a ride along personally with him. So Dr. Cushman, we really appreciate that. But we're really excited we went and did a site visit there. And

there's a lot of great things that's going to be happening there.

There's a flyer going around. You'll see more of it on social media as well, please come join us, really think it will be a great weekend and it is home of the first white mittens. And if you don't understand what that means, ask anybody from that portion of the State. It will make sense.

I was -- it was eye opening. So moving forward, E.P.R., you know, we just had the eclipse. Thank you to all the E.M.S. providers who participated in providing that coverage around the State as well as those who participated in the State E.M.S. Task Force Deployment.

We had ten different agencies that put twenty different ambulances in different parts of the State. So I want to thank you for -- for that part and helping move that forward and -- and with some of that coverage.

So we have a lot of exciting stuff going on in the world of regulations. This is important to pretty much everybody around the table. Most important and it's been a long time coming, the education regs will be voted on at the SEMSCO today,

that is the final step.

Once it completes that final step, it takes about four to six weeks after that for the final processes to happen. That's going through State registry and -- and what you need to do to get posted. During that time period where that gap is closed, we'll also be working on some policy statements for clarification of how new processes work and things like that.

So just want to say thank you to everybody around this room who helped make that possible. The equipment regs is moving along. We've been getting questions about that one, which is a good sign, because that means it's moving.

Hoping to see it out for public comment this summer. Community paramedicine reg set is the next set to -- to -- is one of the reg sets that we'll be working on in the near future. I want to thank the Innovation Committee on some of the work that they're doing.

They're going to be passing over to the community paramedicine group. The system and agency performance standards. We have two regulations that we'll be working on -- on behalf of

this group that was given to us to turn into regs.

And then, the blood regs is the other reg set that is in draft right now. We've been meeting with Wadsworth and it looks like there might even be some more movement on it, not just affecting air medical. There's some movement going on that in the legislative session might include ground.

So I know Dr. Isaacs would be excited about that one if that does go through, but either way, we're seeing a lot of good progress on that and it's exciting to see the results of, you know, blood administration in the field and what that has to offer.

Part V, as many of you know, was a big part of this year. There was a lot going on in the past couple of months. Got around the State, talking about a lot of different things. Unfortunately, didn't get into the final budget.

But I still, you know, people are like, are you upset that it didn't get in. And, you know, yes, you know, is it sad to see that it didn't get in, absolutely. But there's still a lot of motion going on with E.M.S. right now.

There is a number of bills that are in

the -- the senate and the assembly. And people are talking about E.M.S., they're talking about the crisis, they're talking about where the problems are. And that is something that we didn't see for a long time.

So this is exciting, so please, you know, everybody around this room, you are the advocates, you're the voice and so please, you know, they, unfortunately it didn't get in this year, but there's still a lot of opportunity to help advance things and move things in a great direction.

I want to say thanks to Dr. Isaacs, who made it down for, unfortunately only pre-con for MSOC this year, but the special operations conference that happens with F.D.N.Y., really eye opening if you get the opportunity, it's just a different, you know, kind of component of what we do and they put together a great little conference down there.

So I was really excited to -- to get there last weekend and -- and get to see what was happening there. E.M.S. providers from around the country, I think internationally too, come in for this one and really specialize stuff.

And you get to go to the ROC, which

is, you know, just a series of opportunities to -- to use your skills in a -- in very different environment. Including a full subway train, if you've never been there before.

Exciting for us, so we've had two amazing public health fellows over the past year. One of ours, Alex Blue is our data and informatics one. He is ending the end of his time as a public health fellow. But he, congratulations, is going to medical school at Upstate, so he's not going far. If you're up in that region, say hello to him next year. But also excited to -- and let me stop and say, thank you for all your service and everything that you've done in the past year. Most of our data and analysis has come from him. So we're going to -- we have some large gaps we're going to have to fill in a short period of time.

But on an exciting front, we were approved for two more policy -- public health fellows, one for data and informatics and one for policy. So if you know people, those just posted this week, there'll be up, I'm not sure how long they're open for, but we'll make sure to share them.

It's an amazing opportunity to do a

twelve to eighteen month fellowship with the Department of Health, if you don't want to work in E.M.S., there's an -- I think thirty-eight positions within the Department of Health.

Great opportunity, well-paying and some of them lead to med school opportunities. So, you know, I think, you know, it's a good thing. So please take a look, happy to share information on that one. Last, just leaving out a couple things, you know, this past week I had to attend a funeral for someone who is pretty significant in E.M.S., Phil Malini was the AAREMS Program Agency Director for forty-eight years, from 1975 until 2023.

And so if we can just have a moment of silence for him and his years of service, I would appreciate it. Thank you. On the completely other side, a little sad on that side, but on the completely other side, we have another program agency director who is retiring.

So on a positive note, but retiring, Marie Diglio from New York City has done, been the program -- has been with the REMSCO for thirty-two years and been the program agency director for, I'm not sure, but many and -- and -- since 1987.

So I -- and she is retiring now and so thirty-two years, helping E.M.S. An amazing job leading, you know, at times probably a challenging, you know, kind of environment and -- and area. And really just helping advance E.M.S. in so many ways.

And so I just want to say thank you and I wish you all the best in retirement, as well as some little people you have coming, I think, to your family in retirement too, so thank you Marie for everything you've done for E.M.S.

And also leaving on the last note of, also a happy but sad, because I don't know who I'm going to nudge or bug half the time in my office. This will be Val Ozga's last meeting with SEMSCO. She has been with the State for thirty-seven years.

She's been with the Bureau for twenty-seven years. She's been with the conference for twenty-three years and she's been the executive secretary of the SEMSCO for majority of that time too. And so I just want to say, if you think the texts are going to stop coming, they're not.

I know your personal number, but thank you for everything you've done. You've been tremendous in the advancement of E.M.S. and helping

this council in so many ways. So thank you, but I hope you enjoy retirement too.

If you're looking for them, you'll probably find Val and Marie at the bar later this afternoon. And I apologize for the long report, but, Mr. Chair, that is the end of the Bureau report.

CHAIR DOYNOW: Okay. Thank you, Ryan.

MR. GREENBERG: I agree.

CHAIR DOYNOW: Okay. Moving on old business, well, back to Ryan State E.M.S. Medical Director. Any update?

MR. GREENBERG: Progress on that one and we think we will see the posting in this fiscal year. We're waiting for some budgeting things to go through.

CHAIR DOYNOW: Okay. Thank you. Credential Committee report. Anything to say?

MR. WINSLOW: So I know this was a charge by the SEMSCO and I want to say thank you to Paul Barbara from Staten Island. He did a great job chairing that working group. I can tell you that it's all on Boardable under the SEMSCO Credentialing Working Group documents.

There's a lot of good stuff in there.

We did a survey, which shows credentialing is currently being done differently in different regions of the State, but it is being done. And it also goes over some of the policies that would be affected by changes to credentialing.

I recommend you consider that. As well as some letters in support of and questioning the regional roles of credentialing. I can tell you the workgroup was paused. Sounds like hoping or -- or waiting for some legal clarification from either Part V as in Victor or other current laws that are under discussion under the house assembly and senate.

I guess, we're going to be on hold for the time being, but I can tell you is that regional credentialing is really important, especially with workforce sustainability, as well as acclimatizing providers to regional differences in care.

As we know that E.M.S. is practiced differently in New York City as it is in Suffolk County, as it is in Upstate, but that's all I had to share.

CHAIR DOYNOW: Okay. Thank you. Moving on to new business. Dr. Dorsett.

MS. DORSETT: All right. Well, thank

you very much for having us to talk about a project that we did in Monroe-Livingston. That was really a collaboration between leadership, all the agencies and very thankful for E.M.S.C. for like, funding this initial pilot project that's going to sort of continue to work in our region.

And so the big motivation for this project, the focus was on improving pediatric medication safety. And the rate of pediatric medication error is being very high. Essentially a coin toss was well documented in the E.M.S. literature.

Though previous to 2020, there wasn't a lot of publication about what to do about the problem. And this is something that personally and within the region is something that we wanted to work on, but we were faced with not actually knowing what our pediatric medication error rate was or actually having good change theories about improving it.

In 2020, NAMSP published a position statement and a resource document and really the valuable component of this was the resource document because they did an excellent systematic review of all the evidence around pediatric medications safety.

And came up with a series of five recommendations about what are really best practices and this included things like, determining weight, using things in kilograms but one of the -- I think the two most important recommendations were essentially avoid math at the bedside. Use a volumetric based dosing reference was the one thing that really did have demonstrable effect on pediatric medication error from a project that was done at Denver Health.

Using the Handtevy system, as well as giving E.M.S. clinicians the opportunity to practice these skills. And so based on work that was previously done, our main change theory was about implementation of the Handtevy application within our region to ideally reduce pediatric medication error.

So I just wanted to take a little bit of time to orient somebody on how this application works. Essentially, this is an application, the protocols are integrated into the application and it uses both age as well as a length-based tape, that's congruent with other length-based tapes to determine what the ideal, what the weight is.

Importantly for us, there was also

adult dosing, that was limited when we started but that has been expanded. What this would be able to pull up is it pulls up all the medications, the concentration that would be used as well as the volume to be administered and as well as the route.

And this is something that you vet and is matched to the protocols. But you can also search based on a protocol and it will pull up the protocol as well as all the medications associated with that protocol.

So it can be referenced quite quickly. One of the things I can go back on, it also gives things like normal pediatric vital signs there's a C.P.R. assist, other things like that. This is, you should be able to see this on your computer, because I believe that you have a P.D.F. of the slides because it's hard to read from here.

But we knew it's the change is never just the tool, the change is always about the work you do to correctly implement the tool so that people know, understand how to use it. And so the way we did this, we did this across the region. So this was not like a single agency implementing this.

This was onboarding twelve different

A.L.S. agencies, a couple A.L.S.F.R.s to implement this. The first thing that we had to do was actually a medication concentration survey. We all know that there's variable medication concentrations.

That's disastrous if you're using a volume-based application because you could cause error. And so we were able to do that within our region. We developed a regional policy on medication dosing safety for pediatric patients that was essentially a replication in policy form of the N.A.M.S.P. position statement.

And we used that so that our REMAC passed that. So we have -- we have some carrots and we have some sticks to say, no matter whether or not you participate in our pilot or not, right, this is what evidence- based best practice is.

And so we are going to hold people accountable to do that. And then, we developed a training and implementation plan that essentially used a series of tabletop scenarios that coupled the -- the clinical scenario, the skill, drawing up the medication, using the application and do -- performing a medication cross check.

These scenarios were intended to -- to

do sort of some of the more common medication administrations in children, as well as things that people were uncomfortable with, as well as adult cases. So this is an example of what one of these look like.

We had a seizing infant, we had a pediatric cardiac arrest, we had a school aged child with pain management, we had a ketamine for analgesia and an adult trauma patient and the titration of a norepinephrine drip for a septic shock patient.

We built this as a train the trainer, so we brought in leadership from all the different agencies to come, like, go through the training themselves. So that they can take that, and then, implement it at their agency with the idea that this really would take no more than an hour.

And then, built the -- the background component as an asynchronous format so that they could pre-assign that and save time. Because while I was able to, you know, bring people in my agency and do the entire training in person, we're realistic and realize that that's not possible for everybody. So we needed a system that would work for different agencies.

And then we had a rollout over the region. And I'm not going to say it was all like, you know, hugs and kittens and everybody like did it right away. It required a lot of identification of what the barriers were at different agencies to getting this implemented. But I think we were really able to work through that by asking people what are the barriers to doing this, what are the barriers, not like, do this thing.

So this is a graph of like, our time course of implementation. So in the orange, in the application as an admin, I can pull out who are all the users. So I have an email address of everybody who's a user in our system.

When did they get registered with the application and when was the last time they opened the application, I can also get usage reports. So we have about three hundred and fifty paramedics in our system. So it was really around July that we had like over three hundred, July, August that we had over three hundred paramedics on the -- on the system because I had that many users, which is important for data analysis and thinking when did we really have saturation of at least access to the toll within our

system.

In the blue, so like the tick that goes up, I can look at the last time anybody used the application. So this was pulled like a couple weeks into February. So I can tell you that a hundred and seventy-five of the four hundred and fifty people had opened the application within the last two weeks.

I just ran the numbers right before I came here. I had fifty-six people open the application within the last week. And before that, the majority, more than half of the people had opened the application within the last three to four weeks.

So people are actually using it within our system. Defining when is a pediatric medication error is a little complicated because it differs per medication. Within the literature, the studies that I had looked at it say about eighty to hundred twenty percent of the correct dose is a correct dose.

And if it falls out of that, it's a medication error. I feel a little bit differently of about hundred twenty percent of a one point five m.c.g.s per kilo of fentanyl being administered to a child versus like things that we had a range.

So these are the definitions that we

use. So for midazolam, it's eighty to hundred twenty percent of what like the current, the point one mcgs per kilo, which is now changing, was in there. So these are the definitions and I sent a report that has how we did this.

We were able to pull this data because of the regional data bridge. So much like the discussions that happened earlier, there's a bunch of different E.P.C.R.s trying to get the data from each individual agency.

As I tried to do that early on was, like never, I know when to -- when something is not going to happen. So the State was able to build us a report that requires some cleaning. But that could allow us to for the first time look at what were the doses administered to children.

The doses and the weights, the indications for every med for a child thirteen and under, transported to a hospital in our region. And so that we actually know where we stand, which is really the first part of every quality improvement project.

One of my concerns was, how do I know that I'm calculating this correctly, is the

denominator right, is the weight that's documented in the chart realistic. So thank goodness for Pediatric Emergency Medicine Fellows because we were able to at least pull from like our E.M.S. charts, which is the highest saturation children, age thirteen and under transported to the Strong Memorial Emergency Department.

Where I know there's a policy that the child has to have an actual weight documented. They took all the children who got any medication whatsoever for a year. And wrote down what was the actual calculate, like, weight in the emergency department relative to what we had in the chart.

And you can see that greater than ninety percent accuracy of the weight that was documented in the chart. So we are using the right denominator based on how much the kid weighed. The reality is a lot of those, I know that they're weight -- they're taking the weight of the kid when they come in.

They do triage, they weigh the kid in the hospital and they write it down. But I'm calculating the medication error rate based on what's in the chart. So that -- for the outcome that I care

about, I think we have the right denominator.

So this is our data and we have now, you know, more months of data, so it's thirty day intervals of what our medication error rate was. So this is four years of data. So what you're looking at is a control chart, this is called a p-chart.

So the denominator changes over time, which is why those control limits change over time. And you can see that for years our median percent correct dose, was seventy percent, which means we were missed dosing medications thirty percent of the time.

And since we implemented Handtevy on this, we're eighty-four percent. I can tell you last month, we were ninety-five percent correct dosing for our entire region for children. Which is a continued act to say, is that like a sustained, but to me, greater than ninety percent is the goal.

The reality is not every medication, I think this is sort of an oversimplification, not every medication is mis-dosed at the correct -- at the same rate. And some medications, I'm a lot more worried about than others.

So for example, dexamethasone, which

surprisingly is the most commonly administered medication to children in our region is actually correctly dosed like ninety percent of the time and that's because by the time you're two, you've maxed out on the dose and there isn't much calculation.

But midazolam for seizure was only correctly dosed sixty percent of the time in our region for four years with huge variability with underdosing actually more common than overdosing. And that I found really concerning.

So this is looking at quarterly percent but we don't have enough, statistically enough points on the run chart when you look at quarterly data. But this is something called an X chart. So what you're looking at here is a plot of the calculated correct dose.

Which at the time, right, this is before protocol update point one mcgs per kilo divided by, sorry, the dose they administered divided by the correct dose. So each one of these is an administration over four years and you want it to be one, right.

One means, it was exactly the correct dose. So this is variability around the medium. You

can see there was a huge amount of variability. And then, statistically, that dropped and narrows. And now I have, with the exception of one outlier, a bunch of little dots along the line of one point zero zero.

That was when we reached saturation of Handtevy in our system. So I can tell you since July, we've had three medication errors of midazolam. And every single one, when I dive into it, they are not a user of the application.

Which means now, I'm in a quality control phase among continued quality improvement always, right, of identifying when our errors are occurring informing the agencies and finding that. So I tell people like, I mean, people who know me like know like -- like control charts, like feed my soul.

And like this one is my favorite one I ever made. But this is really what feeds my soul is, I get these kinds of messages from providers in a system and I'm not going to cry when I get like this one, right.

Like about a peds arrest, by the way, this kid walked out of the hospital. So to me, it

feeds both of those things, right, like, statistically, I can say that we are making a difference by designing a system that helps people do the right thing in a moment of stress. I think I'm pretty good at math on a good day.

I'm not very good at math when I have a seizing child. We still have, in that report, I have free text responses of a wide variety of what people think of the app and the use of applications and do paramedics need to know math still and all of this.

There's a spectrum. We haven't won over everybody but I think we need to build the systems to help people do the right thing. And I think at least a big learning point for everybody here is that we actually have a way within the data bridge to let you answer the question of what is your medication error rate within your system and identify it in a way that was really difficult to do from a regional perspective.

And it's hard to do as an agency because if you're not, like, you know, F.D.N.Y. that takes care of a huge number of patients. Most of us have agencies, where this is an infrequent event and

it's really hard to conclude like, what is my performance over time.

But if you can conglomerate that data for your region and let's be real, like everybody is working at all the different agencies in the region and rotating amongst them or all three of them at the same, you know, three different ones at the same time.

It allows you to say like, are we doing a good job, what are our opportunities for improvement. And whatever the tool is, I'm not saying -- I'm not like selling one tool or another. I'm saying that you have to have a tool and you need to implement it and provide the education.

So what are we continuing? We still have room for improvement. One of the big things was more adult dosing. Luckily, Handtevy updated this for now. People, I think one of the reasons I see it more frequently used is we improved our adult options.

We're working into direct integration with the E.P.C.R. We're having some documentation errors where people are writing M.L. instead of milligram, which I have to go do some data on, we

have a few barriers there.

And then, really, I think it's about improving the frequency and the quality of these education opportunities without the education. And in the end, when I surveyed people, it was about eighty percent got some hands-on education. There was some that only had the asynchronous and there was four percent who said they have the app, but they never got the education at all, right.

There was variability. This was not a perfect rollout. But thinking about how we can do that. And I'm already thinking, you know, it's time to start planning this again, because this was July. So for those who are doing the pre-hospital pediatric assessment, which should be everybody, right.

Which looks at all these different components. And one of those is patient and medication safety. I think what this taught us, I mean, it's changed our perspective of how we're going to address this, is that we can do some of this stuff as a region.

Expecting every single agency to reinvent the wheel to create pediatric preparedness, I think is a bit unrealistic and unfair to the -- the

leadership and the agencies there, but what can we do as a region, as a State to help people.

This was like a regional plug and play, right. We gave a tool to the agencies. They had to participate and give us feedback. They had to be engaged, but they didn't have to create the whole system themselves or learn how to analyze the data and the rest of it.

So that's all I have and happy to take questions. I have a lot of -- this was a lot of work of all the people up here.

CHAIR DOYNOW: Thank you, Dr. Dorsett. That was very interesting. Anybody have any questions? Silence, no one? Okay.

MS. DORSETT: All right.

CHAIR DOYNOW: Well, thank you very much. Okay.

MR. DAILEY: So I apologize. Of course, Dr. Dorsett got back to her seat before I could -- could ask her a question. But I apologize. But I just wanted to comment that this was great work.

CHAIR DOYNOW: Okay.

MR. DAILEY: Quite frankly, this is

something that we were looking to do with the collaborative protocols, when we were looking for a protocol app back in 2019.

CHAIR DOYNOW: Uh-huh.

MR. DAILEY: And the dosing calculator was something that we very much wanted to make accessible across the -- across the spectrum of E.M.S. in New York and having now good objective data about how it actually can bring potential benefit to our patients is extremely important.

And we need to think about exactly how we're going to support that. Obviously, this is not going to be an inexpensive proposition across the State. We need to think about what that means. But it can't be a agency by agency process.

We need to come up with one process that's going to make this work appropriately. I think doing it with the collaborative protocols makes a significant amount of sense. We need to come up with a good answer for it.

CHAIR DOYNOW: Thank you, Mike. Okay, if there are no other questions. Moving along. First responder, mental health and current initiatives, Katie.

MS. OLDAKOWSKI: Good morning, everyone. I also have a PowerPoint, but I can dive in. So I'm Katie O. I'm the Director of Training for the Mental Health Association in New York State. I started my journey in healthcare in 2005 at Albany Medical Center.

Dr. Dailey, it's nice to see you. Became a nurse in 2013 or 2011, I can't remember. And since then, moved into the mental health mobile crisis, crisis intervention space. I was the director of a two-county mobile crisis team down in Green and Columbia counties.

And then, within the past year, I've noticed, Aidan just told me it's -- you're referring it to E.M.S. in crisis, but I think healthcare is in crisis. And so when I looked at the kind of calls that we were responding to within mobile crisis, I looked at the system as a whole and kind of looked at training and advocacy as the route that I decided to go down to.

So the Mental Health Association in New York State is a Statewide association. It has twenty-six affiliates in fifty counties across the state. I previously came from the Mental Health

Association of Columbia Green. I think a lot of you have a mental health association in your area that you may or may not already partner with.

One of the things that we do as far as the Mental Health Association is a lot of legislative action. We have an entire legislative action community that focuses specifically on laws related to mental health, legislation related to mental health. Where I think we can expand for the legislate -- our legislative action community is partnering with our first responder community, about legislation that is specific to you and your mental health.

We're currently working with the New York State Sheriff's Association as well. We know that there's bills in the house right now. I asked yesterday, if anyone had heard of the First Responder Peer Support Program Act, is anyone in here, hands, kind of, maybe, a little bit.

Okay. So part of that is when you look at some of these bills and how they haven't been passed, you know, you look at what is up here in the space of a first responder and that there's no confidentiality that protects peers.

So as you're looking at peer support programs and I know there's a lot of agencies in here that have that, there's nothing that protects them confidential, like what they're in an I'm on two critical incident stress management teams, one in Ulster County with Ulster County Sheriff's Office.

The other is one that was created with Aidan O'Connor and Steve Brucato in Greene County, the Upstate First Responder Peer Support Team. You can see there's legislation in other states where peers are being subpoenaed to give the information when they do an intervention.

We have workarounds for that, but we really need to look at some legislation that protects the peers and the work that they do as peers. Specifically, when talking about mental health and substance use within your community.

One of the things that happened within mobile crisis was, first responders asking for training related to mental health substance use de-escalation and like communication one zero one, on how are we communicating on scenes to individuals.

That was requests for training that came to me and we did that for fire, E.M.S., and law

enforcement. I still do those trainings for fire, E.M.S., law enforcement, dispatch, military. So one of the things that came out of that was the creation of the Helping Every Responder Overcome Resiliency program.

Our goal is that we have community language that talks to first responders. We know that there's lots of training out there. We want to bring it into one spot and make sure that all of the first responders are speaking the same language when it comes to mental health literacy and substance use.

The training and resources is compiling all of that. We want to make sure that we're bringing all of the resources in, what works for different agencies is -- is different. We're all in different communities.

And so part of that is creating a peer support system within your agency, community, county, whatever it looks like, your region that matches those needs. So we started with training and making sure that that's the level set that we're all looking at.

So all of these certification trainings in the beginning, you all get an individual

certification for each one of these. I'll talk a little bit more about mental health first aid. SafeTALK is a suicide prevention training which is, they're all national trainings.

You can look at this in any state and say, where does this fit in, mental health first aid is a national, safeTALK is a national, Science of Addiction and Recoveries. There's different versions of that. Ours is from Friends of Recovery in New York State, and then the FBI National Academy Resiliency Officer Training.

So again, all of these trainings are certification trainings. Five days total of training. We do that in-house through the Mental Health Association in New York State. We're currently doing this with the Ulster County Sheriff's Office.

We have additional training opportunities which are the Critical Incident Stress Management. I know that there is considered postvention. So part of that, but I know that there is different information about postvention and psychological first aid.

There's many different postvention

programs. We know that CISM, when we see it work, we see it work. And so understanding that those are expensive trainings, they've kind of iced themselves out from that. We're bringing them in-house and making sure that they're affordable to the agencies.

And then, community health partners is really for family members of the first responder community. We want to teach family members how to support their first responder at home. They're going to see the first signs and symptoms of mental health or substance use crisis or signs that something is getting worse before people at work are going to see that.

So we really want to educate community, family members, support systems, whatever that looks like. Signs and how they can have the conversation at home, but also who do they talk to at the provider at the agency to really look at how do we support them and get them to the resources that they need.

We're looking at this as a C.M.E. and micro credentialing opportunity, so we're still exploring this. One of the things when it comes to the Hero program is, we want to work with agencies in

the State to do that.

Every state is different. When we worked with the Ulster County Sheriff's Office, we surveyed the agency first to see what the operational staff wanted as far as their mental health, as substance use resources.

Did they even have stress, right. So we surveyed, it was about two hundred and seventy-one employees at the time, fifty percent response. The wellness unit was developed on the responses of the operational staff.

So it was, you know, we were informed by the staff, they told us and that is how we created it. This survey can be implemented at any agency at any level. And I include healthcare in that and hospital systems.

We have had requests from hospital systems for mental health, first aid and different trainings looking at resilience. We know the compassion fatigue, we know the burnout. The way I look at this is that if we take better care of our providers, they will take better care of our communities and we have to do better with that.

I'm on like, two different workforce

pipeline committees for behavioral health. There's not a single space of workforce in New York State that I think is doing great. So how are we doing to protect the workforce that we have and make it not so scary to bring new workforce in.

So mental health first aid is, I cover about seven different mental health first aid grants. We have mental health first aid for adults, which also goes into different specialties. So there's fire, E.M.S., public safety, corrections, military veterans and their families, rural populations.

There's a whole bunch that we kind of do with that. We also do youth mental health first aid, which is for adults working with youth ages twelve to eighteen. And then, we have teen mental health first aid, which is teaching teens how to talk to other teens about mental health and substance use.

So there's kind of a wide variety of this. All of our mental health first aid for first responders is taught by a first responder peer that matches that population. We're really excited. It's all evidence based.

I know providers love that term. It talks about recognizing signs and symptoms, but more

importantly, it talks about having the conversation related to those signs and symptoms that we see. It's not just going to tell you how bad it is, what you're going to get from working in this field.

It's really going to talk about how do you have the conversation and make it a productive conversation. And also, what happens when someone says, no, I'm good, I'm fine, right, because I think we know when people are not doing well.

But we're also sometimes fearful of what that conversation looks like. And to be honest, I'm sick of going to provider suicides, right, how many suicides have we had this year alone in our -- our first responder community.

So here's one of the ways that we look at the ecosystem to do this. This training can also be for family members. This is for anyone. It is not -- you're not doing a suicide risk assessment, again, it's that entry level kind of how do we do that.

And more importantly, we don't diagnose in this. I think we, as health care providers, everyone looks to immediate diagnose. We're not going to do that. It's truly connecting

them to care. Again, this is evidence based. What I realized on the website, you have the flyer for fire E.M.S., on the SEMSCO website.

And you're also going to have, it's like forty-seven pages of research. There have been a ton of studies that support this training and the confidence levels and the increased awareness. You can get into the specific fire E.M.S., public safety spaces where it is proven to reduce stigma and increase people's confidence to have a conversation.

We're currently providing mental health first aid in the capital region for free, for military veterans and families, E.M.S. and fire, public safety, and then, primary and specialty care providers. That includes our emergency room staff does not just have to be provider level.

We want to talk to everyone. We're coming to Saratoga County. Mike McEvoy on the 23rd. We're doing some stuff with the veterans and military populations in Saratoga, Rensselaer, and Schenectady counties within the next, I don't know, three weeks.

And I think that about sums it up. Any questions? So what we need from all of you is, if you're looking to bring peer support planning, I

know, I looked at Dr. Dailey and I was like, I have more to say.

So if you're looking for us to come in or want to talk to us about training, we're hosting some of these trainings in the capital district. Like I said, we're working with the Sheriff's Association as well.

We would like to have all of the agencies, E.M.S. of New York State, Sheriff's Association, everybody come together and say, all right, we're going to agree that this is a good level set of training. And that way everyone has the same language.

So at some point, I would like some of your leaders to come meet the sheriff's office leaders and get some of our fire leaders, in-house communications and get everyone together and make sure that this is the direction we want to go.

And create that legislative action community that includes first responders and the mental health side. So we can come up with policy and legislation together that we can work on and make sure is solid across the board and support each other. The end.

CHAIR DOYNOW: Thank you, Katie. Any questions for Katie? Okay.

MR. GREENBERG: If I can comment, just one thing on it. You know, we talk about mental health and well-being of our providers and actually even just yesterday, I was having a conversation about this is not just about our E.M.T.s and paramedics.

But, you know, across healthcare, you know, including nurses and physicians and things of that nature and so. But we're always kind of asking the question of, okay, well, what's the first step or what we can do or how do we get there.

So I know there's been, you know, some work within the Bureau and we're working on some programs. Katie, you know, thank you for being here for yesterday and for today and the programs you're doing. I think, you know, kind of next steps on things too is to hear from each of your agencies as medical directors, you know, what are you doing, has something worked, has something not worked.

Because I think it's equally important to hear what hasn't worked because that tells us, hey, let's not recreate that wheel of doing the wrong

thing again. So, you know, if there is an avenue or a pathway or something or maybe to sit and leave this on for, you know, old business for next meeting to follow back up on and see if there is anything more on steps we can take or things that kind of push that forward?

MS. OLDAKOWSKI: Ryan, I just want to add, we have two interns that are going to be starting with us that we have for the full summer. One of their responsibilities is actually going to be Statewide mapping of the resources specifically out there for first responders.

We want to target, who are the therapist, counselors, the recovery, whatever it looks like for the first responder community and provider community. Map that out, and then, make sure if there's peer support, things that work, trainings that work.

We don't want to recreate the wheel and what we're seeing in all spaces is a recreation of the wheel. And we want to bring it all in-house. And what I talked to, I had a meeting with the Sheriff's Association this morning, evaluate these trainings and see what works and what doesn't work

and make those evaluations public.

So that we know that this is vetted by first responders, by the provider community to say, great, this is working, this is not working. This is what the feedback is for these trainings and make one universal kind of evaluation form that goes with that.

Because again, we just had a training out west. It was mixed reviews, right, but they didn't know what the training was going to look like. So again, we're looking at the different pieces of it and figuring out. So the interns, you may hear from them.

CHAIR DOYNOW: Thank you, Katie. Any other questions or comments? Okay, a few announcements before we -- we adjourn. Next meeting will be September 18th, please note it's at the Embassy Suites in Saratoga, not here in Troy.

E.M.S. Memorial has been moved to September 19th from May. Hopefully everybody will be there. And one last retirement that I'm aware of, Dr. Markowitz, this is his last meeting and he's retiring. Thank you for all your years of service, Dr. Markowitz.

And I must say, happy ballooning, since I know you're a balloonist. I guess that's what we say. Any -- any other business anybody wants to bring up?

MR. GREENBERG: Yes, so just one thing, we did tie the E.M.S. memorial intentionally with the meetings. The memorial, for those of you who weren't aware, was supposed to be delivered, the new memorial was supposed to be delivered in early May.

It unfortunately, in production, wasn't going to make it in time, so we made the choice of moving things to September to make sure it got right and we tied it to these meetings so that those who are attending SEMAC and SEMSCO, it will follow most likely at eleven a.m. on the Thursday after SEMAC and SEMSCO.

Again, SEMAC and SEMSCO is up in Saratoga and we are working on dates for 2025 meetings. Hopefully those will be out by the end of June. And we'll be able to give you confirmed dates as well as locations for all of those meetings as well. Thank you.

CHAIR DOYNOW: Okay. And I've been

informed there's one new piece of business that just came up before we adjourn.

MR. RABRICH: Thanks. So -- so -- one little piece of new business. There was a discussion at MedStandards regarding opioid antagonists and which are the most appropriate to use. So there was no seconded motion.

But wanted to make one now that the SEMAC endorsed the current opioid antagonists remain the only ones approved for public safety use by the Commissioner.

MS. BOMBARD: Second.

CHAIR DOYNOW: Okay. Any discussion?

MR. DAILEY: Thank you. So I apologize that this actually is coming forward as a primary motion here rather than a seconded motion from MedStandards. But I think it's important that we do discuss this a little bit.

You know, we focus a lot on the -- on opioid overdose right now. And it is a horrible scourge on our communities. And I don't want to minimize that. But at the same time, I want to focus on a couple of things that I think will be of -- of help to the Commissioner, as he makes decisions as to

which opioid antagonist should be approved for use by public safety without a patient specific order across this -- across the State.

The biggest question I think that we have behind any medical intervention first is do we need it. And the second and most pertinent to us as physicians is actually whether or not an intervention will do any harm. Opioid antagonist administration is something that has been worked extremely successfully through our E.M.S. interventions and into public safety and law enforcement.

We're using naloxone right now. We use both a two and a four-milligram formulation in E.M.S. And currently we've studied the eight-milligram formulation as well. But do we need either stronger or longer acting opioid antagonists.

And I think it's important for us to focus on that. First, the data from our State police study. We studied the eight milligram versus the four milligram formulation at three of the eleven troops across New York State.

When we did this, we found out that actually there was a significant increase in withdrawal symptoms, including vomiting among those

patients who receive the eight-milligram formulation of naloxone. As we all know that vomiting can lead to aspiration and can be significantly -- can create significant morbidity.

MR. DAILEY: And that ties to that is, have we had patients that didn't receive enough naloxone? And the reality there is that the patients who got the four milligram formulation received about one point seven doses of naloxone.

The patients who got the eight milligram naloxone got about one point seven doses of naloxone. And looking historically back at our two milligram data as well, those patients also received approximately one point seven doses of naloxone.

So I don't think we don't have a strong enough formulation of the medication. The other thing that ties into this that's incredibly important is, we reviewed the fatalities that the State police attended. And of the patients that received either the eight milligram or four milligram formulations, ninety-nine percent of the patients that were potentially able to be saved, were saved if the State police arrived.

Now, we've never looked at a true

fatality review like that before, but I think this is some of the data that we really have to calculate. The other side is, what about harm? Is there harm if we give people higher doses of naloxone? Is there harm if we give longer acting agents?

And I think the answer is unequivocally yes. The reality is that reversal of overdose is about respiration, not conversation. We need to make sure that we get people appropriately breathing. Right now, we have contamination of the drug supply by xylazine.

By one there that I saw the other day, which is Bromazolam, which is a non F.D.A. approved illegal benzodiazepine that's now in the drug supply. But no amount of naloxone or any other opioid antagonist is going to reverse either of those agents.

So we need to focus on the concept of respiration. Now, if you look and you talk to people who use drugs about the potential for harm, the biggest harm we can do is by giving somebody a horrible -- a horrible reversal.

If they have a horrible reversal, there's every chance that they will start to use

alone. Using alone and not having somebody in a position to rescue them is going to give them no opportunity for antagonist administration prior to their death.

We need to make sure that we take into account what is affecting the people who use drugs as we're looking at the interventions that we are going to ask public safety personnel to perform. So with that, I'd like to make a plea from this group.

Endorse Dr. Rabrich's proposal, let's make sure that nalmefene does not make its way into the formulary in New York State. We don't need a longer acting antagonist agent because that longer acting antagonist agent is just going to prolong somebody's misery of withdrawal.

We don't need higher dose of naloxone because the ones that we have are working. And we need to make sure that we are watching the data extremely carefully so that we can follow -- follow the data and then make sure that we can guide medicine appropriately. So thank you all for supporting Dr. Rabrich's motion.

CHAIR DOYNOW: Dr. Rabrich, would you like to make the motion a little more specific?

MR. RABRICH: No. I mean, I think the motion is that the -- that the SEMAC endorsed the currently in use opioid antagonist, which is naloxone, basically. And that the only antagonist for public safety use approved by the Commissioner.

CHAIR DOYNOW: Okay. Go ahead.

MR. WINSLOW: Yeah, I -- I agree with -- with both Dr. Dailey and Dr. Rabrich are saying and getting at. I think that nalmefene is not to be used by E.M.S. providers out of a safety profile concern. We do need to consider removing it therefore, from the alternate medication formulary so there is no mistake.

So I -- I -- I will highly recommend we support the motion. And then afterwards I suggest we remove it from the alternate medication formulary before it goes live.

CHAIR DOYNOW: Okay. I believe that Dr. Rabrich can modify his motion to include that.

MR. RABRICH: So modified.

CHAIR DOYNOW: Okay. All right. And I guess we need another second since we've changed it.

MR. BOMBARD: Second.

CHAIR DOYNOW: Okay.

MS. BOMBARD: Second.

CHAIR DOYNOW: Any discussion before we vote?

MS. BOMBARD: Second. Second, second.

CHAIR DOYNOW: Okay. Can we have a roll call vote?

MR. GREENBERG: Before you do the roll call vote, can you just make sure Theresa has the final verbiage of what that motion would be? I know there is been some changes.

MS. ALLEN: I will get it?

MR. RABRICH: Yeah. I will get it to you, yes. Okay.

MS. ALLEN: Dr. Bombard?

MS. BOMBARD: Bombard, yes.

MS. ALLEN: Dr. Cooper?

MR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Cushman?

MR. CUSHMAN: Cushman, yes.

MS. ALLEN: Dr. Dailey?

MR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Doynow?

CHAIR DOYNOW: Doynow, yes.

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MS. ALLEN: Dr. Isaacs?

MR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kugler?

MR. KUGLER: Kugler, yes.

MS. ALLEN: Dr. Markowitz?

MR. MARKOWITZ: Markowitz, yes.

MS. ALLEN: Dr. Olsson?

MR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Rabrich?

MR. RABRICH: Rabrich, yes.

MS. ALLEN: Dr. Walters?

MR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow?

MR. WINSLOW: Winslow, yes.

MS. ALLEN: Motion passes.

CHAIR DOYNOW: Okay. Thank you. Any other business before we adjourn? Okay. Can I have a motion to adjourn?

MR. COOPER: So moved.

CHAIR DOYNOW: Thank you, Dr. Cooper. Anybody against? I don't think so. Okay. See everybody in September.

(The meeting adjourned at 1:00 p.m.)

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STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription consisting of pages 1 through 81, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 30th day of May 2024.

DANIELLE CHRISTIAN, Reporter

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