

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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(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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2 **APPEARANCES:**
3 AIDAN O'CONNOR
4 AMY EISENHAEUER
5 ARTHUR COOPER
6 BRIAN CLEMENCY
7 BRIAN WALTERS
8 CHIEF ED MAGER
9 DANIEL OLSSON
10 DAVID KUGLER
11 DAVID MARKOWITZ
12 DAVID VIOLANTE
13
14 DONALD DUVALL
15 DONALD HUDSON
16
17 DOUGLAS ISAACS
18 DR. MAIA DORSETT
19 DREW CHESNEY
20 JASON WINSLOW
21 JEFFREY RABRICH
22 JEREMY CUSHMAN
23 JONATHAN WASHKO
24 KATIE OLDAKOWSKI
25 MICHAEL DAILEY
MICHAEL MCEVOY
RYAN GREENBERG
STEVEN KROLL
THERESA ALLEN
TIFFANY BOMBARD

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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. Wicelinski, 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.

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 2 **MS. ALLEN:** Steve Kroll.
 3 **MR. KROLL:** Steve Kroll present.
 4 **MS. ALLEN:** And Jon Washko.
 5 **MR. WASHKO:** Jon Washko present.
 6 **MS. ALLEN:** We have a quorum.
 7 **CHAIR DOYNOW:** Excellent, thank you.
 8 Can we have someone make a motion to approve the
 9 previous minutes?
 10 **MR. COOPER:** So moved.
 11 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
 12 **MR. RABRICH:** Second.
 13 **CHAIR DOYNOW:** Second by Dr. Rabrich.
 14 Anybody against? Okay, we'll assume that was passed.
 15 We're going to go a little out of order here. We'll
 16 hold Ryan's report to after the standing
 17 subcommittees. Medical Standards, Dr. Rabrich.
 18 **MR. RABRICH:** Yes. Thank you. So
 19 medical standards met immediately prior to this
 20 meeting. There is one motion coming forward for
 21 medical standards and that's on the approval of the
 22 New York City Rescue Task Force protocol.
 23 That protocol is specific to FDNY
 24 providers who are appropriately trained and acting in
 25 a rescue task force capacity in a warm zone. The

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 2 biggest change to that protocol really is the
 3 addition of the extended care section on the last
 4 page.
 5 Other than that, it's mostly just some
 6 edits to clean up the protocol.
 7 **CHAIR DOYNOW:** Okay, any discussion?
 8 Anybody have any questions? Okay. Can we have a
 9 roll call vote on that?
 10 **MS. ALLEN:** Dr. Bombard.
 11 **MS. BOMBARD:** Dr. Bombard, yes.
 12 **MS. ALLEN:** Dr. Cooper.
 13 **MR. COOPER:** Yes.
 14 **MS. ALLEN:** Dr. Cushman.
 15 **MR. CUSHMAN:** Cushman, yes.
 16 **MS. ALLEN:** Dr. Dailey.
 17 **MR. DAILEY:** Dailey, yes.
 18 **MS. ALLEN:** Dr. Doynow.
 19 **MR. DOYNOW:** Doynow, yes.
 20 **MS. ALLEN:** Dr. Isaacs.
 21 **MR. ISAACS:** Isaacs, yes.
 22 **MS. ALLEN:** Dr. Kugler.
 23 **MR. KUGLER:** Kugler, yes.
 24 **MS. ALLEN:** Dr. Markowitz.
 25 **MR. MARKOWITZ:** Markowitz, yes.

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 2 **MS. ALLEN:** Dr. Olsson.
 3 **MR. OLSSON:** Olsson, yes.
 4 **MS. ALLEN:** Dr. Rabrich.
 5 **MR. RABRICH:** Rabrich, yes.
 6 **MS. ALLEN:** Dr. Walters.
 7 **MR. WALTERS:** Walters, yes.
 8 **MS. ALLEN:** And Dr. Winslow.
 9 **MR. WINSLOW:** Yes.
 10 **MS. ALLEN:** Motion passes.
 11 **CHAIR DOYNOW:** Excellent. Thank you.
 12 Don Hudson, education.
 13 **MR. HUDSON:** Good afternoon, everyone.
 14 Thank you. So quickly, education most pertinent is
 15 the setting via this and other committees of the C.C.
 16 sunset as we have discussed in numerous meetings in
 17 the past, and then, put into action in the previous
 18 meetings.
 19 It seems to have its intended effect
 20 specifically to bridge enrollment. So just memory
 21 serves that previous bridge classes have seen
 22 diminishing enrollment, leading to the potential
 23 discussion of dropping down to only hosting one
 24 bridge a year.
 25 So the sunset date, that now has

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 2 turned around. So currently, the bridge class that
 3 just started has, let me refer to my notes, how many?
 4 **MR. WALDRON:** Sixty-three.
 5 **MR. HUDSON:** Sixty-three. Thank you,
 6 Ed Waldron from Northwell. Sixty-three people
 7 enrolled in it, which not only secures a robust
 8 bridge program this time around. But also assures us
 9 that we'll be hosting two bridge programs a year for
 10 the duration.
 11 So good news on that front. And thank
 12 you to everyone here that was supporting of that.
 13 **CHAIR DOYNOW:** Okay, thank you, Don.
 14 E.M.S.C., Dr. Cooper.
 15 **MR. COOPER:** Thank you, Dr. Doynow.
 16 My report will be brief. We were honored at our
 17 meeting this past Monday afternoon to have Maia
 18 Dorsett of the University of Rochester present a --
 19 the results of -- of the work in her region on
 20 medication errors, particularly in kids.
 21 In terms of, you know, making sure
 22 that the right dosing is -- is available. It's my
 23 understanding that she will be making that
 24 presentation here today. So I will not belabor that
 25 at this particular time, except to say that we were

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 2 thrilled to have the presentation and represented
 3 such an enormous amount of work.
 4 And as you'll see when you hear the
 5 presentation later today, I think Dr. Dorsett is
 6 going to become an extremely valued member of our
 7 community going forward. So thank you, thank you,
 8 Maia.
 9 To follow up on that Megan Williams,
 10 the -- the Paramedic Program Director at the Borough
 11 of Manhattan Community College has been working on
 12 the -- the -- if you will, the -- the length-based
 13 resuscitation tape issues in terms of ensuring that
 14 all of the various tapes and methods that are
 15 available, such as Handtevy and so on, are yielding
 16 similar results.
 17 More to come on that, I think that the
 18 work that Dr. Dorsett did is -- is going to be
 19 pivotal in the work that Ms. Williams is doing. And
 20 the two of them will be getting together over the
 21 summer to put things together.
 22 The next item I wanted to comment on
 23 is the Always Ready for Children program. Which is a
 24 really vitally important program for those of you who
 25 are running emergency departments throughout the

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 2 State.
 3 And that includes many of you. It's
 4 really important that -- that you participate in this
 5 program. It's a way that we can meet our
 6 requirements under the -- the National Read --
 7 Readiness Program. And as all of you are aware or
 8 most of you are aware, in any event the American
 9 College of Surgeons has included participation in the
 10 National Readiness Project or program as a
 11 requirement for the new gray book.
 12 So participating in the Always Ready
 13 for Children program is a very neat and easy way to
 14 do it for those of you that who are unfamiliar with
 15 this program, please contact Amy Eisenhower, our
 16 E.M.S.C. Program Coordinator.
 17 And last but not least, I have to give
 18 a huge shout out to Amy Eisenhower. Amy is an
 19 amazing human being. She is a force of nature.
 20 There is no task that she's asked to undertake that
 21 she doesn't carry out promptly and with great aplomb.
 22 I know Director Greenberg will have a
 23 few comments on this during his report, but all I
 24 want to say is that Amy has recently been honored
 25 with a promotion to succeed Professor Valerie Ozga

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 2 who is seeking greener pastures, the greener pastures
 3 of retirement.
 4 Amy is going to be taking on her role
 5 and as the person responsible for keeping the Vital
 6 Signs Conference rolling into the future. The Bureau
 7 will be identifying an individual to assume Amy's
 8 role as the E.M.S.C. program manager that that
 9 position has not yet been posted.
 10 I don't believe but will be soon. But
 11 I am going to ask all of you to stand and give Amy a
 12 huge standing ovation for the incredible work that
 13 she has done and will no doubt continue to do. We've
 14 been assured by Director Greenberg that Amy will
 15 still be involved with the E.M.S.C. program, although
 16 at a slightly different level.
 17 And, you know, so we will not have to
 18 miss her entirely. But again, thank you, Amy, for a
 19 job incredibly well done. And with that, I'll be
 20 happy to answer any questions. And if there are
 21 none, turn the meeting back to Chair Doynow.
 22 **CHAIR DOYNOW:** Any questions for Dr.
 23 Cooper? Okay, moving along. Ryan, if you'd like to
 24 give your report.
 25 **MR. GREENBERG:** Sure, I'm going to ask

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 2 for some help from the team on this one. If Ed
 3 Mager, and Drew, and Amy can come up, they're going
 4 to give the first three sections, and then, I will
 5 handle the rest.
 6 **MR. COOPER:** Dr. Doynow, if I might, I
 7 forgot to mention one short item. The Peds Agitation
 8 Work Group continues to do a great deal of work. The
 9 scripts for the -- the presentations that -- that
 10 they're putting together should be ready by the next
 11 meeting in the fall and we're indebted to that group
 12 for their participation in the program. Thank you.
 13 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
 14 Chief Mager.
 15 **MR. MAGER:** Thank you. Good morning,
 16 Ed Mager, E.M.S. Operations Western Branch and I'm
 17 representing the East too for Rich Robinson Branch
 18 Chief. From the operations side, a few things,
 19 obviously we've -- we're conducting multiple full-
 20 service agency inspections.
 21 One of the things that has sort of
 22 surfaced out of the eastern portion of the State is
 23 E.M.S. vehicle labeling matching the naming
 24 convention that is -- that is required. So that some
 25 -- some agencies that we're finding have not labeled

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 2 their vehicles in accordance with what is on their
 3 E.M.S. operating certificates.
 4 So we remind them that is part of the
 5 regulations and should be complied with. Other than
 6 that, full-service inspections, we -- we are finding
 7 significant operational improvements, good things
 8 specifically on expired items.
 9 We're finding less frequent S.O.D.
 10 issuance related to expire --expired items,
 11 disposable items obviously have significant
 12 expiration dates that even suction canisters expire
 13 these days. So we -- we do remind agency operations
 14 chiefs and directors to confirm their vehicle
 15 inspections in accordance with Part 800.
 16 So we are also approaching rapidly
 17 Part 18 season. So on the eastern portion of the
 18 State, excuse me, District Chief Ricardo takes care
 19 of all the Part 18s on the eastern half of the State.
 20 District Chief Lockwood takes care of the western
 21 portion of the State.
 22 So there's significant requirements if
 23 any E.M.S. agency or E.M.S. leader gets involved with
 24 the planning efforts of any party team events, those
 25 events that are anticipate having five thousand or

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 2 more people.
 3 We want those applications in
 4 completely thirty to sixty days prior to the event
 5 and certainly prior to advertising the event in
 6 accordance with the -- the party team regulations.
 7 We are in the process of updating our -- our policy
 8 statement 1201, which is blood glucometry.
 9 There's been some recent changes and
 10 interpretations of Public Health Law 579,
 11 specifically 579.3, which defines what entities are
 12 eligible for a fee waiver. So we'll come up with a
 13 clarification policy statement related to that
 14 specific issue that has -- has arisen is there's a
 15 bunch of, we've changed based on complying with the
 16 regulations and the -- and the law to ensure that
 17 we're meeting the -- the statutory requirements.
 18 But we have provided multiple updates
 19 at various meetings across the State. We are getting
 20 some pushback and we're trying to communicate and
 21 over communicate, but the policy statement is being
 22 written.
 23 Additionally, we'll be -- we'll be
 24 currently, the blood glucose policy 1201 also
 25 includes albuterol. Our goal will be to develop a

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 2 policy statement that takes all of the adjuncts that
 3 are required for approvals and summarize all those
 4 adjuncts in one -- one place.
 5 So that policy will be under
 6 development and we'll be proceeding with that. It
 7 will take some time. I don't want to give a timeline
 8 on it, but that is in progress or certainly one of
 9 our objectives and goals.
 10 I always like to remind people about
 11 the (unintelligible) training. It's an excellent
 12 opportunity, phenomenal work went into that program
 13 and it is available on Vital Signs Academy.
 14 Operationally, we're also reviewing our -- our
 15 submission portals for agency renewals and controlled
 16 substances and ensuring that we're optimizing and
 17 trying to make it less bureaucratic to -- to optimize
 18 the renewal process and ensure compliance.
 19 And I think, Director, would you like
 20 me to stop and give you -- I won't mention the
 21 staffing changes, I'll -- I'll leave that to the
 22 director. But other than that, I have nothing
 23 further. Amy?
 24 **MS. EISENHOWER:** Okay, so hey,
 25 everybody. So I'll do the report from Coverdell

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 2 since that is the shorter version. So the Coverdell
 3 grant notice of funding came out. The team is
 4 working on putting together future plans based on
 5 what C.D.C. has asked for in the NOFO.
 6 I can say that no substantive changes
 7 have happened with our work with E.M.S. agencies and
 8 regions. So we plan to continue the work that we've
 9 been doing specifically in -- in high-need regions
 10 right, like pre-notification, working on quality
 11 measures, all of that stuff and continuing to be a
 12 resource for the E.M.S. community as needed.
 13 So for E.M.S. For Children it is that
 14 time of year where I ask you to please do your
 15 survey. So the E.M.S. For Children survey has
 16 returned. It is three months late because it has
 17 been updated. Previously the survey has asked things
 18 like, do you have a pediatric emergency care
 19 coordinator, are you planning on getting one, what
 20 kind of training do you do.
 21 And it was very -- very brief, only
 22 really focusing on performance measures of the grant.
 23 Some of our noted physicians from the E.I.I.C. and
 24 work groups over the past few years have gone through
 25 and made the survey more similar to the N.P.R.P., the

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 2 hospital survey.
 3 So they are still asking, do you have
 4 a PECC, what does that PECC do, what kinds of things
 5 do you provide, you know, kind of understanding the
 6 foundation of championship education at agencies,
 7 like, how -- how many pediatric calls do you go on.
 8 What other kinds of things do you do
 9 at your service to be pediatric prepared, because
 10 really there is no solid understanding of E.M.S.
 11 preparedness for pediatric care across the nation.
 12 And so that is really what the updated survey is, is
 13 trying to give us an understanding of, what's there,
 14 what are people doing, what is working well.
 15 And how can we, E.M.S.C., federally
 16 and at the State level support E.M.S. agencies and
 17 regions in their care for pediatrics. So please
 18 complete your survey and you can find it at
 19 emspedsready.org. And just -- just like previously,
 20 you go to your county, you pick out your agency.
 21 If it is grayed out, somebody at your
 22 agency has already completed your survey, so thank
 23 you. I think we are two percent complete in the last
 24 week, although a new reminder went out yesterday. So
 25 I'm hoping more have gone through because I got some

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 2 confirmations.
 3 Also, on Vital Signs Academy, there's
 4 a tutorial going through the survey, a brief overview
 5 of what's in there, kind of what are they asking,
 6 explaining questions and of course, if you have any
 7 questions, you can always reach out to me or to
 8 Allison Lynch.
 9 She's our student assistant and will
 10 be heading the work on the pre-hospital PECC program,
 11 right over here. So you can reach out to either of
 12 us and we'll be happy to help you with whatever you
 13 need related to either of those processes. So please
 14 complete your survey.
 15 Also on the E.M.S.C. kind of things
 16 that have been in process many months ago I talked
 17 about some rural health funding for education at --
 18 from E.M.S.C. around pediatric emergency care
 19 coordinators, specifically to pre-hospital and PECC
 20 kits.
 21 So these kits will go out to each PECC
 22 agency. And if you are -- if you are a PECC agency,
 23 come see me later and I will give you your PECC kit,
 24 so you don't have to wait for the mail. But it is
 25 comprised of a variety of different things, including

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 2 our Pediatric Assessment Triangle Card, which has
 3 recently been updated in the last two months, so if
 4 you haven't gotten an updated one you can order them
 5 online on our website as usual.
 6 We also will include our pediatric
 7 agitation documents, which is also newly released.
 8 So if you don't have any, please order them. Some
 9 badge buddies that have been around. But you can
 10 also order them on our website separately, if you
 11 need more.
 12 We also include a P.D. wheel for
 13 dosing measurements, a P.D. tape and a Handtevy tape.
 14 And then, some communication cards. So these are
 15 also something that has kind of been on our radar and
 16 came through with this process.
 17 And much thanks to Florida E.M.S.C.,
 18 Michigan E.M.S.C. And I want to say Kansas E.M.S.C.
 19 So at E.M.S.C. we all help each other so we don't
 20 have to create the wheel. So inside there are
 21 pictures. It's in English and in Spanish.
 22 And then, in the back, it has a place
 23 where you can write on it. These are laminated. And
 24 we even give you a branded pen. So you have a dry
 25 erase pen. There's also some stim toys because what

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 2 kid really wants to be in our ambulance.
 3 And all of this comes in a lovely dry
 4 bag because I know how it can be in the ambulance.
 5 It's all in here, it won't get wet, it will be safe.
 6 The bag might get dirty, but the stuff inside won't.
 7 So these will be going out over the next few months
 8 to the PECC agencies.
 9 New PECC agencies, if you see this and
 10 you're like, oh my gosh, I need that. You just have
 11 to sign up to be a pre-hospital PECC agency and you
 12 can do that again on our website. All the
 13 information is there, the sign-up form is on there.
 14 Send it on in, we'll send this out to you, we'll give
 15 you, you know, a welcome kit.
 16 And if you have questions, Allison or
 17 -- or I will be happy to answer them. And then, I
 18 believe the rest of my report was related to
 19 staffing. We're in the process of interviewing for -
 20 - for our pediatric data coordinator.
 21 Yes, E.M.S. Data Coordinator
 22 Pediatric, we went through a bunch of different
 23 titles and I -- it's a big soup in my brain. So
 24 we're hiring for that. We're doing the interviews
 25 this week. I introduced you to Allison. She's

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 2 wonderful. I am very thankful that she's here to
 3 help with this and -- and do all the minutiae and be
 4 dedicated to it because it is a lot.
 5 And then, of course, as you all just
 6 heard, we will be putting out the -- the work to H.R.
 7 to hire for a new E.M.S. for Children program manager
 8 coming out soon.
 9 **MR. GREENBERG:** Thank you, Amy. Ed,
 10 did you want to talk about your two staff positions
 11 before we go to Drew?
 12 **MR. MAGER:** Yeah, director, I'm happy
 13 to, we're happy to announce that Vinnie Wiemand
 14 (phonetic spelling) will be starting with us actually
 15 tomorrow in the Syracuse office. So we're excited
 16 about that opportunity and he brings a wealth of
 17 knowledge, experience and -- and certainly comes from
 18 the Mid-state area.
 19 He'll be primarily focused in the --
 20 the Syracuse Central -- Central New York Office and
 21 we'll develop a transitional plan for the district
 22 chief assignments going forward. But he'll start his
 23 intense training process tomorrow. Welcome him to a
 24 staff meeting and we'll go from there.
 25 We've -- we're also out of the western

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 2 branch, Don Tripez (phonetic spelling) has actually
 3 got a promotional opportunity, he'll be moving to a
 4 position in E.M.S. licensure. He'll be the branch
 5 chief of E.M.S. licensure.
 6 So we'll hopefully be able to backfill
 7 his position, you know, in due -- due time. So we're
 8 really excited about those two promotional
 9 opportunities and bringing on new staff and --
 10 **MR. GREENBERG:** And now, one more.
 11 **MR. MAGER:** Yes, Carol Ackerman will
 12 be joining the -- the eastern branch and she'll be
 13 starting in -- in early June. So we've got some new
 14 district chiefs that'll be coming through to the
 15 Bureau and we're excited to have them on boarded and
 16 -- and trained and get them working, as it's an
 17 important mission. So thank you.
 18 **MR. GREENBERG:** We'll go to Drew, and
 19 then -- no. Go ahead, Ed.
 20 **MR. CHESNEY:** Good -- yeah, still good
 21 morning. Good morning, everyone. Drew Chesney, the
 22 Education Unit. Two quick staffing updates for us
 23 before going on with the full report. One item is
 24 that we are losing one of our longer serving student
 25 assistants, Rosalie Garcia who's been working with

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 2 Gene and C.M.E. for a few years now.
 3 And she will be graduating and moving
 4 on with her life and we wish her nothing but the
 5 best. That will be a spot that we fill over the
 6 summer. Rosalie has been, again, working with
 7 C.M.E., most notably with a lot of the F.D.N.Y.
 8 processing.
 9 So we will miss her sorely. But we
 10 are excited that we are having an addition to the
 11 education team. A name that's not new to anybody,
 12 hopefully, in the room. Jenny Solomon will be
 13 joining the team as our new eighteen, her first day
 14 is tomorrow.
 15 As you all know, Jenny comes with a
 16 good foundation of knowledge and experience with the
 17 Bureau, as serving with the OASIS grant in the mental
 18 health education programs that we've been running
 19 over the State over the last year, year-and-a-half.
 20 So we're really excited to join Jenny.
 21 She'll be working mostly out of the mayoral office
 22 and that will mean there will be a little bit of
 23 reshuffling with a couple of the responsibilities of
 24 staff. But as that's figured out, we'll of course
 25 keep everyone apprised through the education calls at

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 2 the next meeting.
 3 Sponsor renewals, it is that time of
 4 year for sponsors to renew. That has gone out and
 5 those are due back by June 30th. That includes about
 6 sixty sponsors who are up for renewal. If you feel
 7 that you should have been one of them and you did not
 8 receive an email and you're a little bit confused
 9 about that, please feel free to reach out to Kevin or
 10 I and we can take a look and see what was missed on
 11 that.
 12 It is a streamlined process that is
 13 completely used in the Drupal this year. So the
 14 submission is completely online, adding attachments
 15 and whatnot. So it -- we used it a little bit of a
 16 hybrid last year.
 17 And we've gone completely to it this
 18 year and it makes that process a lot easier. Up-to-
 19 date on many processing items, I think if you find
 20 that we're putting course application numbers out,
 21 rosters out next day, our timelines have been great
 22 on that.
 23 So we're very pleased with the team
 24 overall. Our C.M.E. processing is still sitting out
 25 about six weeks. That's just due to sheer volume.

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 2 So and that will probably sit that way as a norm.
 3 C.M.E. again is -- it is picking up now that we're
 4 starting to see the bulk of this COVID extensions
 5 expire.
 6 Processing times may be affected with
 7 that, so we do appreciate patience. Things that can
 8 help the process along for agencies and -- and
 9 leaders is to make sure that you're double checking
 10 your applications for errors.
 11 Please read them, read them twice,
 12 read them thrice and make sure that, you know, you're
 13 -- you're dotting your I's on everything that you
 14 possibly can. And also if you have questions,
 15 calling Gene with a submission number is important so
 16 he can readily look up what your inquiry is about.
 17 But we're happy overall with that.
 18 Some changes will be coming with the
 19 processing for C.M.E.s. We will announce these
 20 gradually as we react to the regulations that are
 21 coming up. But one of the big items is we're going
 22 to be switching from a bulk submission to individual
 23 submissions for the agencies to help with processing.
 24 And also, it will help agencies as we
 25 go because entire lots will not have to be rejected

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 2 if there's an error in one or two applications. So
 3 again, more changes to that as we do react to the
 4 regulations as they come through.
 5 We're using Boardable as we increase
 6 networking and the ability for sponsors to talk to
 7 each other, share best practices and engage each
 8 other on different levels. Everybody who is a core
 9 sponsor administrator or liaison should have access
 10 to that Boardable.
 11 Feel free again to talk to one of us
 12 if you do not. New policy statements hit the press
 13 yesterday on our website. You will see that there is
 14 a new policy statement on instructor processing. It
 15 fills in a lot of the most common questions that came
 16 up.
 17 I think it addresses advanced standing
 18 better when it comes to individuals who have educator
 19 credentials in other areas of life. And also expands
 20 upon reciprocity. And it builds the instructor
 21 process to becoming an instructor more into our
 22 portfolio of work rather than just check boxes and
 23 dates.
 24 So we're pretty excited about that. I
 25 do appreciate the work of the TAG that worked on

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 2 that. There's some excellent individuals. It wasn't
 3 just a Bureau work. It was educators from across the
 4 State that reviewed it and their time is greatly
 5 appreciated.
 6 The other education policy that hit
 7 was HAZMAT educational requirements for courses.
 8 Those are providing a little bit more clarity since
 9 the old course is no longer applicable that was
 10 provided by NIMS and I.C.S.
 11 So it gives two options, both again,
 12 no cost to students or core sponsors, so there's no
 13 entrance problems there. And it also provides
 14 flexibility for core sponsors who have subject matter
 15 experts to do things in-house if they want to.
 16 Some responses on P.S.I., in case you
 17 were not aware, P.S.I. does provide end of exam
 18 surveys for all test takers and users of the process.
 19 And we got some feedback on that over the first over
 20 '23 and the first part of '24.
 21 And we just thought it would be nice
 22 to highlight them since sometimes when we talk about
 23 test taking, it's not entirely positive, but overall
 24 experience in '23 by over ten thousand test takers
 25 was rated at ninety-seven point three percent as

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 2 excellent or good.
 3 So far in '24, it's at ninety-seven
 4 point one percent. So again, we hear a lot of noise
 5 about individuals that are having problems and
 6 they're legit. But it's also good to know that we do
 7 this on a grander scale and there's a lot of test
 8 takers who do go through the process without having
 9 those issues and that's -- that is good to know.
 10 There's about a dozen questions that
 11 they're asked to touch upon scheduling, site
 12 conditions, staff interactions and the overall
 13 registration process and interaction with their
 14 system so. The other thing that we're working with
 15 P.S.I. on is a mobile testing solution for areas that
 16 have low access or to testing sites.
 17 Whether it's a longer drive or
 18 whatever it may be or they have a high volume of
 19 students that when they all graduate at the same
 20 time, it puts real strain on the testing sites that
 21 are available. Basically it's a mobile testing site
 22 that will set up predetermined dates, we'll go into
 23 an area with P.S.I., P.S.I. sets it up with their own
 24 equipment and their own staff.
 25 They set up for two or three days,

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 2 they test eighty, a hundred plus, whatever it ends up
 3 being, and then, they go away. This will be pretty
 4 decent solution I think, once it's working, we're
 5 testing it out in the Finger Lakes region in June.
 6 And then, hopefully expand it out from
 7 there. For the paramedic programs across the State,
 8 we're trying to figure out better ways of pointing
 9 students from perspective students to them, answer
 10 their questions on basic foundations of what the
 11 programs are about, when they register, who the good
 12 contact is for, some of the highlights in that
 13 program.
 14 We surveyed all the programs, we
 15 received all that data back, so we appreciate the
 16 prompt response from everybody and what we're going
 17 to do is we're going to spend a little time
 18 collecting that, putting it together in a pretty
 19 decent format, posting it on our website so that,
 20 again, prospective students can go to the Bureau
 21 website, see all the programs in the State that offer
 22 an original program, and maybe choose, two or three
 23 that they can reach out to and have those contacts
 24 readily available. Course access and the promotion
 25 of that is an issue and we do realize that. This is

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 2 just one step to trying to solve that problem
 3 overall.
 4 And just a quick reminder on some of
 5 the pilot programs that we have outstanding, when it
 6 comes to funding for education back in September '23,
 7 you -- on our website, you can see policy 2308B, it
 8 was enacted to support the recruitment and retention
 9 of career and volunteer providers throughout the
 10 State. There were three specific items there that
 11 really helped with funding that we really try and
 12 keep the word out. And we talked about yesterday a
 13 lot. One is the academy programs, which are FAST
 14 based programs for certification, about four to eight
 15 weeks.
 16 Another one is a community intern
 17 program that allows the creation of a ten-hour
 18 orientation for people that gets them access to State
 19 funding, if they participate that and allows agencies
 20 to sign off on the verification of membership for
 21 them.
 22 And the last one is a retention and
 23 recruitment pilot program that if somebody pays out
 24 of pocket, works or volunteers for twelve months,
 25 they can have their agency voucher back for their

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 2 funds of their course.
 3 We continue to try and put the word
 4 out on these as best we possibly can through
 5 education calls and here at meetings like this, and
 6 then, educator updates. And there are three non-
 7 traditional avenues for these programs that we hope
 8 that people will take more advantage of, because to
 9 date it's been nil or nothing at all and that's
 10 unfortunate. So that is the report for the education
 11 unit.
 12 **MR. GREENBERG:** Thank you very much.
 13 I'll wrap it up with just a couple of things. One,
 14 for many of you have asked about licensure. We --
 15 our -- our R.F.P. is out right now for a new
 16 licensure platform. It has been homegrown for the
 17 past twenty years.
 18 We're excited about this because we'll
 19 be able to do more web based things and be able to
 20 fill in some more gaps and things happening with
 21 that. So you'll hear more about that over the next
 22 probably year to year-and-a-half.
 23 In the data and informatics world,
 24 we're moving towards three point five and the bulk of
 25 the larger providers will be moving in June of 2024.

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 2 Also if you're part of MedStandards, it appears that
 3 MedStandards would like to be able to do more work.
 4 But no, related to regulations,
 5 related to E.P.C.R.s and information and data. So
 6 we're going to take that one up. I think talk more
 7 over summer and into September, kind of a more long-
 8 term project, not a short-term thing.
 9 But to help with some of our data
 10 movement and getting data to the right places at the
 11 right time. We are -- we spoke about the data
 12 coordinator that's in the process of being hired
 13 there, as well as working with quality metrics and
 14 Dave and his group and trying to make sure that, you
 15 know, good data is flowing in his direction so that
 16 he can get what he needs.
 17 Next trauma meeting is here, in Troy,
 18 on May 29th. So hopefully we'll see some of you
 19 there. E.M.S. for Children was already reported on.
 20 Thank you very much for that one. Vital Signs,
 21 coming to Rochester in October, October 16th to 20th.
 22 Jeremy said that he'll take everybody
 23 out on a ride along personally with him. So Dr.
 24 Cushman, we really appreciate that. But we're really
 25 excited we went and did a site visit there. And

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 2 there's a lot of great things that's going to be
 3 happening there.
 4 There's a flyer going around. You'll
 5 see more of it on social media as well, please come
 6 join us, really think it will be a great weekend and
 7 it is home of the first white mittens. And if you
 8 don't understand what that means, ask anybody from
 9 that portion of the State. It will make sense.
 10 I was -- it was eye opening. So
 11 moving forward, E.P.R., you know, we just had the
 12 eclipse. Thank you to all the E.M.S. providers who
 13 participated in providing that coverage around the
 14 State as well as those who participated in the State
 15 E.M.S. Task Force Deployment.
 16 We had ten different agencies that put
 17 twenty different ambulances in different parts of the
 18 State. So I want to thank you for -- for that part
 19 and helping move that forward and -- and with some of
 20 that coverage.
 21 So we have a lot of exciting stuff
 22 going on in the world of regulations. This is
 23 important to pretty much everybody around the table.
 24 Most important and it's been a long time coming, the
 25 education regs will be voted on at the SEMSCO today,

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 2 that is the final step.
 3 Once it completes that final step, it
 4 takes about four to six weeks after that for the
 5 final processes to happen. That's going through
 6 State registry and -- and what you need to do to get
 7 posted. During that time period where that gap is
 8 closed, we'll also be working on some policy
 9 statements for clarification of how new processes
 10 work and things like that.
 11 So just want to say thank you to
 12 everybody around this room who helped make that
 13 possible. The equipment regs is moving along. We've
 14 been getting questions about that one, which is a
 15 good sign, because that means it's moving.
 16 Hoping to see it out for public
 17 comment this summer. Community paramedicine reg set
 18 is the next set to -- to -- is one of the reg sets
 19 that we'll be working on in the near future. I want
 20 to thank the Innovation Committee on some of the work
 21 that they're doing.
 22 They're going to be passing over to
 23 the community paramedicine group. The system and
 24 agency performance standards. We have two
 25 regulations that we'll be working on -- on behalf of

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 2 this group that was given to us to turn into regs.
 3 And then, the blood regs is the other
 4 reg set that is in draft right now. We've been
 5 meeting with Wadsworth and it looks like there might
 6 even be some more movement on it, not just affecting
 7 air medical. There's some movement going on that in
 8 the legislative session might include ground.
 9 So I know Dr. Isaacs would be excited
 10 about that one if that does go through, but either
 11 way, we're seeing a lot of good progress on that and
 12 it's exciting to see the results of, you know, blood
 13 administration in the field and what that has to
 14 offer.
 15 Part V, as many of you know, was a big
 16 part of this year. There was a lot going on in the
 17 past couple of months. Got around the State, talking
 18 about a lot of different things. Unfortunately,
 19 didn't get into the final budget.
 20 But I still, you know, people are
 21 like, are you upset that it didn't get in. And, you
 22 know, yes, you know, is it sad to see that it didn't
 23 get in, absolutely. But there's still a lot of
 24 motion going on with E.M.S. right now.
 25 There is a number of bills that are in

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 2 the -- the senate and the assembly. And people are
 3 talking about E.M.S., they're talking about the
 4 crisis, they're talking about where the problems are.
 5 And that is something that we didn't see for a long
 6 time.
 7 So this is exciting, so please, you
 8 know, everybody around this room, you are the
 9 advocates, you're the voice and so please, you know,
 10 they, unfortunately it didn't get in this year, but
 11 there's still a lot of opportunity to help advance
 12 things and move things in a great direction.
 13 I want to say thanks to Dr. Isaacs,
 14 who made it down for, unfortunately only pre-con for
 15 MSOC this year, but the special operations conference
 16 that happens with F.D.N.Y., really eye opening if you
 17 get the opportunity, it's just a different, you know,
 18 kind of component of what we do and they put together
 19 a great little conference down there.
 20 So I was really excited to -- to get
 21 there last weekend and -- and get to see what was
 22 happening there. E.M.S. providers from around the
 23 country, I think internationally too, come in for
 24 this one and really specialize stuff.
 25 And you get to go to the ROC, which

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 2 is, you know, just a series of opportunities to -- to
 3 use your skills in a -- in very different
 4 environment. Including a full subway train, if
 5 you've never been there before.
 6 Exciting for us, so we've had two
 7 amazing public health fellows over the past year.
 8 One of ours, Alex Blue is our data and informatics
 9 one. He is ending the end of his time as a public
 10 health fellow. But he, congratulations, is going to
 11 medical school at Upstate, so he's not going far. If
 12 you're up in that region, say hello to him next year.
 13 But also excited to -- and let me stop and say, thank
 14 you for all your service and everything that you've
 15 done in the past year. Most of our data and analysis
 16 has come from him. So we're going to -- we have some
 17 large gaps we're going to have to fill in a short
 18 period of time.
 19 But on an exciting front, we were
 20 approved for two more policy -- public health
 21 fellows, one for data and informatics and one for
 22 policy. So if you know people, those just posted
 23 this week, there'll be up, I'm not sure how long
 24 they're open for, but we'll make sure to share them.
 25 It's an amazing opportunity to do a

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 2 twelve to eighteen month fellowship with the
 3 Department of Health, if you don't want to work in
 4 E.M.S., there's an -- I think thirty-eight positions
 5 within the Department of Health.
 6 Great opportunity, well-paying and
 7 some of them lead to med school opportunities. So,
 8 you know, I think, you know, it's a good thing. So
 9 please take a look, happy to share information on
 10 that one. Last, just leaving out a couple things,
 11 you know, this past week I had to attend a funeral
 12 for someone who is pretty significant in E.M.S., Phil
 13 Malini was the AAREMS Program Agency Director for
 14 forty-eight years, from 1975 until 2023.
 15 And so if we can just have a moment of
 16 silence for him and his years of service, I would
 17 appreciate it. Thank you. On the completely other
 18 side, a little sad on that side, but on the
 19 completely other side, we have another program agency
 20 director who is retiring.
 21 So on a positive note, but retiring,
 22 Marie Diglio from New York City has done, been the
 23 program -- has been with the REMSCO for thirty-two
 24 years and been the program agency director for, I'm
 25 not sure, but many and -- and -- since 1987.

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 2 So I -- and she is retiring now and so
 3 thirty-two years, helping E.M.S. An amazing job
 4 leading, you know, at times probably a challenging,
 5 you know, kind of environment and -- and area. And
 6 really just helping advance E.M.S. in so many ways.
 7 And so I just want to say thank you
 8 and I wish you all the best in retirement, as well as
 9 some little people you have coming, I think, to your
 10 family in retirement too, so thank you Marie for
 11 everything you've done for E.M.S.
 12 And also leaving on the last note of,
 13 also a happy but sad, because I don't know who I'm
 14 going to nudge or bug half the time in my office.
 15 This will be Val Ozga's last meeting with SEMSCO.
 16 She has been with the State for thirty-seven years.
 17 She's been with the Bureau for twenty-
 18 seven years. She's been with the conference for
 19 twenty-three years and she's been the executive
 20 secretary of the SEMSCO for majority of that time
 21 too. And so I just want to say, if you think the
 22 texts are going to stop coming, they're not.
 23 I know your personal number, but thank
 24 you for everything you've done. You've been
 25 tremendous in the advancement of E.M.S. and helping

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 2 this council in so many ways. So thank you, but I
 3 hope you enjoy retirement too.
 4 If you're looking for them, you'll
 5 probably find Val and Marie at the bar later this
 6 afternoon. And I apologize for the long report, but,
 7 Mr. Chair, that is the end of the Bureau report.
 8 **CHAIR DOYNOW:** Okay. Thank you, Ryan.
 9 **MR. GREENBERG:** I agree.
 10 **CHAIR DOYNOW:** Okay. Moving on old
 11 business, well, back to Ryan State E.M.S. Medical
 12 Director. Any update?
 13 **MR. GREENBERG:** Progress on that one
 14 and we think we will see the posting in this fiscal
 15 year. We're waiting for some budgeting things to go
 16 through.
 17 **CHAIR DOYNOW:** Okay. Thank you.
 18 Credential Committee report. Anything to say?
 19 **MR. WINSLOW:** So I know this was a
 20 charge by the SEMSCO and I want to say thank you to
 21 Paul Barbara from Staten Island. He did a great job
 22 chairing that working group. I can tell you that
 23 it's all on Boardable under the SEMSCO Credentialing
 24 Working Group documents.
 25 There's a lot of good stuff in there.

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 2 We did a survey, which shows credentialing is
 3 currently being done differently in different regions
 4 of the State, but it is being done. And it also goes
 5 over some of the policies that would be affected by
 6 changes to credentialing.
 7 I recommend you consider that. As
 8 well as some letters in support of and questioning
 9 the regional roles of credentialing. I can tell you
 10 the workgroup was paused. Sounds like hoping or --
 11 or waiting for some legal clarification from either
 12 Part V as in Victor or other current laws that are
 13 under discussion under the house assembly and senate.
 14 I guess, we're going to be on hold for
 15 the time being, but I can tell you is that regional
 16 credentialing is really important, especially with
 17 workforce sustainability, as well as acclimatizing
 18 providers to regional differences in care.
 19 As we know that E.M.S. is practiced
 20 differently in New York City as it is in Suffolk
 21 County, as it is in Upstate, but that's all I had to
 22 share.
 23 **CHAIR DOYNOW:** Okay. Thank you.
 24 Moving on to new business. Dr. Dorsett.
 25 **MS. DORSETT:** All right. Well, thank

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 2 you very much for having us to talk about a project
 3 that we did in Monroe-Livingston. That was really a
 4 collaboration between leadership, all the agencies
 5 and very thankful for E.M.S.C. for like, funding this
 6 initial pilot project that's going to sort of
 7 continue to work in our region.
 8 And so the big motivation for this
 9 project, the focus was on improving pediatric
 10 medication safety. And the rate of pediatric
 11 medication error is being very high. Essentially a
 12 coin toss was well documented in the E.M.S.
 13 literature.
 14 Though previous to 2020, there wasn't
 15 a lot of publication about what to do about the
 16 problem. And this is something that personally and
 17 within the region is something that we wanted to work
 18 on, but we were faced with not actually knowing what
 19 our pediatric medication error rate was or actually
 20 having good change theories about improving it.
 21 In 2020, NAMSP published a position
 22 statement and a resource document and really the
 23 valuable component of this was the resource document
 24 because they did an excellent systematic review of
 25 all the evidence around pediatric medications safety.

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 2 And came up with a series of five
 3 recommendations about what are really best practices
 4 and this included things like, determining weight,
 5 using things in kilograms but one of the -- I think
 6 the two most important recommendations were
 7 essentially avoid math at the bedside. Use a
 8 volumetric based dosing reference was the one thing
 9 that really did have demonstrable effect on pediatric
 10 medication error from a project that was done at
 11 Denver Health.
 12 Using the Handtevy system, as well as
 13 giving E.M.S. clinicians the opportunity to practice
 14 these skills. And so based on work that was
 15 previously done, our main change theory was about
 16 implementation of the Handtevy application within our
 17 region to ideally reduce pediatric medication error.
 18 So I just wanted to take a little bit
 19 of time to orient somebody on how this application
 20 works. Essentially, this is an application, the
 21 protocols are integrated into the application and it
 22 uses both age as well as a length-based tape, that's
 23 congruent with other length-based tapes to determine
 24 what the ideal, what the weight is.
 25 Importantly for us, there was also

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 2 adult dosing, that was limited when we started but
 3 that has been expanded. What this would be able to
 4 pull up is it pulls up all the medications, the
 5 concentration that would be used as well as the
 6 volume to be administered and as well as the route.
 7 And this is something that you vet and
 8 is matched to the protocols. But you can also search
 9 based on a protocol and it will pull up the protocol
 10 as well as all the medications associated with that
 11 protocol.
 12 So it can be referenced quite quickly.
 13 One of the things I can go back on, it also gives
 14 things like normal pediatric vital signs there's a
 15 C.P.R. assist, other things like that. This is, you
 16 should be able to see this on your computer, because
 17 I believe that you have a P.D.F. of the slides
 18 because it's hard to read from here.
 19 But we knew it's the change is never
 20 just the tool, the change is always about the work
 21 you do to correctly implement the tool so that people
 22 know, understand how to use it. And so the way we
 23 did this, we did this across the region. So this was
 24 not like a single agency implementing this.
 25 This was onboarding twelve different

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 2 A.L.S. agencies, a couple A.L.S.F.R.s to implement
 3 this. The first thing that we had to do was actually
 4 a medication concentration survey. We all know that
 5 there's variable medication concentrations.
 6 That's disastrous if you're using a
 7 volume-based application because you could cause
 8 error. And so we were able to do that within our
 9 region. We developed a regional policy on medication
 10 dosing safety for pediatric patients that was
 11 essentially a replication in policy form of the
 12 N.A.M.S.P. position statement.
 13 And we used that so that our REMAC
 14 passed that. So we have -- we have some carrots and
 15 we have some sticks to say, no matter whether or not
 16 you participate in our pilot or not, right, this is
 17 what evidence- based best practice is.
 18 And so we are going to hold people
 19 accountable to do that. And then, we developed a
 20 training and implementation plan that essentially
 21 used a series of tabletop scenarios that coupled the
 22 -- the clinical scenario, the skill, drawing up the
 23 medication, using the application and do --
 24 performing a medication cross check.
 25 These scenarios were intended to -- to

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 2 do sort of some of the more common medication
 3 administrations in children, as well as things that
 4 people were uncomfortable with, as well as adult
 5 cases. So this is an example of what one of these
 6 look like.
 7 We had a seizing infant, we had a
 8 pediatric cardiac arrest, we had a school aged child
 9 with pain management, we had a ketamine for analgesia
 10 and an adult trauma patient and the titration of a
 11 norepinephrine drip for a septic shock patient.
 12 We built this as a train the trainer,
 13 so we brought in leadership from all the different
 14 agencies to come, like, go through the training
 15 themselves. So that they can take that, and then,
 16 implement it at their agency with the idea that this
 17 really would take no more than an hour.
 18 And then, built the -- the background
 19 component as an asynchronous format so that they
 20 could pre-assign that and save time. Because while I
 21 was able to, you know, bring people in my agency and
 22 do the entire training in person, we're realistic and
 23 realize that that's not possible for everybody. So
 24 we needed a system that would work for different
 25 agencies.

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 2 And then we had a rollout over the
 3 region. And I'm not going to say it was all like,
 4 you know, hugs and kittens and everybody like did it
 5 right away. It required a lot of identification of
 6 what the barriers were at different agencies to
 7 getting this implemented. But I think we were really
 8 able to work through that by asking people what are
 9 the barriers to doing this, what are the barriers,
 10 not like, do this thing.
 11 So this is a graph of like, our time
 12 course of implementation. So in the orange, in the
 13 application as an admin, I can pull out who are all
 14 the users. So I have an email address of everybody
 15 who's a user in our system.
 16 When did they get registered with the
 17 application and when was the last time they opened
 18 the application, I can also get usage reports. So we
 19 have about three hundred and fifty paramedics in our
 20 system. So it was really around July that we had
 21 like over three hundred, July, August that we had
 22 over three hundred paramedics on the -- on the system
 23 because I had that many users, which is important for
 24 data analysis and thinking when did we really have
 25 saturation of at least access to the toll within our

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 2 system.
 3 In the blue, so like the tick that
 4 goes up, I can look at the last time anybody used the
 5 application. So this was pulled like a couple weeks
 6 into February. So I can tell you that a hundred and
 7 seventy-five of the four hundred and fifty people had
 8 opened the application within the last two weeks.
 9 I just ran the numbers right before I
 10 came here. I had fifty-six people open the
 11 application within the last week. And before that,
 12 the majority, more than half of the people had opened
 13 the application within the last three to four weeks.
 14 So people are actually using it within
 15 our system. Defining when is a pediatric medication
 16 error is a little complicated because it differs per
 17 medication. Within the literature, the studies that
 18 I had looked at it say about eighty to hundred twenty
 19 percent of the correct dose is a correct dose.
 20 And if it falls out of that, it's a
 21 medication error. I feel a little bit differently of
 22 about hundred twenty percent of a one point five
 23 m.c.g.s per kilo of fentanyl being administered to a
 24 child versus like things that we had a range.
 25 So these are the definitions that we

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 2 use. So for midazolam, it's eighty to hundred twenty
 3 percent of what like the current, the point one mcgs
 4 per kilo, which is now changing, was in there. So
 5 these are the definitions and I sent a report that
 6 has how we did this.
 7 We were able to pull this data because
 8 of the regional data bridge. So much like the
 9 discussions that happened earlier, there's a bunch of
 10 different E.P.C.R.s trying to get the data from each
 11 individual agency.
 12 As I tried to do that early on was,
 13 like never, I know when to -- when something is not
 14 going to happen. So the State was able to build us a
 15 report that requires some cleaning. But that could
 16 allow us to for the first time look at what were the
 17 doses administered to children.
 18 The doses and the weights, the
 19 indications for every med for a child thirteen and
 20 under, transported to a hospital in our region. And
 21 so that we actually know where we stand, which is
 22 really the first part of every quality improvement
 23 project.
 24 One of my concerns was, how do I know
 25 that I'm calculating this correctly, is the

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 2 denominator right, is the weight that's documented in
 3 the chart realistic. So thank goodness for Pediatric
 4 Emergency Medicine Fellows because we were able to at
 5 least pull from like our E.M.S. charts, which is the
 6 highest saturation children, age thirteen and under
 7 transported to the Strong Memorial Emergency
 8 Department.
 9 Where I know there's a policy that the
 10 child has to have an actual weight documented. They
 11 took all the children who got any medication
 12 whatsoever for a year. And wrote down what was the
 13 actual calculate, like, weight in the emergency
 14 department relative to what we had in the chart.
 15 And you can see that greater than
 16 ninety percent accuracy of the weight that was
 17 documented in the chart. So we are using the right
 18 denominator based on how much the kid weighed. The
 19 reality is a lot of those, I know that they're weight
 20 -- they're taking the weight of the kid when they
 21 come in.
 22 They do triage, they weigh the kid in
 23 the hospital and they write it down. But I'm
 24 calculating the medication error rate based on what's
 25 in the chart. So that -- for the outcome that I care

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 2 about, I think we have the right denominator.
 3 So this is our data and we have now,
 4 you know, more months of data, so it's thirty day
 5 intervals of what our medication error rate was. So
 6 this is four years of data. So what you're looking
 7 at is a control chart, this is called a p-chart.
 8 So the denominator changes over time,
 9 which is why those control limits change over time.
 10 And you can see that for years our median percent
 11 correct dose, was seventy percent, which means we
 12 were missed dosing medications thirty percent of the
 13 time.
 14 And since we implemented Handtevy on
 15 this, we're eighty-four percent. I can tell you last
 16 month, we were ninety-five percent correct dosing for
 17 our entire region for children. Which is a continued
 18 act to say, is that like a sustained, but to me,
 19 greater than ninety percent is the goal.
 20 The reality is not every medication, I
 21 think this is sort of an oversimplification, not
 22 every medication is mis-dosed at the correct -- at
 23 the same rate. And some medications, I'm a lot more
 24 worried about than others.
 25 So for example, dexamethasone, which

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 2 surprisingly is the most commonly administered
 3 medication to children in our region is actually
 4 correctly dosed like ninety percent of the time and
 5 that's because by the time you're two, you've maxed
 6 out on the dose and there isn't much calculation.
 7 But midazolam for seizure was only
 8 correctly dosed sixty percent of the time in our
 9 region for four years with huge variability with
 10 underdosing actually more common than overdosing.
 11 And that I found really concerning.
 12 So this is looking at quarterly
 13 percent but we don't have enough, statistically
 14 enough points on the run chart when you look at
 15 quarterly data. But this is something called an X
 16 chart. So what you're looking at here is a plot of
 17 the calculated correct dose.
 18 Which at the time, right, this is
 19 before protocol update point one mcgs per kilo
 20 divided by, sorry, the dose they administered divided
 21 by the correct dose. So each one of these is an
 22 administration over four years and you want it to be
 23 one, right.
 24 One means, it was exactly the correct
 25 dose. So this is variability around the medium. You

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 2 can see there was a huge amount of variability. And
 3 then, statistically, that dropped and narrows. And
 4 now I have, with the exception of one outlier, a
 5 bunch of little dots along the line of one point zero
 6 zero.
 7 That was when we reached saturation of
 8 Handtevy in our system. So I can tell you since
 9 July, we've had three medication errors of midazolam.
 10 And every single one, when I dive into it, they are
 11 not a user of the application.
 12 Which means now, I'm in a quality
 13 control phase among continued quality improvement
 14 always, right, of identifying when our errors are
 15 occurring informing the agencies and finding that.
 16 So I tell people like, I mean, people who know me
 17 like know like -- like control charts, like feed my
 18 soul.
 19 And like this one is my favorite one I
 20 ever made. But this is really what feeds my soul is,
 21 I get these kinds of messages from providers in a
 22 system and I'm not going to cry when I get like this
 23 one, right.
 24 Like about a peds arrest, by the way,
 25 this kid walked out of the hospital. So to me, it

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 2 feeds both of those things, right, like,
 3 statistically, I can say that we are making a
 4 difference by designing a system that helps people do
 5 the right thing in a moment of stress. I think I'm
 6 pretty good at math on a good day.
 7 I'm not very good at math when I have
 8 a seizing child. We still have, in that report, I
 9 have free text responses of a wide variety of what
 10 people think of the app and the use of applications
 11 and do paramedics need to know math still and all of
 12 this.
 13 There's a spectrum. We haven't won
 14 over everybody but I think we need to build the
 15 systems to help people do the right thing. And I
 16 think at least a big learning point for everybody
 17 here is that we actually have a way within the data
 18 bridge to let you answer the question of what is your
 19 medication error rate within your system and identify
 20 it in a way that was really difficult to do from a
 21 regional perspective.
 22 And it's hard to do as an agency
 23 because if you're not, like, you know, F.D.N.Y. that
 24 takes care of a huge number of patients. Most of us
 25 have agencies, where this is an infrequent event and

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 2 it's really hard to conclude like, what is my
 3 performance over time.
 4 But if you can conglomerate that data
 5 for your region and let's be real, like everybody is
 6 working at all the different agencies in the region
 7 and rotating amongst them or all three of them at the
 8 same, you know, three different ones at the same
 9 time.
 10 It allows you to say like, are we
 11 doing a good job, what are our opportunities for
 12 improvement. And whatever the tool is, I'm not
 13 saying -- I'm not like selling one tool or another.
 14 I'm saying that you have to have a tool and you need
 15 to implement it and provide the education.
 16 So what are we continuing? We still
 17 have room for improvement. One of the big things was
 18 more adult dosing. Luckily, Handtevy updated this
 19 for now. People, I think one of the reasons I see it
 20 more frequently used is we improved our adult
 21 options.
 22 We're working into direct integration
 23 with the E.P.C.R. We're having some documentation
 24 errors where people are writing M.L. instead of
 25 milligram, which I have to go do some data on, we

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 2 have a few barriers there.
 3 And then, really, I think it's about
 4 improving the frequency and the quality of these
 5 education opportunities without the education. And
 6 in the end, when I surveyed people, it was about
 7 eighty percent got some hands-on education. There
 8 was some that only had the asynchronous and there was
 9 four percent who said they have the app, but they
 10 never got the education at all, right.
 11 There was variability. This was not a
 12 perfect rollout. But thinking about how we can do
 13 that. And I'm already thinking, you know, it's time
 14 to start planning this again, because this was July.
 15 So for those who are doing the pre-hospital pediatric
 16 assessment, which should be everybody, right.
 17 Which looks at all these different
 18 components. And one of those is patient and
 19 medication safety. I think what this taught us, I
 20 mean, it's changed our perspective of how we're going
 21 to address this, is that we can do some of this stuff
 22 as a region.
 23 Expecting every single agency to
 24 reinvent the wheel to create pediatric preparedness,
 25 I think is a bit unrealistic and unfair to the -- the

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 2 leadership and the agencies there, but what can we do
 3 as a region, as a State to help people.
 4 This was like a regional plug and
 5 play, right. We gave a tool to the agencies. They
 6 had to participate and give us feedback. They had to
 7 be engaged, but they didn't have to create the whole
 8 system themselves or learn how to analyze the data
 9 and the rest of it.
 10 So that's all I have and happy to take
 11 questions. I have a lot of -- this was a lot of work
 12 of all the people up here.
 13 **CHAIR DOYNOW:** Thank you, Dr. Dorsett.
 14 That was very interesting. Anybody have any
 15 questions? Silence, no one? Okay.
 16 **MS. DORSETT:** All right.
 17 **CHAIR DOYNOW:** Well, thank you very
 18 much. Okay.
 19 **MR. DAILEY:** So I apologize. Of
 20 course, Dr. Dorsett got back to her seat before I
 21 could -- could ask her a question. But I apologize.
 22 But I just wanted to comment that this was great
 23 work.
 24 **CHAIR DOYNOW:** Okay.
 25 **MR. DAILEY:** Quite frankly, this is

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 2 something that we were looking to do with the
 3 collaborative protocols, when we were looking for a
 4 protocol app back in 2019.
 5 **CHAIR DOYNOW:** Uh-huh.
 6 **MR. DAILEY:** And the dosing calculator
 7 was something that we very much wanted to make
 8 accessible across the -- across the spectrum of
 9 E.M.S. in New York and having now good objective data
 10 about how it actually can bring potential benefit to
 11 our patients is extremely important.
 12 And we need to think about exactly how
 13 we're going to support that. Obviously, this is not
 14 going to be an inexpensive proposition across the
 15 State. We need to think about what that means. But
 16 it can't be a agency by agency process.
 17 We need to come up with one process
 18 that's going to make this work appropriately. I
 19 think doing it with the collaborative protocols makes
 20 a significant amount of sense. We need to come up
 21 with a good answer for it.
 22 **CHAIR DOYNOW:** Thank you, Mike. Okay,
 23 if there are no other questions. Moving along.
 24 First responder, mental health and current
 25 initiatives, Katie.

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 2 **MS. OLDAKOWSKI:** Good morning,
 3 everyone. I also have a PowerPoint, but I can dive
 4 in. So I'm Katie O. I'm the Director of Training
 5 for the Mental Health Association in New York State.
 6 I started my journey in healthcare in 2005 at Albany
 7 Medical Center.
 8 Dr. Dailey, it's nice to see you.
 9 Became a nurse in 2013 or 2011, I can't remember.
 10 And since then, moved into the mental health mobile
 11 crisis, crisis intervention space. I was the
 12 director of a two-county mobile crisis team down in
 13 Green and Columbia counties.
 14 And then, within the past year, I've
 15 noticed, Aidan just told me it's -- you're referring
 16 it to E.M.S. in crisis, but I think healthcare is in
 17 crisis. And so when I looked at the kind of calls
 18 that we were responding to within mobile crisis, I
 19 looked at the system as a whole and kind of looked at
 20 training and advocacy as the route that I decided to
 21 go down to.
 22 So the Mental Health Association in
 23 New York State is a Statewide association. It has
 24 twenty-six affiliates in fifty counties across the
 25 state. I previously came from the Mental Health

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 2 Association of Columbia Green. I think a lot of you
 3 have a mental health association in your area that
 4 you may or may not already partner with.
 5 One of the things that we do as far as
 6 the Mental Health Association is a lot of legislative
 7 action. We have an entire legislative action
 8 community that focuses specifically on laws related
 9 to mental health, legislation related to mental
 10 health. Where I think we can expand for the
 11 legislate -- our legislative action community is
 12 partnering with our first responder community, about
 13 legislation that is specific to you and your mental
 14 health.
 15 We're currently working with the New
 16 York State Sheriff's Association as well. We know
 17 that there's bills in the house right now. I asked
 18 yesterday, if anyone had heard of the First Responder
 19 Peer Support Program Act, is anyone in here, hands,
 20 kind of, maybe, a little bit.
 21 Okay. So part of that is when you
 22 look at some of these bills and how they haven't been
 23 passed, you know, you look at what is up here in the
 24 space of a first responder and that there's no
 25 confidentiality that protects peers.

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 2 So as you're looking at peer support
 3 programs and I know there's a lot of agencies in here
 4 that have that, there's nothing that protects them
 5 confidential, like what they're in an I'm on two
 6 critical incident stress management teams, one in
 7 Ulster County with Ulster County Sheriff's Office.
 8 The other is one that was created with
 9 Aidan O'Connor and Steve Brucato in Greene County,
 10 the Upstate First Responder Peer Support Team. You
 11 can see there's legislation in other states where
 12 peers are being subpoenaed to give the information
 13 when they do an intervention.
 14 We have workarounds for that, but we
 15 really need to look at some legislation that protects
 16 the peers and the work that they do as peers.
 17 Specifically, when talking about mental health and
 18 substance use within your community.
 19 One of the things that happened within
 20 mobile crisis was, first responders asking for
 21 training related to mental health substance use de-
 22 escalation and like communication one zero one, on
 23 how are we communicating on scenes to individuals.
 24 That was requests for training that
 25 came to me and we did that for fire, E.M.S., and law

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 2 enforcement. I still do those trainings for fire,
 3 E.M.S., law enforcement, dispatch, military. So one
 4 of the things that came out of that was the creation
 5 of the Helping Every Responder Overcome Resiliency
 6 program.
 7 Our goal is that we have community
 8 language that talks to first responders. We know
 9 that there's lots of training out there. We want to
 10 bring it into one spot and make sure that all of the
 11 first responders are speaking the same language when
 12 it comes to mental health literacy and substance use.
 13 The training and resources is
 14 compiling all of that. We want to make sure that
 15 we're bringing all of the resources in, what works
 16 for different agencies is -- is different. We're all
 17 in different communities.
 18 And so part of that is creating a peer
 19 support system within your agency, community, county,
 20 whatever it looks like, your region that matches
 21 those needs. So we started with training and making
 22 sure that that's the level set that we're all looking
 23 at.
 24 So all of these certification
 25 trainings in the beginning, you all get an individual

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 2 certification for each one of these. I'll talk a
 3 little bit more about mental health first aid.
 4 SafeTALK is a suicide prevention training which is,
 5 they're all national trainings.
 6 You can look at this in any state and
 7 say, where does this fit in, mental health first aid
 8 is a national, safeTALK is a national, Science of
 9 Addiction and Recoveries. There's different versions
 10 of that. Ours is from Friends of Recovery in New
 11 York State, and then the FBI National Academy
 12 Resiliency Officer Training.
 13 So again, all of these trainings are
 14 certification trainings. Five days total of
 15 training. We do that in-house through the Mental
 16 Health Association in New York State. We're
 17 currently doing this with the Ulster County Sheriff's
 18 Office.
 19 We have additional training
 20 opportunities which are the Critical Incident Stress
 21 Management. I know that there is considered
 22 postvention. So part of that, but I know that there
 23 is different information about postvention and
 24 psychological first aid.
 25 There's many different postvention

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 2 programs. We know that CISM, when we see it work, we
 3 see it work. And so understanding that those are
 4 expensive trainings, they've kind of iced themselves
 5 out from that. We're bringing them in-house and
 6 making sure that they're affordable to the agencies.
 7 And then, community health partners is
 8 really for family members of the first responder
 9 community. We want to teach family members how to
 10 support their first responder at home. They're going
 11 to see the first signs and symptoms of mental health
 12 or substance use crisis or signs that something is
 13 getting worse before people at work are going to see
 14 that.
 15 So we really want to educate
 16 community, family members, support systems, whatever
 17 that looks like. Signs and how they can have the
 18 conversation at home, but also who do they talk to at
 19 the provider at the agency to really look at how do
 20 we support them and get them to the resources that
 21 they need.
 22 We're looking at this as a C.M.E. and
 23 micro credentialing opportunity, so we're still
 24 exploring this. One of the things when it comes to
 25 the Hero program is, we want to work with agencies in

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 2 the State to do that.
 3 Every state is different. When we
 4 worked with the Ulster County Sheriff's Office, we
 5 surveyed the agency first to see what the operational
 6 staff wanted as far as their mental health, as
 7 substance use resources.
 8 Did they even have stress, right. So
 9 we surveyed, it was about two hundred and seventy-one
 10 employees at the time, fifty percent response. The
 11 wellness unit was developed on the responses of the
 12 operational staff.
 13 So it was, you know, we were informed
 14 by the staff, they told us and that is how we created
 15 it. This survey can be implemented at any agency at
 16 any level. And I include healthcare in that and
 17 hospital systems.
 18 We have had requests from hospital
 19 systems for mental health, first aid and different
 20 trainings looking at resilience. We know the
 21 compassion fatigue, we know the burnout. The way I
 22 look at this is that if we take better care of our
 23 providers, they will take better care of our
 24 communities and we have to do better with that.
 25 I'm on like, two different workforce

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 2 pipeline committees for behavioral health. There's
 3 not a single space of workforce in New York State
 4 that I think is doing great. So how are we doing to
 5 protect the workforce that we have and make it not so
 6 scary to bring new workforce in.
 7 So mental health first aid is, I cover
 8 about seven different mental health first aid grants.
 9 We have mental health first aid for adults, which
 10 also goes into different specialties. So there's
 11 fire, E.M.S., public safety, corrections, military
 12 veterans and their families, rural populations.
 13 There's a whole bunch that we kind of
 14 do with that. We also do youth mental health first
 15 aid, which is for adults working with youth ages
 16 twelve to eighteen. And then, we have teen mental
 17 health first aid, which is teaching teens how to talk
 18 to other teens about mental health and substance use.
 19 So there's kind of a wide variety of
 20 this. All of our mental health first aid for first
 21 responders is taught by a first responder peer that
 22 matches that population. We're really excited. It's
 23 all evidence based.
 24 I know providers love that term. It
 25 talks about recognizing signs and symptoms, but more

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 2 importantly, it talks about having the conversation
 3 related to those signs and symptoms that we see.
 4 It's not just going to tell you how bad it is, what
 5 you're going to get from working in this field.
 6 It's really going to talk about how do
 7 you have the conversation and make it a productive
 8 conversation. And also, what happens when someone
 9 says, no, I'm good, I'm fine, right, because I think
 10 we know when people are not doing well.
 11 But we're also sometimes fearful of
 12 what that conversation looks like. And to be honest,
 13 I'm sick of going to provider suicides, right, how
 14 many suicides have we had this year alone in our --
 15 our first responder community.
 16 So here's one of the ways that we look
 17 at the ecosystem to do this. This training can also
 18 be for family members. This is for anyone. It is
 19 not -- you're not doing a suicide risk assessment,
 20 again, it's that entry level kind of how do we do
 21 that.
 22 And more importantly, we don't
 23 diagnose in this. I think we, as health care
 24 providers, everyone looks to immediate diagnose.
 25 We're not going to do that. It's truly connecting

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 2 them to care. Again, this is evidence based. What I
 3 realized on the website, you have the flyer for fire
 4 E.M.S., on the SEMSCO website.
 5 And you're also going to have, it's
 6 like forty-seven pages of research. There have been
 7 a ton of studies that support this training and the
 8 confidence levels and the increased awareness. You
 9 can get into the specific fire E.M.S., public safety
 10 spaces where it is proven to reduce stigma and
 11 increase people's confidence to have a conversation.
 12 We're currently providing mental
 13 health first aid in the capital region for free, for
 14 military veterans and families, E.M.S. and fire,
 15 public safety, and then, primary and specialty care
 16 providers. That includes our emergency room staff
 17 does not just have to be provider level.
 18 We want to talk to everyone. We're
 19 coming to Saratoga County. Mike McEvoy on the 23rd.
 20 We're doing some stuff with the veterans and military
 21 populations in Saratoga, Rensselaer, and Schenectady
 22 counties within the next, I don't know, three weeks.
 23 And I think that about sums it up.
 24 Any questions? So what we need from all of you is,
 25 if you're looking to bring peer support planning, I

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 2 know, I looked at Dr. Dailey and I was like, I have
 3 more to say.
 4 So if you're looking for us to come in
 5 or want to talk to us about training, we're hosting
 6 some of these trainings in the capital district.
 7 Like I said, we're working with the Sheriff's
 8 Association as well.
 9 We would like to have all of the
 10 agencies, E.M.S. of New York State, Sheriff's
 11 Association, everybody come together and say, all
 12 right, we're going to agree that this is a good level
 13 set of training. And that way everyone has the same
 14 language.
 15 So at some point, I would like some of
 16 your leaders to come meet the sheriff's office
 17 leaders and get some of our fire leaders, in-house
 18 communications and get everyone together and make
 19 sure that this is the direction we want to go.
 20 And create that legislative action
 21 community that includes first responders and the
 22 mental health side. So we can come up with policy
 23 and legislation together that we can work on and make
 24 sure is solid across the board and support each
 25 other. The end.

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 2 **CHAIR DOYNOW:** Thank you, Katie. Any
 3 questions for Katie? Okay.
 4 **MR. GREENBERG:** If I can comment, just
 5 one thing on it. You know, we talk about mental
 6 health and well-being of our providers and actually
 7 even just yesterday, I was having a conversation
 8 about this is not just about our E.M.T.s and
 9 paramedics.
 10 But, you know, across healthcare, you
 11 know, including nurses and physicians and things of
 12 that nature and so. But we're always kind of asking
 13 the question of, okay, well, what's the first step or
 14 what we can do or how do we get there.
 15 So I know there's been, you know, some
 16 work within the Bureau and we're working on some
 17 programs. Katie, you know, thank you for being here
 18 for yesterday and for today and the programs you're
 19 doing. I think, you know, kind of next steps on
 20 things too is to hear from each of your agencies as
 21 medical directors, you know, what are you doing, has
 22 something worked, has something not worked.
 23 Because I think it's equally important
 24 to hear what hasn't worked because that tells us,
 25 hey, let's not recreate that wheel of doing the wrong

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 2 thing again. So, you know, if there is an avenue or
 3 a pathway or something or maybe to sit and leave this
 4 on for, you know, old business for next meeting to
 5 follow back up on and see if there is anything more
 6 on steps we can take or things that kind of push that
 7 forward?
 8 **MS. OLDAKOWSKI:** Ryan, I just want to
 9 add, we have two interns that are going to be
 10 starting with us that we have for the full summer.
 11 One of their responsibilities is actually going to be
 12 Statewide mapping of the resources specifically out
 13 there for first responders.
 14 We want to target, who are the
 15 therapist, counselors, the recovery, whatever it
 16 looks like for the first responder community and
 17 provider community. Map that out, and then, make
 18 sure if there's peer support, things that work,
 19 trainings that work.
 20 We don't want to recreate the wheel
 21 and what we're seeing in all spaces is a recreation
 22 of the wheel. And we want to bring it all in-house.
 23 And what I talked to, I had a meeting with the
 24 Sheriff's Association this morning, evaluate these
 25 trainings and see what works and what doesn't work

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 2 and make those evaluations public.
 3 So that we know that this is vetted by
 4 first responders, by the provider community to say,
 5 great, this is working, this is not working. This is
 6 what the feedback is for these trainings and make one
 7 universal kind of evaluation form that goes with
 8 that.
 9 Because again, we just had a training
 10 out west. It was mixed reviews, right, but they
 11 didn't know what the training was going to look like.
 12 So again, we're looking at the different pieces of it
 13 and figuring out. So the interns, you may hear from
 14 them.
 15 **CHAIR DOYNOW:** Thank you, Katie. Any
 16 other questions or comments? Okay, a few
 17 announcements before we -- we adjourn. Next meeting
 18 will be September 18th, please note it's at the
 19 Embassy Suites in Saratoga, not here in Troy.
 20 E.M.S. Memorial has been moved to
 21 September 19th from May. Hopefully everybody will be
 22 there. And one last retirement that I'm aware of,
 23 Dr. Markowitz, this is his last meeting and he's
 24 retiring. Thank you for all your years of service,
 25 Dr. Markowitz.

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 2 And I must say, happy ballooning,
 3 since I know you're a balloonist. I guess that's
 4 what we say. Any -- any other business anybody wants
 5 to bring up?
 6 **MR. GREENBERG:** Yes, so just one
 7 thing, we did tie the E.M.S. memorial intentionally
 8 with the meetings. The memorial, for those of you
 9 who weren't aware, was supposed to be delivered, the
 10 new memorial was supposed to be delivered in early
 11 May.
 12 It unfortunately, in production,
 13 wasn't going to make it in time, so we made the
 14 choice of moving things to September to make sure it
 15 got right and we tied it to these meetings so that
 16 those who are attending SEMAC and SEMSCO, it will
 17 follow most likely at eleven a.m. on the Thursday
 18 after SEMAC and SEMSCO.
 19 Again, SEMAC and SEMSCO is up in
 20 Saratoga and we are working on dates for 2025
 21 meetings. Hopefully those will be out by the end of
 22 June. And we'll be able to give you confirmed dates
 23 as well as locations for all of those meetings as
 24 well. Thank you.
 25 **CHAIR DOYNOW:** Okay. And I've been

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 2 informed there's one new piece of business that just
 3 came up before we adjourn.
 4 **MR. RABRICH:** Thanks. So -- so -- one
 5 little piece of new business. There was a discussion
 6 at MedStandards regarding opioid antagonists and
 7 which are the most appropriate to use. So there was
 8 no seconded motion.
 9 But wanted to make one now that the
 10 SEMAC endorsed the current opioid antagonists remain
 11 the only ones approved for public safety use by the
 12 Commissioner.
 13 **MS. BOMBARD:** Second.
 14 **CHAIR DOYNOW:** Okay. Any discussion?
 15 **MR. DAILEY:** Thank you. So I
 16 apologize that this actually is coming forward as a
 17 primary motion here rather than a seconded motion
 18 from MedStandards. But I think it's important that
 19 we do discuss this a little bit.
 20 You know, we focus a lot on the -- on
 21 opioid overdose right now. And it is a horrible
 22 scourge on our communities. And I don't want to
 23 minimize that. But at the same time, I want to focus
 24 on a couple of things that I think will be of -- of
 25 help to the Commissioner, as he makes decisions as to

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 2 which opioid antagonist should be approved for use by
 3 public safety without a patient specific order across
 4 this -- across the State.
 5 The biggest question I think that we
 6 have behind any medical intervention first is do we
 7 need it. And the second and most pertinent to us as
 8 physicians is actually whether or not an intervention
 9 will do any harm. Opioid antagonist administration
 10 is something that has been worked extremely
 11 successfully through our E.M.S. interventions and
 12 into public safety and law enforcement.
 13 We're using naloxone right now. We
 14 use both a two and a four-milligram formulation in
 15 E.M.S. And currently we've studied the eight-
 16 milligram formulation as well. But do we need either
 17 stronger or longer acting opioid antagonists.
 18 And I think it's important for us to
 19 focus on that. First, the data from our State police
 20 study. We studied the eight milligram versus the
 21 four milligram formulation at three of the eleven
 22 troops across New York State.
 23 When we did this, we found out that
 24 actually there was a significant increase in
 25 withdrawal symptoms, including vomiting among those

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 2 patients who receive the eight-milligram formulation
 3 of naloxone. As we all know that vomiting can lead
 4 to aspiration and can be significantly -- can create
 5 significant morbidity.
 6 **MR. DAILEY:** And that ties to that is,
 7 have we had patients that didn't receive enough
 8 naloxone? And the reality there is that the patients
 9 who got the four milligram formulation received about
 10 one point seven doses of naloxone.
 11 The patients who got the eight
 12 milligram naloxone got about one point seven doses of
 13 naloxone. And looking historically back at our two
 14 milligram data as well, those patients also received
 15 approximately one point seven doses of naloxone.
 16 So I don't think we don't have a
 17 strong enough formulation of the medication. The
 18 other thing that ties into this that's incredibly
 19 important is, we reviewed the fatalities that the
 20 State police attended. And of the patients that
 21 received either the eight milligram or four milligram
 22 formulations, ninety-nine percent of the patients
 23 that were potentially able to be saved, were saved if
 24 the State police arrived.
 25 Now, we've never looked at a true

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 2 fatality review like that before, but I think this is
 3 some of the data that we really have to calculate.
 4 The other side is, what about harm? Is there harm if
 5 we give people higher doses of naloxone? Is there
 6 harm if we give longer acting agents?
 7 And I think the answer is
 8 unequivocally yes. The reality is that reversal of
 9 overdose is about respiration, not conversation. We
 10 need to make sure that we get people appropriately
 11 breathing. Right now, we have contamination of the
 12 drug supply by xylazine.
 13 By one there that I saw the other day,
 14 which is Bromazolam, which is a non F.D.A. approved
 15 illegal benzodiazepine that's now in the drug supply.
 16 But no amount of naloxone or any other opioid
 17 antagonist is going to reverse either of those
 18 agents.
 19 So we need to focus on the concept of
 20 respiration. Now, if you look and you talk to people
 21 who use drugs about the potential for harm, the
 22 biggest harm we can do is by giving somebody a
 23 horrible -- a horrible reversal.
 24 If they have a horrible reversal,
 25 there's every chance that they will start to use

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 2 alone. Using alone and not having somebody in a
 3 position to rescue them is going to give them no
 4 opportunity for antagonist administration prior to
 5 their death.
 6 We need to make sure that we take into
 7 account what is affecting the people who use drugs as
 8 we're looking at the interventions that we are going
 9 to ask public safety personnel to perform. So with
 10 that, I'd like to make a plea from this group.
 11 Endorse Dr. Rabrich's proposal, let's
 12 make sure that nalmeferene does not make its way into
 13 the formulary in New York State. We don't need a
 14 longer acting antagonist agent because that longer
 15 acting antagonist agent is just going to prolong
 16 somebody's misery of withdrawal.
 17 We don't need higher dose of naloxone
 18 because the ones that we have are working. And we
 19 need to make sure that we are watching the data
 20 extremely carefully so that we can follow -- follow
 21 the data and then make sure that we can guide
 22 medicine appropriately. So thank you all for
 23 supporting Dr. Rabrich's motion.
 24 **CHAIR DOYNOW:** Dr. Rabrich, would you
 25 like to make the motion a little more specific?

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 2 **MR. RABRICH:** No. I mean, I think the
 3 motion is that the -- that the SEMAC endorsed the
 4 currently in use opioid antagonist, which is
 5 naloxone, basically. And that the only antagonist
 6 for public safety use approved by the Commissioner.
 7 **CHAIR DOYNOW:** Okay. Go ahead.
 8 **MR. WINSLOW:** Yeah, I -- I agree with
 9 -- with both Dr. Dailey and Dr. Rabrich are saying
 10 and getting at. I think that nalmeferene is not to be
 11 used by E.M.S. providers out of a safety profile
 12 concern. We do need to consider removing it
 13 therefore, from the alternate medication formulary so
 14 there is no mistake.
 15 So I -- I -- I will highly recommend
 16 we support the motion. And then afterwards I suggest
 17 we remove it from the alternate medication formulary
 18 before it goes live.
 19 **CHAIR DOYNOW:** Okay. I believe that
 20 Dr. Rabrich can modify his motion to include that.
 21 **MR. RABRICH:** So modified.
 22 **CHAIR DOYNOW:** Okay. All right. And
 23 I guess we need another second since we've changed
 24 it.
 25 **MR. BOMBARD:** Second.

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 2 **CHAIR DOYNOW:** Okay.
 3 **MS. BOMBARD:** Second.
 4 **CHAIR DOYNOW:** Any discussion before
 5 we vote?
 6 **MS. BOMBARD:** Second. Second, second.
 7 **CHAIR DOYNOW:** Okay. Can we have a
 8 roll call vote?
 9 **MR. GREENBERG:** Before you do the roll
 10 call vote, can you just make sure Theresa has the
 11 final verbiage of what that motion would be? I know
 12 there is been some changes.
 13 **MS. ALLEN:** I will get it?
 14 **MR. RABRICH:** Yeah. I will get it to
 15 you, yes. Okay.
 16 **MS. ALLEN:** Dr. Bombard?
 17 **MS. BOMBARD:** Bombard, yes.
 18 **MS. ALLEN:** Dr. Cooper?
 19 **MR. COOPER:** Cooper, yes.
 20 **MS. ALLEN:** Dr. Cushman?
 21 **MR. CUSHMAN:** Cushman, yes.
 22 **MS. ALLEN:** Dr. Dailey?
 23 **MR. DAILEY:** Dailey, yes.
 24 **MS. ALLEN:** Dr. Doynow?
 25 **CHAIR DOYNOW:** Doynow, yes.

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2 MS. ALLEN: Dr. Isaacs?
3 MR. ISAACS: Isaacs, yes.
4 MS. ALLEN: Dr. Kugler?
5 MR. KUGLER: Kugler, yes.
6 MS. ALLEN: Dr. Markowitz?
7 MR. MARKOWITZ: Markowitz, yes.
8 MS. ALLEN: Dr. Olsson?
9 MR. OLSSON: Olsson, yes.
10 MS. ALLEN: Dr. Rabrich?
11 MR. RABRICH: Rabrich, yes.
12 MS. ALLEN: Dr. Walters?
13 MR. WALTERS: Walters, yes.
14 MS. ALLEN: And Dr. Winslow?
15 MR. WINSLOW: Winslow, yes.
16 MS. ALLEN: Motion passes.
17 CHAIR DOYNOW: Okay. Thank you. Any
18 other business before we adjourn? Okay. Can I have
19 a motion to adjourn?
20 MR. COOPER: So moved.
21 CHAIR DOYNOW: Thank you, Dr. Cooper.
22 Anybody against? I don't think so. Okay. See
23 everybody in September.
24 (The meeting adjourned at 1:00 p.m.)
25

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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 81, 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 2024.
11
12
13 DANIELLE CHRISTIAN, Reporter
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