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Chair Doynow CHAIR DOYNOW: Everyone welcome. Let's start out with the Pledge of Allegiance, please, if we can all stand. I pledge Allegiance to the flag of Unfoted States of America, and to the republic for which it stands

Speaker 2 one nation under God, indivisible, with liberty and justice for all.

Chair Doynow Thank you all. Now if we can have a roll call.

Speaker 3 MS. OZGA: Yes, good afternoon, everyone. Good afternoon, everyone. OK. Dr. Alexandrou. Is that there, Alexandro, on virtual? OK. Dr. Bart, here; Dr. Berkowitz. here; Dr. Cherise Berry, here; Dr. Tiffany Bombard, here; dr. Arthur Cooper, here; dr. Jeremy Cushman, here; Dr. Michael Dailey. Note, for the record, Dr. Dailey is here, doctor DeTraglia, here; Dr. Doynow, hear; Dr. Gomez, Dr. Kugler,

Speaker 2 Dr. Kugler here;

Speaker 3 Dr. Joshua Lynch, dr. David Markowitz, dr. Matthew Maynard, here; Dr. Lewis Marshall, here; Dr Pam Murphy, Murphy here; dr. Olson, Dan Olsson

Speaker 2 Olsson here;

Speaker 3 Dr. Pigott.

Speaker 2 Greg Pigott from Suffolk County, I'm here remote, we have Dr Jason Winslow also in the room for Suffolk County.

Speaker 3 Thank you very much, Dr Matthew Talbott, here; Dr Brian Walters, walters here; dr Robert Wiceliniske, Wicelinski here; non-voting members, Oren Barzilay, Aidan O'Connor,

Speaker 2 Good afternoon, Present virtually.

Speaker 3 Mark Philippy, Mark Philippy Present; Maryanne Portoro, let the record show Maryanne is on virtually, Dr. Rabrich, Michael McEvoy, hear; michael McEvoy is present Steve Kroll, I see his face. John Washko, present; we have 18 voting members and we have a quorum.

Chair Doynow CHAIR DOYNOW: Excellent, thank you, Mr. Chair.

Speaker 4 I also want to recognize First Deputy Commissioner Dr. Heslin, who is joining us as well.

Chair Doynow A few opening comments before we start the meeting, unfortunately, today is Dr Young's last SEMAC meeting. He is retiring. He's been a great help to myself and the SEMAC for years. We are going to miss him and I did want to mention a few of his accomplishments in his career. He serves as the acting associate commissioner and medical director for the western region, was a practising emergency physician for over 30 years. He received his medical degree from SUNY at Buffalo School of Medicine. They maintain board certifications in both emergency medicine and internal medicine. He has served as an associate clinical professor of emergency medicine and assistant clinical

professor of internal medicine for SUNY Buffalo. He was a former chair of emergency services for Millard Fillmore Hospital System. He served as clinical chief of emergency medicine at five other hospitals. Position he maintained until joining the department in 2002. He has been published as a participant in research studies related to emergency medicine services. He is a fellow of the American College of Emergency Physicians and American College of Physicians, and he currently maintains active membership and leadership responsibilities on numerous regional and statewide boards and committees, and I personally will miss his knowledge and help every schematic meeting. Thank you, Dr. Young.

Speaker 2 I appreciate it.

Chair Doynow Any comments you'd like to make to the group?

Speaker 5 DR. YOUNG: Well, it's been a real honor privilege to have been part of this group started back and ready for this 1985 is when I came forward and joined the what was the Medical Standards Committee for some school at the time. I had the pleasure of working with ACIP reps. Mike Jacoby, Steve Linde, some of you remember them. Art Cooper was around. A number of you in the audience were. We worked together as a team and we developed the first Basic Life support protocols. And we also rewrote Article 30 to include these things called REMACS, which I had the pleasure of sharing for many years out of my region. So it's been a wonderful time. It's great seeing where you've gone. I remember I've always sort of been a, you know, I speak my mind, sort of. I think most I think most of you know that. And I remember when at the end of the SEMSCO days, I said it was too Jacobus. I said, I'm Mike, OK, we've done Basic Life support. Let's do the ALS protocols. Because Greg, no, no, no. This SEMAC is going to form next year because he says, I think you're going to be on it as well. SEMAC will have that done. We'll get that done in a year or two. Well, that was back in 1990 something. And I I remember as soon as we deliberated and we heard the strong opinions from folks that they felt there were a lot of there was a need for regional variation that someday maybe we do it, and I'm glad I've lived long enough to see the collaborative efforts that you're all doing. And so by the time I need emergency care, I know whether it's in the city or Long Island or buffalo wherever, I know I want to get the same care. So I thank you for all you're doing and for continuing with the charge because it's going to be a it's going to be exciting times two years ahead. I wish I could still join you, but it's it's time. So thank you all so much.

Speaker 2 Thank you.

Chair Doynow CHAIR DOYNOW: Thank you, Greg, we will miss you. Other opening comments, some of you may know that Mark Philippy and myself met with Commissioner Bassett virtually. She was very supportive of this group. She's very supportive of forming a statewide EMS medical director of which we've been charged to put together a job description. More on that later in the meeting. But it was a very, very, very good meeting and hopefully we'll have future ones or whatever. Moving on here, let's have approval of the January minutes. Do we have anybody who would like to make that motion? dr. Kugler, anybody a second

Speaker 2 dr. Marshall second.

Chair Doynow Dr. Marshall second. Anybody against that, the easier way of doing this virtually. OK, the minutes have been approved. Ryan, it goes to your Bureau Bureau staff report.

Speaker 4 DIRECTOR GREENBERG: Thank you so much. We do have our bureau staff report, but if it's OK with you, I'd like to go a little bit out of order than what we had originally planned. And we would like to start off with what I believe is the first time that we will be issuing a state EMS. Lifetime Achievement Award to Dr. Young. While the team walks up. You know, Dr Young has spoken about a lot, and I've only been here about four years, four years, actually next week, which is nothing compared to Dr Young's 35 years of state service in many different roles. Dr Young is the Associate Commissioner and the medical director for our western region. He has also been an emergency department physician for the past 30 years, is board certified in emergency medicine and internal medicine. But as you start to look at his CV, you really start to see the history. He's a founding member of the Western REMAC. Not many people can say that one. He has also started his career pre state service before he actually was a state employee as a committee member for the SEMAC Medical Standards from 1987 to 1997. I won't tell you where I was in those years. He also served as a SEMAC on the SEMAC committee from 1995 to 2002. He's been the medical director. Like I said, we became a state employee in 2002. Starting off as a medical director for the western region and then the associate commissioner since 2009, he has a lot of accomplishments. But I will tell you probably, and I will tell you, at least me personally, one of the most amazing is he is a historian. He is an advocate for EMS. He wants right by the patient and by the provider, and did everything, everything he could at every turn to help achieve those. For those of you who know him a little bit more on the personal side or if you follow any of him on Facebook, you will also know that hopefully he will enjoy his retirement. I am told that is Honey Do list is quite long of things that the spouse may want. He will hopefully be chasing many grandkids, but also that his avid in the STEM program, in helping children and helping people learn about technology moving forward and hands down one of the best family Christmas displays I've ever seen. That means actually make it out to you. And so for many, many reasons, it's a true honor to issue the first state EMS. Lifetime Achievement Award to our very own Associate Commissioner, Dr Young. Got to pick this up to say the State EMS Lifetime Achievement Award is presented to Dr. Gregory E. Young in recognition of your thirty five years of dedicated service to New York State EMS system and the New York State Department of Health. Your knowledge, expertise, professionalism and commitment to quality has been instrumental in the growth and development of the New York Stadium system. Thank you for your service to all the EMS providers and the residents of New York City.

Speaker 3 You have to figure out how to get it back and what.

Unidentified Talk to you the most. A lot of it

Speaker 5 DR. YOUNG: I'm overwhelmed, thank you for this honor, and it again, it all goes out to all of you. We've all been a team over the years and I know you're going to continue to go forward and health care is going to just keep on improving in New York state thanks to everything you're all doing. Thank you so much.

Chair Doynow CHAIR DOYNOW: Congratulations, you. But if we're ready for it, Ryan, if you want to go ahead with the bureau report.

Speaker 2 All right.

Speaker 4 DIRECTOR GREENBERG: So some staff updates are staff reports. Thank you to everybody, by the way, who's able to attend here and who's attending virtually. Our

COVID operations continue. Shockingly enough, what many people may or may not know is up until just about two weeks ago, we had over hundred and twenty five assets do federal assets and state mobilization assets responding to our COVID emergencies, and they were dealing a lot with load balancing, backing up the EMS systems in New York City and throughout the entire state. Actually, a majority of the work was done upstate in this particular case. Big thank you to District Chief Lenihan, who really led that team, as well as District Chief Picardo and the entire staff who were all a part of that one. On the operation side, we're happy to say that we are starting to get back to some normal operations agency inspections, ambulance inspections and some of the normal paperwork that comes with it, which has definitely taken a slight pause over the past two years. There's some major developments going on in some technology platforms that we're continuing to put into place, including a statewide diversion platform that would allow any provider to go on to a website and see live any diversions that are out there. I know some regions have some systems. We are working on one statewide system. It would be free to the entire state currently. Right now we're actually in beta testing of it and we're hopefully it would roll out in the second quarter of 2022. More information on that one will definitely be available by the next meeting on whether or not it probably will roll out by region. Just to let people know on the administration side, Lynn Perugia, who is with us for a number of years, has transitioned to a new position in the Department of Health, and we're very happy for her for that one, and she's helping us in the transition since she's left. And Chief Clayton has taken on the roles for a short period of time to help on the administration side. Thank you on that side. Part of that, though, in being successful is also we're happy to report that we have several new staff members. Todd and Shannon and Tony are all new staff members stood out and I know many of you are already working with Shannon. We had actually asked her to show up today so she can meet many of the program agencies and REMSCO Chairs wave Shannon. And now everybody know who she is. Please go up and introduce yourself to her. And we're very excited, particularly for this group to announce that Teresa has come back to our group. She was with the bureau prior in education. She has since returned back to us and her job will actually be to work with the REMSCO and the SEMSCO and the SEMAC and be both a contract support, but also State Council support. So one of the things that we have identified is there's no question the amount of work in progress that's being done now that these council members and we know how much time Val has in her day, that we need to get more support and more focused support. And so we're happy that a portion of her job responsibilities will be just to support these council operations. So very excited about that part and to have Teresa part of the team community power medicine. So we've we've heard a number of things about community para-medicine. Obviously, many of you know about the part F definition change that unfortunately did not go through, and there's been questions on whether or not community para-medicine will continue. For those who are wondering, community para-medicine is still in effect through the executive order that is in place. However, as soon as that executive order expires, which it currently right now, renews every 30 days, all community paramedicine programs would have to stop. So keep that one in mind. So a little upsetting on that one. For those of you who don't know, we have just over 50 community paramedics and programs and they are in over 40 counties. You know, one of the other challenging parts, too, that we've been asked is, Well, what about vaccinations? Will EMS providers still be able to vaccinate? And the answer is no. Once the executive orders do conclude, then the ability for our community paramedics and programs, as well as for EMS providers to vaccinate will no longer be an option on the education side. There is a new higher drew who's, I think, somewhere in the back. I don't know if he's still here. Nope, he left. OK? So Drew Chesney has joined the team. Also, if you get an email from George Chesney. That's Drew. He goes by his middle name, so don't get confused. Uh, the regional faculty training program is being developed right now, and we've made some

significant progress on that one. And for the CLI classes, for our lab instructors, we're actually moving that one to a class that will be online or the the portion of it will be online and then the in-person for skills. And so you'll be looking forward to that one in the near future. And data and informatics are really happy to see great progress, both with the paper PCR portal and the agencies who are submitting their paper PCR that way, as well as a number of agencies who have gotten on board with the image trend, the free platform or by purchasing their own PCR EPCR platform. More agencies on board allows us to give real data and informatics and look at the state statewide. For those of you who are wondering about 50 percent of our agencies prior to these rollouts, we're still on paper and it made it very challenging. We were upwards of about a year and a half later to when their paperwork would actually be entered in. And obviously, it's a little bit outdated now. We're normally, even if they're charting on paper, about a week to two weeks out from when their chart is actually submitted. For some basic data, at least. Does that sound right, Peter? And the number of agencies that are on the free platform is nearing 500 agencies, so about 500 agencies have taken advantage of our free EPCR platform through image trend. One of the presentations that will happen a little bit later today is biospatial. This is a new analytic platform that hopefully will be rolling out towards the end of 2022. Very excited about that one and being able to look at different things, different trends and really to look at this group to turn and say, What do we want to look at? How do we want benchmark it? The partnership with Biospatial has been phenomenal. Our our quality assurance group is working with them and has had a presentation with them, so we'll be providing quality metrics in there. But I also would encourage particularly the physicians and this group to think about what are other things that are valuable to look at and to monitor, and we can see if that can be put into those as well. Our EMS-E. program, there's recent the recent meetings that just happened a couple of weeks ago. They discuss some new protocols and some update to things and did some work as well as with the pandemic protocol. I believe that you'll be talking about later today. Anybody who's interested in becoming a PEC or if you're not a PEC, please contact Amy Eisenhower. She will be taking on the responsibilities of working with new PEC'S, as well as the EMS for Children's Web pages had some significant updates to it in regards to our trauma side there. Our next meeting is the first week in May for Vital Signs Academy or site vital signs that is happening in Albany right here. Actually, this will be one of the rooms October 27 to the 30th, so we hope everybody can attend now that you know how to find your way here. For those regarding sorry regarding the EMS Memorials are EMS Memorial, this year will not happen in May and we have moved it to September, which is in line where we were last year. This is not a permanent move. This is a temporary move because unfortunately there is no more space for any more stars and there's an expansion that needs to happen. I would like to thank the six or seven members of the State Council who have participated in determining what that future memorial would look like, playing a very active role, working with myself and Valand OGS to understand what our options are for the future. We have determined what that will be. We are working or should I say yes, is working on ordering the stone and the memorial will be happening Tuesday, September 20th. Hopefully seeing the stone comes in in time. And I say that because there seems to be a shortage of everything. But we do believe in part of the reason that we moved it from May to September was to meet the ability to update that stone. There are 10 honorees who are going on the memorial this year. And again, thank you to everybody who's participated in what the future of that memorial will be, as well as some members of that committee who have really added a storyline to the meaning of how things will go in the future on that. And so just the personal touch in that storyline, it's really, I think, important to the legacy of that from the director's office. EMS Week is coming up in May, so everybody here please think about that one. What are you doing? Maybe an opportunity for recruitment, retention or even just recognition? You know, we we often are so focused on recruitment. We forget

that we also should value the people who were there and making sure that they enjoy the organization and want to stay. For those of you who are interested in putting in for EMS week awards, that will open up, most likely next week, we'll be sending out a link to all the program agencies, and we encourage you to submit if you have someone who is worthy of that. We are very excited to announce that a probably two year project right now for digital EMT cards, as well as EMS instructor cards will be going live. The project is actually done. We're just working on the instructions that will go out to the program agencies as well. With those instructions are. And then to distribute out to the agencies. So in regard to the digital card, they will tell you that we will still be printing cards. Education will still be printing cards. When you're first, complete your class, but you will also have the option to go online and to get a digital card. Or maybe you lost your card and you can go online and get digital cards. So that will be coming out, most likely by May 1st. For those of you who are not familiar with the sustainability tag, the EMS sustainability tag, a terrific work being done. I think there's a report out later on that. But truly, this started as a what was a small group and has become a very, very large group looking at some great things from different ideas. Just want to give a thank you to all those for Surge and Flex Operation Center? The bureau continues to run that 24 hours a day, seven days a week and just to give you some numbers. So from September to March, they've handled just under 6000 cases through the Surge Operation Center. They've handled just about 2700 diversion notifications. Coordinated transport requests for just under 4000 patients dealt with about 350 bed matching requests, sent out multiple strike teams at strike teams to help in EDs that we're having capacity issues and dealt with just under 10000 911 requests of support for number one. So just a little bit of an idea of what's going on over there from regulation side and updates to regulations. So for those of you who had asked prior to Part F did not pass, the statute is not changing. However, there are some things that were on the docket prior to COVID related to regulatory updates, some related to the safety committee and operations and equipment for vehicles, as well as others that are recruited to the education standards. We're hoping to have that process moving and possibly even out for public comment between now and the next council meeting. So please keep your eyes open for that one when they do go out for public comment. We will again share it with all the program agencies. Please take the time to look at it. Make sure that it meets all the needs. And if you have any comments that go along with it, the executive orders, they are still in place. 4.7 related to staffing emergencies expires April 30th. Eleven point four related to COVID emergencies expires April 15. Again, many of those things relate to EMS, relate to reciprocity, relate to different things that we're able to do that. Unfortunately, things like community paramedicine that could come to a pause after that. So please keep that one in mind for those of you looking for an update on the role of task force. We are now in the process of selecting the members we are waiting for. A lot of the elected officials who have different positions to the assembly gets two nominees. The Senate gets two nominees the Department of Labor gets two state fire gets two city muskets two. So right now that is being built into it. There's about four of the 16 positions that are already filled and several that are in the vetting process. So we are just waiting on that one to move that forward. Really excited to to say that we had a very successful EMT pilot program where we did an EMT academy style pilot program that happened in February and March. There were about 650 students who entered into the program. Some of them, about 400 of them, were National Guard members. About 250 were civilians. We are working sorry, about 250 were civilians. Over four hundred and fifty of those who entered the program are already certified providers and many of which are using those skills. We have about another a good amount that are still waiting to test. And of course, being at this went through the middle of omicron and things like that. There were several of them who unfortunately weren't able to complete the process and are looking into taking an EMT class at another time. But thank you to you and Chief McMillan and Deputy Chief Taylor and everybody

from the education unit who helped to make that program happen, as well as everyone from the administration who helped to make the contracts happen for that one. It was not our traditional model of how we did it, but it definitely was a proof of concept, with a lot of lessons learned to length of class Type of class type of learning. We are in the process of putting together a survey to further learn from that one and figure out which classes worked really well, which ones had their challenges, and hopefully to identify what those challenges are. And then the last part which we moved to the front, which was our first state EMS Lifetime Achievement Award. But Dr Young, I just want to again say thank you for everything. Thank you for all your advice and wisdom and historian. And I hope you realize that you can try and leave, but will probably still be calling you. So thank you.

Chair Doynow CHAIR DOYNOW: I think, Dr Young, you need to change your cell phone number. I don't know.

Speaker 2 I'm turning it in.

Chair Doynow But let's move on to standing subcommittees. Dr Marshall, if you'd like to begin.

Speaker 2 DR. MARSHALL: OK, thank you. Good afternoon, everybody. Medical standards met earlier this morning, and we have three action items to bring forward and seconded motions from medical standards. And then a few items for information purposes. So I will do the motions first and the Valerie is going to put it up on the screen.

Speaker 3 But which one do you want to start with? Dr. Marshall? Number one was that a trick question. Hold on, I got.

Speaker 2 But I think a number of people.

Speaker 3 Yeah, the ones first. All right.

Speaker 2 So the second in motion was to approve, so we had a discussion, a long discussion on the pediatric viral pandemic triage protocol that we had asked EMS-C to to work on. And they did a lot of work on this and brought forward a very nice document after some discussion. We made some recommended changes, which you see here. We accept the pediatric viral pandemic triage protocol with the following changes vital signs. So in box number three, if you remember, there's a set of. Vital signs or parameters for respirations, pulse and systolic blood pressure on top of that is a statement which you see here vital signs consistently outside these normal parameters. So we're going to bold the word outside. And we added the word normal. So in addition to that, we're going to remove the systolic blood pressure column. Because there was a lot of discussion on that in terms of, you know, you already have criteria that would identify children who are ill based upon work of breathing, capillary refill, modeling, cyanosis, et cetera, and and blood pressure may or may not play into it. And the accuracy of blood pressure, especially in newborns and infants, may not be that accurate. In addition to that, on the adolescent side, since this is for children under the age of 15, we changed it from 13 to 18 years to 13 to 14 years in the vital signs grid. And that's consistent with what we have done in the past. In addition to that, the last change we made was because this is we wanted to make it more of a generic pandemic triage protocol in the final box on the bottom of the red box. We're just removing the COVID 19. So we'll just read provide the patient with the New York state, the DOH hotline number and patient information packet. And that comes forwarded as a second in most.

Chair Doynow CHAIR DOYNOW: Thank you. Is there any discussion? OK, if we can have a Roll-call vote.

Speaker 3 OK. Dr. Bart. Yes. Dr. Berkowitz, yes. Dr. Berryf. Dr. Berry. Dr. Bombard. Yes. Dr. Cooper. Yes. Dr. Cushman Cushman, yes. Dr. Dailey Dailey, yes, Doctor DeTraglia. Dr. DeTraglia Dr. Doynow. yes. Dr. kugler Dr DiTraglia is a yes. dr. Kugler,

Speaker 2 Yes. And thank you again, Dr Young Dr. Lynch.

Speaker 3 I'm sorry he's not here today. Dr. Maynard. Maynard, yes. Dr. Marshall Marshall, yes, Dr. Murphy. Murphy, yes. Dr. Olsson

Speaker 2 Olsson yes

Speaker 3 Yes, Dr. Pigott, pigott Yes. Dr. Talbott, yes. Dr. Walters.

Speaker 2 Walters, yes.

Speaker 3 And Dr. Wicelinski.yes. oK, thank you very much. Motion passes.

Chair Doynow Thank you, Bill. Dr. Marshall would continue.

Speaker 2 DR MARSHALL: Yeah. So the next second emotion that comes forward, I. Wanted to do. Number three, the adult pandemic. Three hours. Yes. So being consistent with the pediatric pandemic for the adult pandemic triage protocol, the final box at the bottom in red, we are also going to remove COVID 19 to make it more generic and that come forward it as a second emotional.

Chair Doynow OK, thank you, Dr. Marshall. We'll need a Roll-call vote on this as well, please.

Speaker 3 Dr. Barak. Ah, yes. Dr. Berkowitz reports, yes. Dr. Bombard, bombard, yes, I did, Dr. Barry. It's Dr. Barry on. OK. Dr. Cooper. Yes. Dr. Cushman Bushman, yes.

Speaker 2 Dr. Daley Daley, yes.

Speaker 3 Dr. Richard Yang d'Italia Yes, Doctor. Join now. I'm going, Oh yes, Dr. Kugler. Yes. Dr. Maynard. Maynard, yes. Dr. Marshall.

Speaker 2 Dr Marshall, yes,

Speaker 3 Dr Murphy, I can report yes. Dr. Olson,

Speaker 2 yes.

Speaker 3 Dr, pick it again.

Speaker 2 Yes.

Speaker 3 Dr. Talbot. Yes. Dr. Walters. Walters, yes. And Dr. Wicelinski, yes, motion passes.

Chair Doynow Thank you, Dr. Marshall, continue.

Speaker 2 DR MARSHALL: Yeah, the next one, we actually had some discussion about the opioid pilot project. Dr. Dailey discussed it a little bit, and we're waiting for some information from BNE and the DEA. But after that discussion in preparation for approval of this pilot project. The motion was made to add buprenorphine and naloxone to the state EMS formulary, and that was approved unanimously with very little discussion.

Chair Doynow Thank you, Dr. Marshall, one more roll call vote, please.

Speaker 2 DR OLSSON: Can I say something real quick olsson I would ask dr dailey and dr cushman talking about a combination drug, right? Not two separate drugs. Yes, sir. Well, because the naloxone is already in the formulary. It's the combination, agent Dr. Olsson. All right, so it should be buprenorphine slash naloxone. I suspect,

Unidentified yes. Thank you.

Chair Doynow CHAIR DOYNOW: Any other discussion? Val, one more time, please.

Speaker 3 MS. OZGA: OK. Dr. Bart, yes; dr. Berkowitz, Berkowitz, yes; dr. Bombard, bombard yes; dr Cooper, Cooper, yes; Dr. Cushman, cushman yes; dr. Dailey

Speaker 2 Daley yes;

Speaker 3 doctor DeTraglia, dr DeTraglia yes; Dr. Doynow, yes; Dr. Kugler, Dr. Kugler.

Speaker 2 Yes;

Speaker 3 Dr. Maynard. Dr. Maynard yes; Dr. Marshall. Marshall, yes; Dr. Murphy. Dr Murphy, yes; dr. Olsson.

Speaker 2 Olsson, yes, Dr.Piggot. Yes.

Speaker 3 Dr. Talbot. Yes. Dr. Walters. Walters, yes, Dr. Wicelinski, yes, motion passes.

Chair Doynow CHAIR DOYNOW: Thank you, Val. Dr. Marshall, did you want to speak about the collaborative protocol committee structure?

Speaker 2 DR. MARSHALL: Yeah, so we had there were a couple of discussion items, one was the collaborative and the collaborative update. And Dr. Daly reviewed some of revealed that there are some changes that were made over the year and have been included in the collaborative, which will be posted, I believe after this meeting and after all these meetings, these two days. And we talked about the process for the collaborative in terms of. Collaborative, asking for input from other groups, and then if whatever the input is coming back should go to the collaborative before coming to MED standards and SEMAC. So we're going to work on that after that. As part of that, we also had a discussion about defining advisories, policies, procedures and protocol, and Dr. Cushman was kind enough to find for us a draft document from December of 2019 that the committee developed and that was made right before the pandemic. So I think it kind of got put on the back burner. So I would like that the discussion the working group to discuss procedures, protocols and definitions could start with that document because I

think it's very well done. So thank you, Dr. Cushman, for that. The other information items were the scope of practice document, which was approved in January. They were January packet as well as telemedicine visits, and I had asked committee members to please take a look at those documents and if there's any changes you would like or updates or were things we should consider. So please let us know. And then the last information item and maybe Dr. Murphy might want to join in. Here is an update of the I-GEL pilot project that's been approved as a concept, and we're waiting for some additional information which Dr. Murphy kindly provided us earlier, and she can talk to that for a minute,

Speaker 6 if you will. DR. MURPHY: Sure. Thank you, Dr. Marshall. So as you all know, pre-COVID, we introduced the concept of trying a pilot project with utilization of the I-GEL air way superglotic process for our providers in the area. There was a few things that we needed to do, and so we've met multiple times and with the bureau, we decided that this is all on a scale should be a New York state wide pilot project. And so we've devised a mechanism for areas of the state who want to work with their rematch and their medical director to become one of the members of the project. We've delivered an application process, kind of an outline of how it's to occur. We have developed a educational process and a PowerPoint, along with a psychomotor skills evaluation and an exam. These are all things that we're going to standardize for the educational process and thank you to both the training and our division. And Dr. David Violante from Arlington Fire. We put together this process and I loaded it up on board a boat so people can look at it. We're just going to wait for the next meeting to officially pass it through. Look, everyone's comments and looks at it and feels how and how we have structured and how it should come off. It is going to be isolated to only those agencies that are in New York state certified who are on PCR status because we want to be able to acquire all the EPCR'S and the information and really make a good two way project out of this. So more to come. But you can definitely view all the processes I just talked about. I loaded them up on portable and we will hopefully come back on to the next meeting in July and bring it forward for everybody.

Speaker 4 So, Dr. Dr. Murphy, in regards to this, and I know we had the policy statement that didn't seem to have too many comments on it before in an ever

Speaker 2 and everything, Paul

Speaker 4 said Aiden

Speaker 2 Atkins aperture

Speaker 4 DIRECTOR GREENBERG: in regards to the policy statement that there weren't too many comments on that before, it didn't seem like anything significant. I guess my question to this group would be we can work on this in between and have that meeting and go over all the documents or we can meet at some point in the near future. And if there are no major changes or things like that of any substantive change, we can move forward on possibly putting out that policy statement and starting that process even before the next meeting. Mr. Chair, I would leave that up to you as well as Dr. Murphy. I want to make sure that you'd be comfortable with that. Timing wise, it may work out to be about the same. But again, I would want this group to be comfortable with that before moving forward with that, if that is an option.

Speaker 6 DR. MURPHY: I would love that, Ryan, if that could occur, but we will do whatever we need to make this a smooth process. A really defined process. And that the education gets out there appropriately to the right individual. So, you know, we can start

working on it, meet on it, push things forward. And, you know, we can see what the timing is. But I'll do whatever we need to do to make this work

Chair Doynow done and working with anybody like to make a motion as to what Ryan described.

Speaker 2 MARK PHILIPPY: Doctor Doynow. Mark Philippy I'd like to make a motion that the group involved in the I-GEL review, including Deputy chief Clayton and any representatives of the bureau that the director believe are appropriate, Dr. Marshall yourself and Dr. Murphy meet again in approximately two weeks via tele presence. And if there are no substantive changes at that time, we move the document forward. If there are substantive changes, then it comes back to this body in July for our affirmation.

Chair Doynow OK, thank you. Does anybody want to second that motion?

Speaker 3 DR. MURPHY: I'll second that motion.

Chair Doynow Thank you, Dr. Murphy, is there any discussion on this before we vote?

Speaker 2 Yes, please.

Chair Doynow Dr. Daley,

Speaker 2 DR. DAILEY: why? That that's a lot more administrative work for what really appears to be a pretty complete package. I don't think this needs to come back anywhere else if it's been approved, if it ultimately gets approved by the bureau. I think we should be done. Let's get this project started.

Chair Doynow Mike, can you speak up one more time there? I think we've missed that.

Speaker 2 No one's ever told me that before.

Chair Doynow There's a first for everything.

Speaker 2 Now, my only real question is why. They've been trying to get this pilot going now for well over two years. The package of information that they've put together, quite frankly, looks excellent. I would say that the bureau should review it. If the bureau thinks it looks fine, take it through whichever approval process needs to happen from there and just let them get started next month.

Speaker 4 I think that's the process that we're asking for is not to have to wait until the next meeting. Permitting that there's no substantive changes in Dr. Murphy is comfortable with the policy statement, as it's written in the procedures that are there. So that's the goal of what we're trying to achieve here is not to wait to July. But if the committee comes back with any. I think what Mark was saying is if that if the whole group meet and some document has a substantive change or something, then they would bring it back to group. But if they don't, and we all agree that this is good the way it is, which I believe it is, then it would immediately move forward.

Chair Doynow OK, there's a motion on the floor. Any other comments, Mike

Speaker 2 just

Speaker 7 just for reference training and ed also involved in as they reviewed it today, they had had some questions previously about methodology for statewide implementation. The educational component of it and the quality assurance components. And today, when they reviewed it, they felt as though every single one of those pieces is in place in the package as it was submitted.

Chair Doynow Thank you, Mike. Any further discussion before we vote.

Speaker 2 Dr. Doynow, sorry, it's going on. So to Dr. Daily's point, I am in full agreement and there was actually discussion that the director and I had earlier this morning. I think the main issue here is that there are a lot of moving parts, and part of that involves the fact that many of the physicians and leaders in the room have not had the opportunity to review the final product of that that policy. Normally, the bureau probably wouldn't come to us asking for approval of the policy, but I think this was significant enough and there's enough interest in seeing this go statewide that they're asked to just look at it, make sure there's nothing that anyone's missed. A lot of subject matter expertise involved in this, and people who are very involved can sometimes miss a comma here or word there. So I would just say that if there is concern at all, it's just to make sure that we're putting forth, as Dr. Murphy said, the best product we can and that would move the motion. Thank you.

Chair Doynow CHAIR DOYNOW: Thank you, Mark. Any other discussion, OK, Val one more vote, please.

Speaker 3 Dr. Bart.

Speaker 8 I don't know what we're voting on, but I'm I'm listening, but there's two motions, I think on the table here wasn't one to approve this from med standards, and then there was another motion to

Speaker 2 do something else.

Chair Doynow Another motion, as I haveryan state it one more time.

Speaker 2 Thank you.

Speaker 4 DIRECTOR GREENBERG: I believe the motion Dr Bart is to have the group meet confirm that there is no substantive changes to the current policy document that's been drafted or the other documents that Dr Murphy has worked on. If there is no change, substantive changes we would work to implement immediately. If there are substantive changes, we would bring it back to this group for the July meeting.

Chair Doynow Does that answer your question?

Speaker 2 It does go far.

Speaker 8 Val, can you say my name again? Because then I can say this, especially

Speaker 3 I'm

Speaker 8 kidding that.

Speaker 3 Yes, no. Wait, I didn't say your name. That's all right. Dr. Bart, I'm impatient.

Speaker 8 We all know. I'm impatient. Yes.

Speaker 3 Dr. Berkowitz Berkowitz, yes; and Dr. Bombard. Yes; Dr. Cooper Cooper. Yes; dr. Cushman cushman, Yes; dr. dailey

Speaker 2 Daley. Yes.

Speaker 3 Dr. DeTraglia, yes. dr. Doynow

Chair Doynow Doynow. Yes.

Speaker 3 Dr. kugler. dr kugler Yes. Dr. Maynard. Dr. Maynard, yes, Dr. Marshall Marshall, yes, Dr. Murphy. Murphy, yes. Dr. Olsson.

Speaker 2 Olsson, yes.

Speaker 3 Dr. Pigott.

Speaker 2 Yes.

Speaker 3 Dr. Talbot, yes. Dr. Walters.

Speaker 2 Walters, yes.

Speaker 3 And Dr Wicelinski. Yes, the motion passes.

Chair Doynow CHAIR DOYNOW: Excellent. Thank you, Dr. Murphy. Move forward. Dr. Lewis and Dr. Marshall, anything else you have for us?

Speaker 2 DR MARSHALL: No, I think we're going to get education was going to comment on the scope of practice document that came out in January. So we'll speak to them later and see what their comments are. And then that's the end of my report. Thank you.

Chair Doynow Thank you, Dr. Marshall, Ryan.

Speaker 4 DIRECTOR GREENBERG: You had some Dr. Marshall. I do have one question in relation to the telemedicine and the scope of practice document. I would also ask that if there is no substantive changes to either those documents, would we be able to move that? Would you would it be OK with this group to move that forward before the January meeting? Again, same thing if there is happy to hold off, but if there isn't happy to move those forward?

Speaker 2 DR MARSHALL: Right? You know, I don't think I have not seen any comments about the two documents. So if they do, if there are any comments after people have a chance again to review them, then I would move it forward. Recommend.

Chair Doynow CHAIR DOYNOW: Do we want to make a motion to do that,

Speaker 2 STEVE KROLL. Dr. Marshall, Sir? Hi, this is Steve Kroll. I do have some comments on the telemedicine document that I came forward to after the meeting. I worked in with a telemedicine provider that does pretty hospital telemedicine for treating place, and we get we've reviewed the work and we'd like to share some thoughts with you. That would be great. Thank you so much. Thank you for the opportunity.

Chair Doynow CHAIR DOYNOW: Do we still want to put a motion through if there's no significant change to pass those? Does anyone want to make that motion? OK. If no one wants to make that motion, then the next it will be brought to the next meeting, which will be in July. All right. Moving along. Anything else, Dr. Marshall?

Speaker 2 No, that's the end of my report. Thank you very much.

Chair Doynow Okay, thank you. All right. Let's move on to medical education. I'm sorry.

Speaker 7 DR. MCEVOY: So training and ED met this morning. We don't have any seconded motions to bring forward. We had a somewhat lengthy and slightly contentious meeting, which I'll get to the contention later, but we started out with a staff report. Gene Taylor reported that Drew Chesney has joined the staff and is currently working on reciprocity. So they're getting some relief from having to do a million jobs each so that that will help to improve the workflow in the education department. The regional faculty program is moving along with a plan to introduce some training for the newly selected regional faculty on the Vital Signs Academy, and that should be launching in a couple of weeks and that will allow them to get fully on board. It is acceptable for regions to and program agencies to use the regional faculty that have been appointed to do course audits and other duties prior to them getting fully onboarded with the rest of their functions. The practical skills exam and changes for the Blues level should be released probably in time for classes that start in the fall. That will change from the current practical skills that are administered to three out of possible scenarios that incorporate those skills into them. Let's see. I'll skip over this one for now. There was discussion about CIC/CLI and a certified instructor updates. CIC now are totally on the NAEMSE program, so people who would like to become a CIC, there are no more CIC courses in New York state. People should take the NAEMSE course in order to do that and then do their internship through an appropriate course, sponsor CLI. So there are some CLI courses, and the bureau is working on creating an online version of a CLI course that would just require people to do their practical internship with a course. One slight change in the process for that is that an individual who takes the NAEMSE one course can actually function or become a CLI just by doing the practical internship. Previously, they had eliminated that option, but it seemed rather unfair if a person had every intention of becoming a CIC, took the NAEMSE course and then realized that they weren't able to complete the requirements to become a CIC. It seems reasonable that they could complete those to become a seelye so that currently is in process for a certified instructor. Updates. There are a number of updates running around the state. One of the solutions that the bureau is going to be putting together is to take the last Vital Signs Academy or Last Vital Signs Conference Education Day and put that onto the website so that people who need state credit to renew their instructor certification would be able to get all those credits in one spot by looking at last year's Vital Signs conference instructor deck. And that should happen probably at some point in the next couple of months, so it's available to folks who need it. There are some reminders from the bureau that all CME that gets submitted to them should be coming through the portal, not being mailed, not being sent by pigeon carrier or other mechanisms that should go through the online portal so that it gets to the people that it needs to go to. There was some. Discussion about the course that had been done for program agencies recently on

leadership and mental health training and that program, both of those programs are being completed by the contractor that had put those together, and we'll see some more about that coming out in the line of train to train or programs for each one of those, as well as launching some programs around the state with the people who are already trained. Ryan already mentioned digital card option, which will be available through the health commerce system. If you're using that system now, the instructor cards did go online and you can check instructor credentials through the health commerce system. There was some question about the dates on instructor cards, and it appears as though the errors that may have happened with that data transfer are very small. So if you have an individual with an instructor card where the date is incorrect, please rely on that date in the system and just check in with Jean Taylor or someone at the bureau to confirm that. That's correct. So the things that caused a little bit of controversy are the sunset of the practical skills exam by the national registry of EMT in the paramedic program that's intended to take place nationwide in the fall of twenty twenty three next year, intended for November. I sit on the board of the national registry and at our meetings last week in Ohio, the board instructed the national registry to try to accelerate that process a little bit. What it intends to do is to test critical thinking skills through a new series of exam questions that would be incorporated into the actual exam that's taken at the testing center and then to have most of the skills that ordinarily would have been tested in practical skills exam at the end of the program tested as a portfolio during the class, so people would be signed off on each one of their skills during the paramedic class itself. The registry recognizes that there are states like New York that by statute or by regulation, require practical skills exam. And so they're going to maintain the ability to give that exam with the reference material and the training for a number of years. And I think New York at some point will probably require regulatory change so that they also can fold into that process if that becomes the intent. And I think some of our experience that we see with the BLS exam as that rolls out will probably flavor what people would like to do as they move forward. One of the other items that was discussed extensively and we didn't really have time to address is the new EMS educational standards that rolled out last year. There are six or seven items in there that are directly necessary to include in the curriculum at all levels from CFR up to paramedic, and they are not in there currently. The NHTSA folks that write this made a very clear statement in the document, which I posted on Bortable anyone's interested in some bedtime reading, they made a very clear statement that they are not going to be writing objectives, they're not going to be writing curriculum. It puts us in a little bit of an uncomfortable situation in New York because our exams that we administer in the testing center are predicated on NHTSA objectives and now there are no Netzer objectives. So to that end, we formed a small committee of folks from training and education are going to take a look at the new educational standards and do two things one. Make some recommendations for what and how has to be changed in the current curricula at each level. And secondly, to resolve some of the issues that repeatedly come up when we compare protocols to the education. And a fine example of that is that we are still seeing protocols that have AEMT's intubating, but we had taken intubation theoretically out of the AEMT curriculum a year or two ago. So they're going to work to resolve some of those conflicts that occur and probably have to come back to medical standards and to SEMAC with some potential changes that each one of the levels that are influenced by that. So that group will start working over the next couple of months and see see how difficult it's going to be to come to some conclusions along those lines. The more complicated conflict that fortunately didn't erupt. Into fisticuffs, but could have is the division of legal affairs opinion that was issued to, of course, sponsor about a year or so ago saying that it's not really within the scope of the bureau to define geographic territories for course sponsors. This has resulted in core sponsors running courses that overlap each other sometimes. An example that was given is that two different course sponsors are running the same course

in the same firehouse on different nights without anyone knowing that the other was there. It became evident when they saw two sets of equipment that something was going on. So the bureau is working on a policy statement that will help to clarify how that should be resolved. There are a couple of things that could potentially facilitate better communication, one of which is ultimately get a statewide calendar where you type in your address and it tells you where the nearest courses are. We're also looking very closely at training plans that are submitted by the regions and trying to hone down what courses are approved based on those training plans. Ultimately, that problem exists more downstate in Nassau, Westchester, Suffolk, the city than it does in the rest of the state. So that's an ongoing issue that will need to be addressed at some point immediately by having a little bit better communication between the Bureau and the program agencies of what courses are approved. And the bureau is going to look to develop some spreadsheets that they'll send to the program agency, saying these are the course approvals that we've given so that everyone's aware of those and then to facilitate better communication between the program agencies and the REMSCO's about what courses are going on in their region so that there's not a lot of duplicity. The fear is that there that you could put course sponsors out of business if it becomes the Wild West, and that's really a legitimate fear in some places because they certainly need a certain number of students in order to make the course worthwhile to run. So that was pretty much all of the topics that came up. I might I might mention. Also, just on a personal note, this is National Telecommunicators Week. And so if you haven't had a chance to thank your 9-1-1 center as an EMS coordinator, I feel that those are one of the key pieces of our entire operation that we do and some of the most important people that we work with every day. So if you haven't had a chance to put in a good word with them, I would encourage you to do that this week and I'll take any questions,

Chair Doynow any questions for Dr. McEvoy. Thank you, Mike. EMS-C Dr. Cooper. Dr. Cooper, I believe I see you up on the screen

Unidentified on the left.

Speaker 2 DR. COOPER:, thank you. Dr.Doynow, I know I was a thoroughly muted there for a minute. The EMS-C report that I will give will be very brief. We met in March. We reviewed the pandemic triage protocol, which previously voted. We also reviewed proposed changes to the to the agitation protocol, which was discussed this morning at medical standards and will be forwarded to the collaborative group for review. And those were the main issues that were discussed at that meeting. Of course, we had a report from iAmy Eisenhower of the current status of the Readiness Project of the National Readiness Project and and the Pediatric emergency Care Coordinator Project and reports from many of our sister committees within the Department of Health. Those are the major items of business that were discussed. We had hopes to receive a report from the the department's Office of Quality and Patient Safety regarding the pediatric sepsis issues. But that report is being deferred until our June meeting. That's all I have at the moment. Amy Eisenhauer, do you have anything to add to that, that brief report?

Speaker 3 AMY EISENHAUER: I think that covers it. Dr. Cooper, all the other MSD announcements were covered by Ryan earlier.

Speaker 2 Thank you so much. Thank you.

Chair Doynow CHAIR DOYNOW: You're welcome, Dr. Cooper. Does anybody have any questions for Dr. Cooper? OK. Moving along old business and the old business that we

need to bring up at the moment. OK, we'll move to a new business, Dr. Dalley you do have old business there.

Speaker 2 DR DAILEY: Yeah, I do, Doctor Doynow. So the air medical transfusion law was passed and it tasks SEMAC and SEMSCO I believe, with working with the bureau to develop regulations that will allow this term to work. I'm just wondering whether or not the bureau had started working on that process and how that was going to move forward.

Speaker 4 DIRECTOR GREENBERG: So we've started working on the process. We know that there's a number of air medical programs who are already operational with blood. And we are working with our colleagues and subject matter experts within the department on those regulations. So hopefully we'll have more of an update for you by July based on some deadlines and some things that were in there on when it can happen. We can start doing anything until the final wording and everything else start with it. So now that we have that, we will move forward on the regulations. I will say if anybody from, you know, the physician side or things like that thinks there's any particular best practices on a pre-hospital side that maybe the the other subject matter experts don't have that same viewpoint on. We're happy to welcome and welcome any feedback, suggestions, comments or research.

Speaker 2 DR. DAILEY: The only thing I think I would ask you to make sure happens is in the past, some of the work that's been done regarding blood transfusions and ambulances has been. Shall we say, a little bit onerous for compliance? So I would ask for some of the physicians at this table and some of the physicians that represent air medical organizations to make sure to be assisting you with how this is going to work, to make sure that EMS is appropriately represented as transfusion services are making their concerns known.

Speaker 4 DIRECTOR GREENBERG: I would agree with the onerous statement, and the nice part about this one is that it does fall under Article 30, so it is within our regulations and our development and our ability to make it a streamlined process that is realistic, achievable and sustainable.

Chair Doynow CHAIR DOYNOW: Thank you, Dr. Dailey, and Ryan other old business. Moving on to our new business, as I previously mentioned, Commissioner Bassett has requested this group put together a job description for a statewide EMS medical director. I want to thank Dr. Dalley's fellow here in Albany, as well as that of EMS Fellows from Buffalo who put together a nice report, which I have here. And Dr. Daley can send out that actually looked at all 50 states to see what the requirements and job descriptions were. Also in the AMSP and ASUP also have job descriptions. So I'd like to form a small group to put this together and present it at next SEMAC meeting. And then we'll presented to Commissioner Bassett for their approval and hopefully start a search for a statewide EMS medical director. Do I have any volunteers that would like to do that? Dr. Dalley? Was that Dr. Bart up there? I can tell. Did you raise your hand there, Dr. Bart?

Speaker 8 I was scratching my head, but did I make eye contact with you?

Chair Doynow You did. You step forward?

Speaker 4 I think that's enough by contacting that works.

Chair Doynow Thank you, doctor.

Speaker 8 Let me let me deal myself in here. I'm happy to help you, Dr. Doynow a volunteer.

Speaker 2 Yes. Well, I will help as well. Marshall, Steve Kroll volunteers as well.

Chair Doynow OK, so let's do this after the meeting. Why don't we all meet separately? And we'll be able to exchange everybody's email address and set up a meeting and not tie up this meeting. So I'll meet you all afterwards. All right. More new business moving along. I believe Mr. Brody has some new business you'd like to bring up.

Speaker 9 MR. BRODY: thank you. Can everybody hear me all right? My staff says I like to be heard on the radio and seen on the big screen, I don't know if that's the case. What's that? Oh good God, you need to wear this thing. So Amy is going around the PowerPoint. But what I asked for presentation today was on EMS Data that action using the platform Biospatial that the department has contracted with to what we've done with this so far, where we are with it and where we're moving forward with it. Ryan referred to it briefly earlier, and we're going to talk a little bit more in depth about it and talk about where we were. This presentation, just as a forewarning, was prepared for the last meeting that was truncated, so you might notice some more aged notes in there. But the concepts are still the same, and I'm able to talk about where we are. So moving forward in the slides, Amy actionable data, historically we would we would. In my job, we would do a quarterly reporting on certain things related to opioids, the administration of naloxone in the treatment of an opioid overdose. Work on annual reporting and dashboard development. When I first started developing, the analyzing the data for the quarterly report would usually take approximately two and a half weeks. And that included collecting it and then analyzing it and trying to make sure we were only reporting one incident per multiple responders on a tiered response. So we moved forward in that process and approaching modernization and collaboration between the Bureau and the Public Health Information Group within the Bureau, within the Department of Health to move to that. And as part of this, we increased not only the quantity, but also the quality of the data coming to New York state from the EPCR data through a variety of documentation and standard updates in the implementation of them since three point four point zero. So now that we contract that the department has contracted with Biospace, so as soon as the data is received at the state, it automatically is transmitted to bio spatial. Through this arrangement, Biospatial all has the data and has it actionable, usually very efficiently. So we're very pleased with how that works out for us. So this has given us additional opportunities for how to utilize our data to best serve the public need. So it's not simply a repository of EMS data that I that someone in my position would report upon, but it's also what can we do with it and how quickly can we do that? EMS data, as you all know, and some of the fastest received health care data in the state of New York over the course of time between 2012 and 2021. We improved and shortened to the period of time with which data was transmitted. In some cases, it was right away. In other cases, it was daily, in some cases was monthly and in people like we needed to pursue to get them to submit the data, it was much less frequently and much more time consuming. NAEMSE three point four point zero allowed us to be able to have that data. And New York State Department of Health Policy Twenty one 04 indicates that EMS data should be completed and sent to the state, as well as to the receiving hospital within four hours of completion of the incident. At least 90 percent of the time we recognize that there are times that that is not able to happen. But I will say that EMS agencies have been quite attentive to this requirement and responsive to questions that we've raised about how their process works and encouraged and encouraged by their willingness to work with us to get that done. The director also referred

earlier to how many EMS agencies have moved towards documenting electronically with the implementation of the free platform, provided there are two different documentation standards in two different forms available for electronics documentation one for a Basic Life support first response agencies with many, many, many fewer fields and a simpler process for submitting the data. And then we also have one for regulated or certified agencies for our ALS first responders, agencies in transporting that has the standard set for the submission, and we're nearing 500 EMS agencies using that platform. So and that's just in little less than a year that we've been able to do that. So the updated approach will allow us to with biospatial. Will allow us to be able to work with local public health departments or local health departments to provide them with data that will provide them with alerts down the road and that they'll be able to look to see where particular problems or particular syndromes are developing. So as we all know, our response as Ryan refers to it B.C., where we were looking at trauma and also looking at opioid overdoses. And now, of course, we have the pandemic in its second or third full year under our belt. You know, we look at where there are cases of influenza like illness or COVID symptoms that we can map out in there. And bio spatial works very well with us in doing that. ESS engagement is also syndromic surveillance. So where our efforts with the syndromic surveillance area is to deploy identified syndromes through the EMS data that will allow us to have a consistent method of reporting across the department. One of the things we've learned as we explored other syndromes from other states is that they, many states use different definitions. So our next effort is to ensure that the definitions that we use for the Public Health Information Group would match those used with data management analysis and research, as well as with the syndromic surveillance areas within the department in upcoming project for us. And then there's also the effort towards research and reporting. So we do. We receive a great number of data requests and we are working to streamline the process. So there's a consistent method of doing that and the team that Jacob and Alex are part of. We're very hard to bring us to that area. Well, all this means is that EMS data is reaching the 21st century. It's not just a black hole where the data goes, which is where some had told me when I took this job back in 2017, it was. And now we're actually doing something with it. And that for me is very, very exciting. What you see there on the right hand side of the screen are some of the syndromes that are available to the department from the at the admin level. And then what we'll be able to make available down the road is what we're still discussing and working with Biospace on how we're able to do that. Next slide. So this is a screenshot from biospatial, just with some logos and information that it has there. Bio Spatial is a very integrative program that allows us to look at possibilities from all over the country and what things were already developed. The overdose to Action Grant, which is the grant that hired me five years ago, had arranged a meeting for those of us who work with the bio spatial platform in the department, in the bureau to also meet with OD2A staff down in Mississippi. So if you had told me four years ago that I'd be meeting with EMS providers and leaders from Mississippi, I would have chuckled and said, That's nowhere near here. But we did. We had a great conversation as we're deploying. This is a great deal of passion and energy. OD2A Mississippi and OD2A in New York are moving forward with deploying bio spatial to assist with the opioid project next month. So brief history here, I've covered some of this, I apologize. This is how we met up with Biospace, so I went with Ryan and attended the National Association of state EMS officials in Salt Lake City, Utah, and we had a walk and talk meeting with them outside in the beautiful environment that was Salt Lake City. We had a fairly significant conversation about the possibilities. And then the pandemic started, and Ryan and I agreed that this was by far something we desperately needed and we were this close to having it done. And unfortunately, leadership changed in the department and we had to start the contract review process all over again. And we finished and completed the contract in June of 2021. So the contract we there was some dataflow work that needed to

be tested and predicted to ensure its consistency and that the flow worked. It required additional data use agreements and we were able to finish that fairly efficiently. And we did a test of the effort at the Great New York State Fair in 2021. So with that, we meet with bio spatial at least one time a month and made multiple presentations with us as we demonstrate this product and the service. Rather, it's a software as a service to other areas within the department, and we explore opportunities for sharing our data with and deploying our data for the best benefit of the public. Next slide. OK, so in with the state fair in 2021, I had the privilege and pleasure of working with representatives from GMR Central New York EMS Program Agency Deputy Chief Mike Pagosi, District Chief Melissa Lockwood, to talk about how we were going to monitor the EMS system in the Greater Onondaga County area. I went out and met with the Onondaga County EMS directors, who I thought I was coming out to tell them that there was a change in the scheme to try and they weren't going to like before, and they were pleased to find out that they were going to be part of our first pilot in this process. So we set up a data flow process with them, with the leaders out there. I believe there are more parts to the slide, Amy. There we go. So we looked at what was done for the last state fair. And then we set up, we looked at what data points we wanted to monitor throughout the process. We pulled all the data from relevant sources. Together, we analyzed and looked at where they were going and what syndromes, what was a daily attendance and how could we turn that all into a daily report? So we were, as I said, we worked with the Greater Syracuse EMS system, the four New York state hospitals in Syracuse, and we did daily monitoring and surveys with the appropriate staff for both the infirmary as well as GMR in Syracuse. And we had a great experience over a very long fair, you know, sharing the data, I was out there for three days during the fair as we worked on the system and addressed any issues and met several times beforehand to implement this. It was a great experience in preparation for a little did I know what would come later down the year in December. Next slide. So what we're showing you here, one of the key issues that we looked at were hospital off load times. We wanted to make sure that if the fair retracted somewhere between seventy five thousand and one hundred and thirty thousand per day, depending on the day of the week that we were not, the patients being transported from the fairgrounds to the hospitals were not overwhelming the hospitals and creating an unsustainable environment in the emergency departments. As most people know, hospital offload times have been a challenge over the course of the past two years. And every day we were looking at the often times if you're looking on the screen, you might notice that some of those dates are from last year, much before the October meeting of this group. So we were looking to make to be sure that we were not overwhelming the system. So we monitor this every day. Next slide. So, and again, a different visual for the impact of the outflow time, the the. As we all know, the EMS system has finite resources to meet system demands. Yeah. And how are we impacting the system? So while our friends at the state fair of of course would have preferred attendance at 75 to 130000 per day, I was glad that we were not spreading COVID at the fair. But we were able to analyze that and look at what we were doing there. And those lines represent the individual hospitals within the Syracuse within Onondaga County who receive patients. Next slide. So biospace will the only two. And as I mentioned before this slide, it was done for the October meeting data submission changes. As I mentioned, voice first responders were now able to ensure that we set up a system where a high percentage of the time the best first responders will know which hospital is the intended recipient of a particular patient. So our hospital will have access to provided the documentation standard as well. Followed will have access to the bloc's first response the ambulance, the ALS, first responders and helicopter EMS all on a program called elite Viewer. As part of that, all of this data would also go into bio. So we change the documentation standard to be able to adapt to the deployment of Biospatial and make sure we were not overreporting patients being delivered to a hospital, which is why the.

Which is why the outcomes were changed, and we're moving towards improving the verbiage utilized in those down the way. But if your area of the state is served by a hospital hub, the charts will automatically appear in hospital hub if your state is not. If your portion of the state is not served by hospital hub, then your charts would be available. All of them would be available in elite viewer if they're properly completed. We have worked very well with Albany Medical Center Hospital to address any documentation concerns where grout, where a helicopter transported a particular patient to Albany Medical Center Hospital and the chart did not appear. And we use that as an excellent educational opportunity and made sure that for the trauma program, the stroke program, all those pieces of information are now available to the hospital, you know, and they are not needing to chase charts or set up individual arrangements. This particular arrangement allows for everything to be there and accessible for them. From a surveillance standpoint, it is. These are actionable data and we're moving forward with data sharing. What we are doing, we have to create a to work with our regional program agencies, but eventually we want to be able to make this available. This program available to EMS agencies directly, so they're able to use this to, as Ryan had said earlier, to assess their

Speaker 2 meeting,

Speaker 9 whether or not they are meeting the state quality measures and to use that as an opportunity to improve their system of how they are working and responding to particular incidents. Our initial targeted approach is working with local health departments and regional program agencies with the intent that we will eventually be working with the EMS agencies in conjunction with the regional program agencies so that they're able to assess how their agency is performing from an analytical standpoint and 21 software programs in the state of New York. That number is probably going to drop as some of them decline to continue to offer EPCR. So not all of them contain analytics as part of their program. Not all of them contain the ability to easily run a report within their program. So we are working to provide that opportunity both to them, both through the image trend elite platform that we currently have, as well as through Biospatial Next Slide. So what are the next steps? We we completed the submission of the 20 21 data. We worked with image trend as well as the NAEMSE TAC to make sure that all of the 2021 data, which would include in our facility moves, cancelled calls, standbys and all of that still goes. All of that continues to go to bio spatial. And we completed that process not that long ago. We will be initiating submission of the 2020 data. We're trying to find an easy way to do that without interfering with the flow of data to the NAEMSE TAC and using the bandwidth that's allocated to New York state to be able to do that. And working with Chairman Violante and the Quality Measures Committee. We're going to be working to implement those quality measures into biospatial shows that when we're ready to deploy this, any more agency will simply be able to press a couple of buttons to link. And the program from our experience is that people are adapting quite easily and quite readily to the program. Additionally, we'll be evaluating and establishing New York state syndromes, and as part of that, we'll be working with our partners, as I mentioned earlier and data management analysis and research, as well as the Public Health Information Group and the syndromic surveillance teams to make sure that we're all reporting on the same syndromes across New York state. It's helpful if we all use the same pathway, the same definitions to get to where we need to be. So we're going to also be developing and implementing data sharing plans where the EMS agencies are regional program agencies, and that is our next step. As you might imagine, the director indicated that earlier that we had approximately 125 assets from both New York state from the State Mobilization Plan, as well as the FEMA assets provided through the National Ambulance contract deployed earlier. And in this particular round, where I don't recall the director mentioning was at this time, instead of

documenting pieces of paper and going back about 30 years in patient care documentation they documented on iPads provided by New York state and they documented on the New York state elite site. So over the course of the three months of the deployment and kudos to Jacob Alex Suzy's, who pronounced Robert McCartan and Amy Eisenhower for all their work in getting all of that deployed, but also to Jacob and Alex for burying a majority of the burden and serving as a help desk for those providers on a 24-7 basis to be able to answer their questions when they're stuck on a chart, if you will. Now, most of their issues related to them aborting their password. So we reset a boatload of passwords throughout that process. But twenty four and seven, we were a help line to be able to support those assets from other states and through those two contracted arrangements that come into New York state to help us out in our time of crisis. So it was a privilege and an honor to work with them. We were happy to have two full weekends off in a row because that hadn't happened for three months. And I know it's nothing compared to the work that they did. So I believe that's our last slide. But. So one more slide, Amy. Oh, sorry, I lied one more. Any questions? Thank you, Mr. Chairman.

Chair Doynow Thank you, Mr. Brody. Ryan, would you like to talk about proposed changes to Article three?

Speaker 2 Sure.

Speaker 4 DIRECTOR GREENBERG: But I don't have too much, I'm happy to take any comments or questions related to proposed changes to Article 30. Obviously, there was for those of you who didn't know Part F, which was part of the budget, which had several things in it, which was all part F was all about EMS Related and several different components of it. The biggest one, I think, and the most involved that this group was in was the definition change. And unfortunately, at the end of the day, Part F was not included and the chain or that the changes, serious changes to the statute did not occur. Therefore, several of the things that we do right now through executive order, such as community para medicine, vaccination and other things unfortunately will not be able to continue once the executive order ends. However, the executive order is still in place and for the period of time that it remains in place, then it will continue. I will say that it was, excuse me, probably some of the most involvement and in most I've heard in regards to EMS across the state. And so that was really nice. During the process, I did have the opportunity to attend the New York State Association of Counties, and we were asked to attend to talk about Part F for a little bit. Well, when we were told, we were asked to tend to give a 20 minute lecture. And so Steve and myself went to this meeting and we get there and we said, Well, yeah, we're here to talk about the EMS for about 20 minutes. And they said, we're like, we're not sure where we're supposed to be going or which session we're speaking in. And they turned in that, Oh, well, you're talking in the EMS crisis committee or session said, OK. They're like, Yeah, it's an hour and 15 minutes. We're like, we were told we were talking for 20 minutes. We got into the meeting and turns out there were several elected who were talking about proposed bills and legislation to work on EMS sustainability. We thought for sure while standing there and talking to some of the New York State County Association staff that, you know, 15 people would show up to this and we'd have a nice conversation about different things. The room ended up being standing room only. It was filled. There were a number of people who were the electeds gave some presentations, and then we spoke about Part F for a little bit. Or should I say the chamber spoke about Part F and we answered some other questions. And some of the things that came up, which was, you know, pretty interesting and I think relevant for this entire group is, well, they turned and said, Well, this doesn't solve our problem tomorrow and to which we said, we agree. And we also said, though, if we don't start to fix the problem in two

years from now, you'll be sitting here saying the same thing, which is my problem has gotten worse and you haven't done anything to help it. So I bring this up for this group because I think it was really important. And I think the legislative committee and now Lewis and his team had a very nice meeting today. But there is a lot

Speaker 2 of talk

Speaker 4 about the EMS right now. There's a lot of things that we've done through the pandemic that is an opportunity to help us advance and share. And Philippy spoke about a little bit earlier today and myself and don about the same conversations that if we lose this momentum, we could miss a window of opportunity just because Part F didn't pass. Whether you liked it, didn't like it. Fill in the blank. There's an opportunity now, and there's a lot of people talking about different things, and there's an opportunity to be collaborative to get different ideas out there, to move things forward that will help our system going forward. And your feedback, your representation, your communications is really valuable in helping move that forward to look at things. So look at things in part F that you liked you didn't like. And you know, what's the next kind of round of things that could happen? Several parts of part are actually in a legislative bill that was presented by an elected right now. So that is also out there. So there's still a lot of movement that's there, too. And I'd be, as we know, the fire department billing has passed. So I forget, I think it's Jeff call sitting here somewhere said, Well, at least that's behind us now. It's true. And that was something that I think in many senses was a distraction to the bigger picture. Not. And so, you know, I think everything is, you know, has different importance to different people in different groups, and that's OK. But I think as we start to move to the side some of the distractions, we have the opportunity to advance some of the things that we need to do as a group and this group, as our physicians and non physicians who sit on this committee also have that opportunity to move things forward. I will tell you that, you know, one of the the most substantial things that we received was a letter of support, I would say, that was signed by multiple associations. Related. To the definition in the support for that, it's communications like that that can happen in discussions like this on, you know, what does the future look like? Was it need to happen? What should it look like? That will help us get to that next level. So I leave it with that. Happy to take any comments, questions or concerns.

Chair Doynow Any questions for ryan? Any other new business. Dr. Berkowitz

Speaker 2 DR BERKOWITZ: Well, hopefully this will be quick. But this is this is particularly relevant given some of the comments at the top of the meeting and stuff is something that has come up a few times that the bureau level and at regional levels. But I don't think there's been a SEMAC opinion on the matter. And so I wanted to kind of bring it up. And the issue at hand is that as a bit of confusion over which protocols should be followed when an agency that operates within multiple regions is is operating in multiple reasons with different protocols, and there's still some variation. I know in the past the bureau has been supportive of the notion that agencies shouldn't be forced to jump protocols, which is kind of how Lee used to phrase it. And obviously, the SEMAC has the opposite the authority to set the standards. So I wanted to kind of bring this up as a discussion. And then and if folks want to, I can make a motion that we can discuss that would make it easier to give that target for people to throw things at. But I kind of wanted to bring up the point as a start.

Chair Doynow CHAIR DOYNOW: Thank you, Dr. Berkowitz. Historically, what I recall before the collaborative protocols, an agency was allowed to follow the protocol from its

home base, right? Whenever it crossed into another region. Ryan. I don't know if you have any comments on that production, Dr Young.

Speaker 5 That's the way we've always done it. And what we did was usually when we know there's going to be a lot of cross-pollination. We reached out to the neighboring REMAC region, whichever and just have that establishment, and it works out both ways. So, yeah.

Speaker 2 And so even even in the absence of mutual aid, I mean, because I think mutual aid is one thing I'm talking about, you know, if if, if you're actually operating in both regions, I think that's that's what's one. I think that that's where there is some opportunity to for clarity.

Speaker 4 So I think it's important also, and I believe that most know here the, you know, the regional differences, but if we look downstate, Westchester follows collaborative New York City, follows a unified Nassau, follows collaborative Suffolk, follows Suffolk County's protocols. And so within a short period or a span of, you know, some agencies that span in that downstate region, this is, you know, some of the confusion that happens. I would agree. You know, I think it's been especially on the on a short term kind of, you know, agencies that are I go over for a single call or mutual aid that they would follow their home kind of operating territory from a, you know, agencies that truly operate, particularly in the 9-1-1 system, in different regions. From my understanding, from historic and actually Dr Young, I would I would say to you on this one, I do believe the local region has provided yes, you can follow, you know, neighboring when you come into this area, that is the way that it's been explained to me. Feel free to crack down on.

Speaker 2 Mr. Chairman, that's correct. Just the point of information. I'd. May I go ahead?
DAVID KUGLER: Thank you. So, David Kugler speaking just to remind you, all of 2016 and 2017 when Director Burns was here and on her way out and director Greenberg was on his way in. We had an issue with an agency that was in multiple regions and they chose to use one particular regions protocols that that agency was also. It came to light not because of the protocol issue, but because of a quality issue and QA/QI stuff, which the agency ultimately, after being suspended un suspended, suspended and un suspended, is now compliant, we think. And one of the four items of discussion that was brought up at this body that was put aside by this body and by the by your office director Greenberg was the issue of protocols and the use of protocols within the region and the. The state clearly said that if you are in multiple regions, you use the protocol from your region. I have an email from in 2017, I guess from you that says that, yeah,

Speaker 4 2017 would probably be

Speaker 2 Lee. Then maybe it's from Lee, but but but it clearly indicates that sort of process. Sure. So we had we had agreed to disagree on a bunch of different things, but that was one of the things that I, while I tried to implement in my region to use my regional protocols. This body, and you're your agency had said no, that that particular EMS agency could use their home protocols

Speaker 4 if you have a copy of that letter and the legal opinion, because that letter probably would have a legal opinion that goes with it. We're happy

Speaker 2 to. I was never given a legal opinion. I was just that was what was that was the verdict handed down based on the the summary judgment of this and the state of suspension of that particular agency by your office.

Speaker 4 Sure. If there's a letter that you can share and Dr. Winslow, yes, we'll come to you in one sec if there's a letter you can share. That'd be wonderful. Like I said, I do think that was before my time. I know, you know, in some of the recent evaluations and some of the questions that have come up in some of the different areas it brought up, you know, these questions about protocols and things of that when the things that was determined is that, you know, a region can't require credentialing of each of the providers within a region. That was something that did come out through the region, which is, I don't think, a surprise to this group. This has been an issue that's been around there. But again, legal looking into it further so that there's not a question of whether or not a provider has to be credentialed in multiple regions from that point of view. Dr. Winslow, I think you want to say something.

Speaker 2 DR WINSLOW: Sure. It was my understanding that every regional rematch can decide what protocols are used for its region period. Therefore, it's a local REMACS decision. What protocols were used for each region? Article 30 is very clear that the SEMAC sets the standards for the regions when it comes to protocol formation.

Speaker 5 One of the reasons we did the back and forth was think about air services, air services come into multiple counties. Are we expecting the medics to have knowledge of multiple protocols if they vary from region to region? So you we, the way we worked it out practically was again, we did REMAC we talked about it and that again involved just transport back and forth. You're talking about if they're actually stationed in a in another county. So that is a little different, though.

Chair Doynow So CHAIR DOYNOW: Dr. Berkowitz, what I believe you're stating is that your agency is in Nassau County and by chance you cross over into Suffolk or New York City. What protocol you should follow? And I believe Ryan and correct me, if I'm wrong, they should be following the Nassau county protocols unless they're stationed in New York City or in Suffolk County. Is that correct?

Speaker 2 I found the email and it was from Director Burns. I can read it if you'd like, but I can with all blank out the name of the agency. That's OK with you.

Speaker 4 I want to know what email search contingent you have because I could never find something that quickly.

Speaker 2 It says Hi, David. Thankfully know I figured the letter memorialized I had. This is in reference to a previous email that memorialized the June decision of the REMAC but was surprised it was sent at this time, as you have said, the agency in question. She mentions it, but I'm just going to leave that have been demonstrating willingness to cooperate and participate in the Nassau County EMS system by credentialing their EMS providers. This is a work in progress, but the key here is that they are actively pursuing the items articulated in the program agency directors letter. The one issue that seems to be a stand out is a process for allowing them to use the New York City ALS protocols. As you know, the bulk of their operation is in the city and jumping protocols as a matter of patient care and safety. I have been told that the Nassau and New York City protocols are remarkably similar, though I have not looked at this myself. Would it be possible to convene a meeting with the REMAC and that agency that would be happy to participate,

participate in any way that you, the REMAC that agency, thought productive? You imagined that this if we could keep going. Um, and so basically after that email, uh, further discussion ensued between the state and that region. I mean, that agency and my region and we were told that they get to do what they want to do in terms of using protocols. So the state has already determined. In Twenty Seventeen, that an EMS agency that operates in multiple regions. Can pick the New York State Protocol with all of our protocols in New York state protocols that they want to use. And so long as there providers are credentialed in that particular region, I may do so. So I'm I just wanted to bring that forward.

Speaker 4 DIRECTOR GREENBERG: so from that. So from that side, I do believe and again, this is from the knowledge I've been told the region is still saying, OK, yes, they're OK to use those protocols in our region and with the overlap. And again, the credentialing part due to some other things going on is no longer an issue. But I do believe it's it's the region that would still approve it to say yes, you can use that one because they are all state approved and it comes from the state side. So whether you're Suffolk County, Nassau County, New York City, Westchester, Hudson Valley, they're all state protocols you can create. Say your own not just you, but any agency that's operating over multiple lines. It's a matter of which set is followed and the given region's desire to participate with the neighboring regions a set of protocols.

Speaker 7 It'd be great if there was a single state protocol.

Speaker 2 DR WINSLOW: Dr. Winslow. Sure. So the other thing that comes up with the same on this same line is regional policies. So for example, if in one region you have a trauma center designation, pediatric center, you have different policies in terms of the procedures that can be performed. Those are the things that are really important for each region. So I think a best practice is not to subvert the usual process of coming to each REMAC and getting discussion and approval for what protocols you're going to use and what policies you're going to follow. But that's how I would think a system would work best.

Speaker 4 DIRECTOR GREENBERG: I mean, as always, we would welcome the feedback and suggestions of this group in a best practice on how to handle it, I mean, yes, we have less regions that this affects, but there is still a number. I mean, even if you just look over the New York City, Long Island regions, or if you look north New York City versus going north into collaborative, you know, the collaborative regions, and they also operate in New York City and the collaborative side that, you know, maybe this group should take a further look into that in how it should operate so that the providers aren't the ones stuck in the middle and that there is a definitive answer because unfortunately, right now, to be blunt, it's the providers who end up having to deal with it.

Chair Doynow So DR Berkowitz did you want to make a motion of some sort

Speaker 2 DR BERKOWITZ: so I can definitely make a motion because I do feel that the providers are in the middle of this and I do think that, you know, we're here to support them. And I do feel that we're here to support them, so I would make a motion and, you know, like I said, everyone can throw things at it and that's fine. I do think that it's within the SEMAC right to set a standard for protocols. So I do think that that we can we can opine on this. So the motion I would make is it is a standard of the SEMAC that agency's operating in multiple regions can follow the protocols of their home region. I would use the primary mailing address as the definition of Home I home region because I think

historically that has how it's been done. And, you know, I'm open to thoughts. That's my motion. Take a second.

Chair Doynow Was there a second there? Who was it?

Speaker 2 OK, I got a second on the motion.

Chair Doynow Is there any second on motion? I'll second, Dr Kugler that now discussion.

Speaker 4 Right? So I guess my only question to it would be the opposite direction. If an agency is located on Long Island, would they now be practicing the collaborative protocols in New York City?

Speaker 2 Potentially. I mean, I mean, how the city operates is very different for the voluntary they the

Speaker 4 move closer to the mic please

Speaker 2 How the city operates is different because the agencies have that are in the New York City system, have a contract with New York City with Finney to provide that service. That's very different than what we're talking about in the kind of the home rules structure for that's the state.

Speaker 4 But is it? I'm just like, I'm playing devil's advocate for a moment. I'm surprised Dr. Dalley hasn't chimed up yet. Former New York City paramedic.

Speaker 2 I want to chime up. Oh, there we go. I'm not Dailey

Speaker 8 Bart, I'm talking. So this rings familiar. In twenty eighteen, we had an appeal for a second suspension. It's again, this is public record here. So the appellate of A+ Services Inc and in that discussion. And I'll just read you here because I was the chairperson of that appellate review. There is a bullet point in here under the question says further. The committee feels that the precedent across the state, such as helicopter services who operate in multiple jurisdictions, are permitted to use their home based credential process and ALS protocols. Obviously, the credential process is a little bit null and void, but. I believe the discussion at that point into the time, I mean, where they sign this thing. This was January 9th, 2018. The discussion was related to the providers being certified under the use of a protocol that were then geographically picking up patients in a different territory. Perhaps that it became both confusing for the providers and potentially dangerous for the providers to remember what side of the line they're on in town when use of different protocols, when it came down to the establishment of, I think it was mentioned, certain policies or procedures. You know, certainly any of those that were already approved across the state and other regions that were adopted by state agencies or regions would have to come with the appropriate training and qualifications for those procedures. So I don't know that that is much of an argument from my perspective. If somebody is training credentialed to do it at their agency in their home protocol and they were taking a call in another another area, they are permitted to use their own protocol. Thank you, Dr. Bart. What what the region could, and I think what if I can read through this a little more? I'm sorry to interrupt somebody, but that particular region that was a different using a different protocol was permitted to ask for copies of those PCR'S, whether they're redacted or otherwise, so that they can also do QA metrics on it. I think that was just something we conceded to.

Chair Doynow Any other comments?

Speaker 2 Yes, I I seem to recall this being a fairly lengthy discussion and there was a. And I. Before and we made a decision. And I think before we make a vote on a motion that could potentially reverse that decision or otherwise alter it. There should be an effort to go back and look at the transcripts and find out what that decision was. That's my concern.

Chair Doynow OK, we can do that, but I don't think we're going to be able to do that at this meeting, per se.

Speaker 4 Dr. Kluger can do a search because pretty quick. No, I'm kidding.

Speaker 2 Yeah, I just found a letter between you, between you, director Greenberg, myself and, uh, Abe Wurzburg regarding a conference call that we had to further clarify the role of ALS services in Nassau County, the requirements for their submission for speakers. I've been there the whole series of emails. So it would this this, uh, condition or issue overlap to your your tenure and leave?

Speaker 4 DIRECTOR GREENBERG: I do believe it. You know, when we. And part of what we discussed and part into my tenure is, yes, you know, if a neighboring Rimac is to approve it or to talk about it. And I think that's what Dr Young was also talking about in other conversations, then absolutely beyond that or different things we'd have to look at. I'm happy to bring it back to legal as well. But I will say, I don't, you know, I think if we were to move forward with this and look at this from that legal perspective, it could set the precedent as well that you follow your home set of protocols regardless of where you work, what you're contracted with or what you're following. Because if that standard is set by this group, then that's one standard that's set. I don't see why that would be seen different in different situation to why it should be followed differently in different situations.

Speaker 2 May I ask then that I'm willing to rescind my second for Dr. Berkowitz's motion? If you're willing to take this back and review the minutes from the meetings that of the tag where Dr. Bart chaired the the, uh, the complaint from the region and came up with its findings that were agreed upon because I believe that did set the standard at that point in 2017 2018. If we could find those notes in the minutes and then uh, and that those determinations that might help clarify everything.

Speaker 4 I'm happy to take a look into that. I think the group that you were working to put together to finalize this one as well, I think is still an important group in the discussion to have including that materials when we bring it to legal and including, I think, the different areas that can, you know, be affected more downstate with these issues. So I think what you're proposing in further discussions on it is important and that our piece would be to help facilitate additional information for that group to discuss with all the counties that might be involved.

Speaker 2 Dr. Doynow?

Chair Doynow Yes, I don't

Speaker 2 want to belabor the point, but while we have the access to Dr. Young's knowledge and experience here, I want to just throw out an example that I have some knowledge of. This goes back into the late 1990s, where a advanced life support service in

the what would be the north eastern corner of Genesee County, Leroy Ambulance operated under Monroe Livingston Protocols while in the western the western REMS area, and there was a decision between the two a REMSCO'S to allow that. So there was precedent for that to occur.

Speaker 5 Maybe a motion to table might be in order so you can do the research you want to come back. This is a suggestion, but yes, it was REMAC chair to REMAC chair. That's how we did it and it worked out well.

Chair Doynow I think we're going to need a little from Dr. Winston. Your advice here as a parliamentarian.

Speaker 2 A motion to table means you put it on the table. It never comes back, ever, unless someone makes another motion to remove it from the table. That's not what I think you want. There's a motion to return to committee. There's no committee here. So that's not a vote on the motion. I think you want is a motion to postpone to the next meeting. And I think that is the same what you wanted to do and that takes precedence over any motion that's on the floor, but that needs a vote. And I'm telling the the chair.

Chair Doynow OK, so Dr. Berkowitz, would you like to make a motion on your motion to postpone this until next meeting

Speaker 4 or to move it to a committee such as Met Standards? If you feel that that's the appropriate place, your systems?

Speaker 2 Yeah, that would work. So I would very much appreciate some of the ancillary information that we're gathering from folks here because I think that there's a lot of history here, kind of as as in my pre discovery, I already obtained some of it, but there's a lot more information history that I think we need to obtain to make sure that past practice is aligned. So I would be comfortable moving this motion to committee. Um, if we think if we agree that met standards would be appropriate.

Chair Doynow By many standards, would it be appropriate, so perhaps we can. I don't know if Dr Marshall is still up there, I can't see it from here, but we can move that to med standards. I think he is. I see him up in the left corner there

Speaker 2 and I'm still here. OK.

Chair Doynow So Dr. Marshall, can we move this to med standards for discussion before the next thematic meeting and come up with the decision? And we will have time to look at the previous minutes as well. Yes. OK.

Speaker 8 So the January 2018 minutes will be particularly helpful for you.

Chair Doynow Do we have a second on that motion? Dr. Kugler.

Speaker 2 I'm sorry, I was reading the emails that was from twenty. 18

Chair Doynow We're going to send this. We're going to send this to Med standard with your assistance, finding the old minutes, I suspect. And we'd have a motion on the floor to do that. We just need a second.

Speaker 2 I'll be happy to second.

Chair Doynow Thank you. All right. I don't think we need a roll call on this. Is anybody against doing that? OK, nothing heard. So, so move that will go to med standards. We'll bring it back to SEMAC next, meeting in July and hopefully resolve the issue and the other new business before we adjourn. Doug Windsor,

Speaker 2 I had a question about regional quality improvement initiatives. I thought each local regional REMSCO and REMAC had regional authority over issues of quality assurance and quality improvement. I guess it's more of a question, since I'm the new kid on the block for the SEMAC. So that was the greater component of the issue in twenty seventeen twenty eighteen. And that was the issue that, uh. Cause the agency we were discussing to ultimately be suspended because they failed to comply with the regional quality issues. So yes, your region does have um based on that, if we're going to go by historical. Absolutely the right to review and see the data and maintain quality for the patient care provided in your region is that through the program agency, through the REMSCO, the REMAC or all three.

Chair Doynow REMAC and be REMAC, I believe

Speaker 2 I think Article 30 says the REMAC. I think you're correct. I'm not a lawyer, but so therefore everybody in one region is under one quality improvement regionally through that process through its REMAC, regardless of what protocol you choose to bring. I believe so. And so if you were to ask Chief Brody to look at particular agencies electronic pictures for calls that occur in your region, your QAQI committee, you should be able to review those PCRS

Chair Doynow And the other new business, OK, nothing heard, Dr Young, would you like to make a motion to adjourn?

Speaker 5 I'd be honored to have motion to adjourn.

Chair Doynow Do we have a second?

Speaker 2 I'll second it.

Chair Doynow Anybody against nothing heard will see you all in July.

Speaker 2 Thank you, Dr. Young.