12/07/2022 – SEMAC Meeting – Troy, N.Y.

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

DATE: December 7, 2022
TIME: 11:47 a.m. to 1:40 p.m.
**CHAIR:** Donald Doynow
**LOCATION:** Hilton Garden Inn
235 Hoosick Street
Troy, New York





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2 **APPEARANCES:**
3 LEWIS MARSHALL
THERESA ALLEN
4 VALARIE OZGA
MARYANNE PORTORO
5 DAVID KUGLER
BRIAN WALTERS
6 JOSHUA LYNCH
JOSEPH BART
7 DONALD HUDSON
JEREMY CUSHMAN
8
DANIEL OLSSON
MATTHEW TALBOT
9
JASON WINSLOW
10 DOUGLAS ISAACS
MICHAEL DAILEY
11 RYAN GREENBERG
JONATHAN WASHKO
12 JEFFREY RABRICH
ARTHUR COOPER
13 MARK PHILLIPY
DAVID MARKOWITZ
14 STEVEN KROLL
MICHAEL MCEVOY
15
CARK GANDOLFO
ED MAGER
16
DAN CLAYTON
AMY EISENHAUER
17
JENNIFER SOLOMON
18 DEAN ROMANO
MICHAEL REDLENER
19
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21
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2 (The meeting commenced at 11:47 a.m.)
3 **CHAIR DOYNOW:** Can we all please be
4 seated? I'd like to welcome everyone back.
5 Hopefully, everybody had a good Thanksgiving. We do
6 have two new members that I'd like to mention, Jason
7 Winslow, if you want to put your hand up there,
8 welcome Jason. And Doug Isaacs also over there,
9 welcome to -- to SEMAC. If we could have a roll
10 call, Val.
11 **MS. OZGA:** Okay. Good -- good
12 morning, right, it's still morning time. Okay. Dr.
13 Bart.
14 **MR. BART:** Present.
15 **MS. OZGA:** Dr. Berkowitz?
16 **MR. BERKOWITZ:** Present.
17 **MS. OZGA:** With the nameplate too, Dr.
18 Barry, Cherisse Barry. Dr. Tiffany Bombard. Dr.
19 Arthur Cooper?
20 **MR. COOPER:** Here.
21 **MS. OZGA:** Dr. Jeremy Cushman?
22 **MR. CUSHMAN:** Cushman here.
23 **MS. OZGA:** Dr. Michael Dailey.
24 **MR. DAILEY:** Dailey here.
25 **MS. OZGA:** Dr. John Detraglia. Dr.





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2 Don Doynow.
3 **CHAIR DOYNOW:** Here.
4 **MS. OZGA:** Dr. Steven Gomez. Dr.
5 Douglas Isaacs.
6 **MR. ISSACS:** Here.
7 **MS. OZGA:** Dr. David Kugler.
8 **MR. KUGLER:** Here.
9 **MS. OZGA:** Dr. Joshua Lynch.
10 **MR. LYNCH:** Here.
11 **MS. OZGA:** That's Joshua, not Joseph.
12 **MR. LYNCH:** Thanks, ma'am.
13 **MS. OZGA:** Dr. David Markowitz.
14 **MR. MARKOWITZ:** Here.
15 **MS. OZGA:** Dr. Matthew Menard. Dr.
16 Lewis Marshall.
17 **MR. MARSHALL:** Present.
18 **MS. OZGA:** Dr. Pam Murphy. Dr. Dan
19 Olsson.
20 **MR. OLSSON:** Olsson here.
21 **MS. OZGA:** Dr. Matthew Talbot.
22 **MR. TALBOT:** Here.
23 **MS. OZGA:** Dr. Brian Walters.
24 **MR. WALTERS:** Walters here.
25 **MS. OZGA:** Dr. Robert Wislinski



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2 (phonetic spelling). And Dr. Jason Winslow.
3 **MR. WINSLOW:** Present.
4 **MS. OZGA:** Non-voting members. Oren
5 Barslay (phonetic spelling). Aiden O'Connor. Mark
6 Phillipy?
7 **MR. PHILLIPY:** Mark Phillipy present.
8 **MS. OZGA:** Maryanne Portoro.
9 **MS. PORTORO:** Maryanne Portoro
10 present.
11 **MS. OZGA:** Dr. Jeffrey Rabrich.
12 **MR. RABRICH:** Rabrich present.
13 **MS. OZGA:** Michael McEvoy?
14 **MR. MCEVOY:** McEvoy's here.
15 **MS. OZGA:** Steve Kroll.
16 **MR. KROLL:** Steve Kroll present.
17 **MS. OZGA:** And John Washko.
18 **MR. WASHKO:** John Washko present.
19 **CHAIR DOYNOW:** Do we have a quorum?
20 **MS. OZGA:** We have quorum.
21 **CHAIR DOYNOW:** Excellent. Okay. If I
22 could have approval of the 04/12/22 minutes, anybody
23 would like to make that motion? And I should mention
24 please state your name for the transcribers when you
25 do talk.





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2 **MR. MCEVOY:** Dr. Chair, I think that
3 would be September 22nd.
4 **MR. OLSSON:** Olsson --.
5 **CHAIR DOYNOW:** Yes. Okay. All in
6 favor?
7 **ALL:** Aye.
8 **CHAIR DOYNOW:** Anybody against? Any
9 abstentions, no, okay. Motion approved. Okay.
10 Ryan, bureau staff report if you would?
11 **MR. GREENBERG:** All right. Good
12 afternoon, everyone. So for the bureau report, in
13 the operations world Marrow (phonetic spelling)
14 continues with their full service inspections and
15 getting through most of Suffolk County, I believe, in
16 working towards Nassau County and up into the Hudson
17 Valley. So if you have any questions on that, please
18 reach out to either Rich Robinson or one of your
19 district chiefs.
20 We are also going through the hiring
21 process for two new district chiefs for the Marrow
22 office. And the renewal paperwork will be coming out
23 shortly so keep in mind if you need renewal paperwork
24 that will be coming out.
25 In the western region they had a small





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2 snowstorm recently and just a couple of inches and I
3 just want to give a shout out to the both the -- the
4 Western Bureau of E.M.S. team as well as I think Greg
5 Gill is here who is Erie County Commissioner for
6 public safety and Deputy Commissioner and just
7 phenomenal job.
8 When you talk about what's the point
9 of, you know, collaboration and everything else, this
10 past storm really just showed it. We almost had a
11 deployment on that one as well, I know many of you
12 received and we got questions related to the state
13 mobilization plan and deployments.
14 We were literally probably within a
15 couple hours of needing to deploy additional
16 ambulances there, thank God things went in a really
17 good direction. But it's also a good test of, you
18 know, again the system that we've improved and
19 unfortunately through COVID it become a little bit
20 too good at in that process.
21 So thank you again to -- to the
22 western team from bureau and everybody who helped
23 make that happen out there. In investigations that
24 continues in normal timelines are continuing on that
25 one, on the administration front, we continue to





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2 execute the program agency contracts.
3 And we have regular discussions with
4 those program agencies in order to see what documents
5 are missing and what we need to in order to execute
6 them. As of right now we have eight executed program
7 agency contracts on the REMSCO side, we have nine
8 executed.
9 So again, if you think -- if you're
10 not sure if your program agency or your REMSCO or
11 your REMAC contract, which REMAC is through to REMSCO
12 is completed, please work with your program agency to
13 see what we can do to help complete that. But there
14 is good process going on in that one.
15 In education we continue processing
16 applications and I think I heard John say that we had
17 about six hundred E.M.T. courses so far this year, so
18 excited to see that one. There are twenty-two core
19 sponsors in New York state in the paramedic side and
20 I believe in -- in short time, by the end of the
21 year, hopefully we'll have twenty-two that will also
22 gone through the accreditation process through
23 national accreditation.
24 So excited to see that one as, you
25 know, standard set in New York for all of our



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2 paramedic education. We're working with the
3 education and training committee related to some
4 regional training plans and I think Mike -- Mike
5 McEvoy is going to report out on that one a little
6 bit later.
7 We're working also with P.S.I. on some
8 feedback that we've gotten this week on testing,
9 testing availability, you know, some things. I know
10 people want to get back to a classroom based test in
11 some cases. That probably won't happen just based on
12 technology and limitations. We've asked, we've tried
13 to get to it.
14 But what we are going to try and move
15 towards is group scheduling to where a core sponsor
16 can schedule their students, because the biggest
17 complaint we get is, well, the student never
18 scheduled their exam. And why you would take an
19 entire E.M.T. class and then get to the end and not
20 take your exam, I'm not sure.
21 But understanding I guess some do it,
22 we're going to try and, you know, limit that and give
23 them every best chance to become certified and get
24 out into the field. We are working on some updates
25 on the reciprocity process, although it is online and





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2 -- and Drew Chesney has been doing a phenomenal job
3 on that one, so thank you on that side.
4 In our data and informatics unit, it
5 continues to grow and continues to take on more
6 responsibilities under Peter Brody and, you know,
7 just excited to see that one. So we are doing an
8 audit right now of all the P.C.R.s that come in.
9 And in some cases, we are noticing
10 that some P.C.R.s that are coming in electronically
11 are either getting held up somewhere or there's a gap
12 or there's a time lag or so on and so forth. And in
13 some of those cases, the agency isn't aware of it and
14 so, you know, that's a little bit of a problem.
15 So we understand, if you're not aware
16 of that problem, you know, how would you fix it so we
17 are working on some solutions. Hopefully going to
18 work with the program agencies as well to, you know,
19 resolve that issue and take a look at, you know, if
20 there's anything that we can do.
21 So far in New York State, we received
22 nearly three point five million to date for 2022 in
23 P.C.R.s and so excited to see that one. We also
24 through that -- through our data and informatics,
25 which does have a nice grant from OD -- OD2A, they --





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2 we continue with some projects with that and
3 partnering with them and -- and the local health
4 departments we're working to get out to local health
5 department's bio spatial, so excited to see that one
6 in three pilot counties.
7 And then we continue to work on new
8 documentation standard, which we know everybody is
9 excited to get and read, so we're excited to get that
10 out there to you. In the trauma world we're working
11 on regulatory reform on four or five point five, if
12 you've been following that one, it's some minor
13 updates in the grand scheme of things.
14 But the big update will be the book
15 and the standards that they follow. There's a major
16 changes happening in 2023, we're trying to get the
17 regulations to align with that in the same time that
18 the national standards do align with it.
19 We're also continuing -- continuing to
20 see an increase in the number of applications for
21 level three trauma centers, so we have three new
22 level three trauma centers and they're not
23 necessarily downstate, which is, you know, nice to
24 see that it's not in the most populated area for
25 trauma centers, but actually starting to see some





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2 more in other areas which we are excited to see.
3 And that next step meeting is on
4 January 24, who want -- those who want to participate
5 or watch. E.M.S. for children is growing, Jacob
6 Demay, who actually was on our data and informatics
7 team for a long time, he's sitting over there at the
8 end. He's also our specialist. He has now accepted
9 a role as a pediatric data specialist within our
10 E.M.S. for children grant. We're excited to have him
11 there.
12 And he'll be working on the hospital
13 portion of the PEC program, so, you know, the pre
14 hospital -- sorry, and the hospital portion that's,
15 you know, going to be rolling out. The E.M.S.C.
16 grant application has been submitted. Hopefully,
17 we'll hear back shortly. The E.M.S.C. E.M.S. survey
18 will be coming out in January for your agencies,
19 please have them reply.
20 And the E.M.S.C. meeting schedule is
21 due to come out shortly. So vital signs we're super
22 excited, we had about seven hundred and fifty people
23 at the end of the day, I will tell you, E.M.S.
24 providers in true fashion sign up last minute and boy
25 did they in this year.



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2 About a month before we had about two
3 hundred registrations and we ended up with about
4 seven hundred and fifty registrations. So thank you,
5 you know, for probably giving Val a slight heart
6 attack in the process there, but it was a -- it was a
7 great success, we got a lot of great feedback, some
8 phenomenal speakers so thank you to everybody who
9 participated.
10 And in particular to doctors and the
11 doctor panel and Dr. Dailey and Mia (phonetic
12 spelling) and everyone who -- who made, you know,
13 some really great panel discussions happen. Next
14 year, by the way, we are back in Syracuse, October
15 17th to 22nd, mark your calendars now.
16 The memorial, so our memorial will be
17 in May and we are working with him on the new
18 memorial. However, at the way things are looking,
19 there's a decent chance the new memorial will not be
20 there in time, supply chain and everything else and
21 making sure that we get the right thing for what we
22 need and not just replace it with something that we
23 think isn't perfect for the amount of meaning that it
24 has.
25 So hopefully I'll have an update for





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2 you back in February or coming up in -- in the
3 February meeting, I'll have a better update. There's
4 a list of all the dates, I think that was on the
5 table, correct me if I'm wrong, Val, excellent.
6 So the -- all the dates for 2023 are
7 up. Please mark your calendars now so that there's
8 no conflicts. With Oasis, we have our mental health
9 grant that continues and Jenny, who should be in the
10 back, where is she. Stand up for a second, Jenny.
11 Jenny is with our mental health
12 program and -- and is traveling around the state to
13 teach the class and if okay with you, Mr. Chair,
14 during new business, or if there's a few minutes, I
15 would love for her to explain to the doctors a little
16 bit about the program.
17 It is free, she travels around the
18 state. She is looking to go to more areas, we're
19 looking to get into certain geographic areas that we
20 haven't scheduled yet. So we'd love to, you know,
21 connect that with the physicians here and help make
22 that partnership happen so we're going to be coming
23 back to you in a few -- in few minutes.
24 From our side I wanted to -- and
25 again, Mr. Chair, it's up to you if you'd like to do





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2 this now or a little bit later. But I would like
3 Chief Mager to talk a little bit about the most and
4 what's happening with facilities. It's up to you if
5 you want now or later.
6 **CHAIR DOYNOW:** We can do it now, go
7 ahead.
8 **MR. GREENBERG:** Yeah, sure. Chief?
9 **MR. MAGER:** Good afternoon, everyone.
10 From the MOLS (phonetic spelling) side we -- we were
11 really making significant progress with Dr.
12 Dorsa(phonetic spelling)) at the MOLS team and a
13 significant number of people in here, Dr. Cushman and
14 some others.
15 What happened was the document the --
16 the MOLS form was in the final approval process, it
17 was actually nearly approved by the department. And
18 then additional feedback came in from O.P.W.D.D.
19 their lawyers or legal team so it's sort of set us
20 back.
21 And I don't have an actual timeline.
22 We've been trying to push that forward to -- to get
23 that finalized and -- and released. So the entire
24 MOLS team, which is diligently worked Mike McEvoy,
25 you've been on this -- you've -- you've experienced





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2 the delays and the other components, but we are -- we
3 did do a session at vital signs which was well
4 attended that's certainly on the vital signs academy.
5 There's a lot of information that is -
6 - that is -- that is changing, including some of the
7 training and education that will come once the form
8 is actually approved. So there's actually a MOLS
9 meeting going on right now, which I'm not attending.
10 Unfortunately, the -- the form is not approved so it
11 won't move forward there.
12 Secondarily, we've had some training
13 opportunities, collaborating with the adult homes
14 division and that rolled out -- basically it was a
15 level setting opportunity, we -- regulations from the
16 adult homes versus E.M.S. regulations have some
17 variances, specifically some of the -- the MOLS
18 things related to what the expectations are from an
19 E.M.S. perspective and adult homes.
20 We have another session which is --
21 which is based on feedback from the first adult homes
22 interaction which is available on vital signs academy
23 if anybody's interested in it. It was well attended,
24 I think over seven hundred providers, it was A.C.F.
25 and E.M.S. providers and leadership that -- that



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2 attended that, but it is also available on vital
3 signs academy.
4 December 13th between one and two
5 o'clock there's a second session based on feedback
6 from E.M.S. as far as educating individuals about
7 what types of facilities and the level of care that
8 can be expected at those facilities that they respond
9 to. There seem to be some confusion related to that.
10 Director, I don't think I have any further comments
11 unless there's questions.
12 **CHAIR DOYNOW:** And questions you may
13 want to hear?
14 **MR. GREENBERG:** Anything else that you
15 would like Chief Mager to bring back to that MOLS
16 committee related to possibly questions with medical
17 control or things -- interactions that you may have
18 with that form? All right, thank you, chief.
19 Moving on from the regulation side,
20 the education regulations have cleared through an
21 internal regulatory process and committee that's to
22 keep moving up. The operations ones are actually due
23 to go to that same committee the week of the night --
24 December 19th, and then we'll move to next steps.
25 The E.O. -- the E.O.s that are in





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2 place, so the only E.O. that is executive order
3 that's in place right now is the staffing, staffing
4 crisis E.O. continues in effect and that was actually
5 recently renewed. The rural health taskforce, there
6 are two members that are -- that are left to be
7 filled, but I hope to have a full list of those
8 vetted members to everybody at this group so that
9 they're aware of who's on the -- the rural health
10 taskforce at the February meeting.
11 But I am excited to announce that Ann
12 Smith has been placed as the chair of the rural
13 health taskforce so we think that's an excellent
14 opportunity. Where is Ann? There she is,
15 congratulations Ann on that appointment.
16 And just for situational awareness,
17 that's actually an appointment through the governor's
18 office by the governor that she is sitting in that
19 seat so congratulations again. And, you know, with
20 that the last thing in -- we have two or three policy
21 statements that are going to be coming out next week.
22 One is about oxygen tanks, we're getting a lot of
23 questions on -- on oxygen tanks related to how to
24 look at them and determine if they are compliant or
25 not.





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2 There's an update on education, that's
3 an update to -- to the education policy statement
4 that came out recently, just some minor updates that
5 are going on in that one. And I believe there's one
6 other one. So I think -- what? Yes, thank you, the
7 IJOB (phonetic spelling) protocol.
8 So the IJOB protocol or process in how
9 to apply and everything else at -- at the request of
10 the IJOB project, we did put into a policy statement
11 with supporting documents, who to call, who to
12 contact, everything else that goes along with that
13 one, and so that is, you know, there.
14 The last thing that I -- I would
15 update on, we are -- as we work on regulatory updates
16 or regulatory reform is blood. We are starting to --
17 to look at blood now and blood statutes that changed
18 last -- recently for air medical or last year for air
19 medical, that allows air medical to carry and store
20 blood.
21 It does have correlating regulations
22 that need to come out and so we're going to start on
23 that process now. If there's anybody who, you know,
24 has input suggestions or comments, we do welcome that
25 as we go through that process. Thank you so much.





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2 **CHAIR DOYNOW:** Thank you, Director
3 Greenberg. Mike McEvoy -- yeah, go ahead.
4 **MR. CLAYTON:** Hello, there we go. Dan
5 Clayton from the bureau, just one correction on a
6 date. State trauma advisory committee is January
7 25th and it will be held here at the Troy Hilton
8 Garden Inn, not the 24th for the record. Thank you.
9 **CHAIR DOYNOW:** Thanks, Dan.
10 Education, Mike McEvoy?
11 **MR. MCEVOY:** Training ... yesterday
12 and kind of exceeded our hour that we were allocated.
13 A couple of things from the staff report, Ryan
14 mentioned 22/02, which is instructor certification
15 policy is going to be reissued with some tweaks to
16 it.
17 There's a link that will appear on the
18 bureau website shortly that has all the forms that
19 people's little hearts could desire to fill out for
20 everything that goes into the Drupal system. The
21 A.E.M.T. exam has been reviewed by the bureau. It
22 turns out that there were no endotracheal intubation
23 questions on that exam so that's been cleared to
24 proceed.
25 There was a trial done on the new



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2 P.S.C. that one of the training and Ed committees has
3 been working on for the E.M.T. exam and that was done
4 at SUNY Cobleskill. There's another trial coming up
5 in Suffolk, and that -- that went pretty well, got
6 some good feedback.
7 The book itself, the draft of that, is
8 still being revised and will be looked at over the
9 course of the next month or so by the committee
10 that's working on that. One thing that became
11 evident when they tried this new practical skills
12 exam was that this cannot roll out immediately and
13 probably will not appear until 2024.
14 Primarily because of the complexity of
15 the exam for the students and the preparation that's
16 necessary for them to take an exam that rather than
17 focusing on exactly the skills that they provide,
18 gives them a scenario -- a comprehensive scenario and
19 that is a different type of tests for the students.
20 It was very challenging for them and
21 probably requires more preparation in the class and
22 more education of the educators that will be working
23 with administering the exam and teaching people how
24 to take it. So you won't see that happening
25 immediately but we'll give you some feedback as the





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2 process develops.
3 There were some discussion on course
4 funding and we're waiting at this point for responses
5 from the finance committee that forty-four core
6 sponsors who have provided data on the actual cost of
7 the courses. Once we get that information, we'll
8 play around with the numbers and see if there needs
9 to be some revisions in the funding allocation.
10 There was a discussion at the December
11 meeting and we continued that on the idea of allowing
12 all core sponsors not just specialty core sponsors to
13 deliver certified instructor updates. And after a
14 very lively discussion, it appeared as though the
15 preference would be to keep that limited to just
16 specialty core sponsors.
17 We are, however, going to create a
18 work group that's going to take a look at certified
19 instructor update requirements and see whether the
20 requirements that we currently have -- currently have
21 in place are reasonable, giving some -- given some of
22 the changes that have happened over the course of
23 time with continuing at, at all levels, so to be
24 continued.
25 There was a discussion as Ryan





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2 mentioned on P.S.I. testing and so we received some
3 good feedback from some of the regions on issues with
4 P.S.I. That contract is going out for R.F.P. and
5 some of the requests that were made from the regions
6 will be considered in the revision.
7 There's a thing called Zendesk, which
8 generates tickets that are issues that happen with
9 the P.S.I. testing, and the bureau is going to
10 provide some data from that Zendesk application to
11 the training and Ed committee so that we can kind of
12 have a better finger on the pulse of what actually
13 are issues that are arising with the P.S.I. testing.
14 The group scheduling has been trialed
15 in a couple of large agencies and will probably get
16 rolled out to the rest of the state at some point in
17 the future once the quirks are ironed out from that
18 and that'll allow core sponsor to group schedule an
19 entire class for their practical exams.
20 There is an email address, which I
21 think we've mentioned here before, which if people
22 are having problems with scheduling their state exam
23 with P.S.I., it is much more effective to email the
24 bureau than it is to try to wrangle with P.S.I. over
25 the phone.





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2 And that address is
3 ems.testingissues@health.ny.gov. So if people have
4 issues, that is a much better route to go with
5 questions or concerns. And my experience with that
6 has been that most people get an answer within about
7 a half a day when they send a query in on that email
8 address, so kudos to the bureau for keeping a close
9 eye on that.
10 We asked for some volunteers from the
11 training and Ed committee, and I'll throw that out to
12 everyone in the room here, to work with the E.M.S.C.
13 folks on developing some education for the new
14 pediatric behavioral protocols.
15 So if there's anyone who has an
16 interest in working with E.M.S.C. on that, they're
17 looking for some folks to help them develop the
18 education there. A couple other things that came up
19 data, the Bureau reported to us that for the past
20 year, there were twelve thousand folks enrolled in
21 courses across the state, sixty of those were C.F.R.
22 classes that graduated one thousand new C.F.R.s.
23 There were six hundred E.M.T.s that
24 graduated, nine thousand new E.M.T.s and thirty-eight
25 E.M.T. courses that produce three hundred A.E.M.T.s





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2 and sixty-six paramedic courses that produced eight
3 hundred paramedics. Some of those who were
4 refreshers and those numbers don't actually include
5 C.M.E. research so that's a large number of folks
6 that are coming through the classes.
7 One item that we have -- well, let me
8 just talk about this last thing and I'll bring the
9 item up for SEMAC. We are in the process of
10 attempting to develop a training plan template to use
11 so that the bureau can approve courses.
12 And we had another lively discussion
13 about this. As you know, the geographic limitations
14 on core sponsors were deemed to not be legitimate by
15 the Division of Legal Affairs, which means that any
16 core sponsor can just plop in and do a course
17 anywhere in the state that they feel like it. That's
18 causing some problems.
19 One of the solutions that the bureau
20 undertook recently is any course app that gets filed
21 goes to the regional program agency and to the REMSCO
22 of the place where the course is going to be
23 delivered. So that keeps people a little bit more in
24 the loop about what's happening in their regions.
25 But to help the bureau to actually





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2 approve courses, we are seeking to develop some sort
3 of a training plan template where we would solicit
4 the proposed or the necessary courses that need to be
5 done in a region looking forward basis, so that the
6 bureau can then use that as a methodology for
7 approving courses.
8 I pulled out one that we had been
9 using for probably fifteen years or so when I chaired
10 the finance committee. It collects data
11 retrospectively and then prospectively asks about
12 classes, but it works very similar to the Hertz
13 system, if you're familiar with that, where people
14 just make up numbers that they want to submit for
15 courses.
16 And when we actually looked at that,
17 there were regions that were proposing to recertify
18 three times the number of providers that actually
19 live in the region, and other regions that put in
20 data that was woefully insufficient.
21 So the training and Ed committee is
22 going to play around with trying to come up with some
23 sort of standard template that we can use to predict
24 what region would need for classes and help the
25 bureau to approve those.





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2 The item that we wanted to bring to
3 SEMAC has to do with a conversation that we had a
4 couple of meetings ago and that had to do with
5 providers' use of medical devices. And our
6 recommendation is that SEMAC come up with a SEMAC
7 advisory, basically describing how medical devices
8 that are used at the local level would be approved.
9 And our understanding is that is
10 generally done by the agency medical director, but
11 this issue continues to come up to training and Ed.
12 It continues to come up here at SEMAC and it
13 continues to come up at SEMSCO when some new whiz
14 bang product comes out.
15 And they come to us and say, could you
16 endorse this, could you approve it, or the opposite
17 of that is complaining about someone using a device
18 that isn't actually approved. And this body never
19 really has approved products but we're passing this
20 along to Dr. Doynow and SEMAC colleagues for
21 development on some sort of a statements so we can
22 resolve that when they come up in the future. And
23 unless there's any questions that's the end of my
24 report.
25 **CHAIR DOYNOW:** Thank you, Dr. McEvoy.





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2 Is there any discussion on that, anybody have any
3 questions, anybody want to make a motion? At the
4 moment, all I hear is crickets. Dr. McEvoy, did you
5 want to make a motion?
6 **MR. MCEVOY:** Well, I would make a
7 motion that SEMAC work with the bureau to develop
8 SEMAC advisory on approval of medical devices for use
9 by providers.
10 **CHAIR DOYNOW:** Is there a second to
11 that?
12 **MR. RABRICH:** Second.
13 **CHAIR DOYNOW:** Who -- who was that?
14 Dr. Rabrich. Any discussion on it? Okay, everybody
15 needs more caffeine. Dr. Olsson.
16 **MR. OLSSON:** Olsson. Can we do that,
17 can we as a body approve a specific device --?
18 **CHAIR DOYNOW:** It wouldn't be a
19 specific device. If I understand what Dr. McEvoy has
20 stated it would be up to the medical director to
21 approve a specific device. We don't -- we don't as a
22 body endorse a specific device.
23 **MR. GREENBERG:** So I think -- for my
24 understanding, what this would be is for this body to
25 determine that they're not going to endorse or



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2 approve any specific device, but that they would
3 clarify both to the region and as a body that they
4 roll of a specific device should be done by a medical
5 director of the agency after the appropriate training
6 and competency has been shown and rolled out.
7 **CHAIR DOYNOW:** Dr. Cooper?
8 **MR. COOPER:** Thank you, Dr. Doynow. I
9 believe the statute does specifically speak to a
10 SEMAC approval of regulated medical devices. So I
11 think some clarity as to how that should be
12 interpreted should be included in the advisory.
13 Thank you.
14 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
15 Dr. Rabrich?
16 **MR. RABRICH:** Yeah -- no, I was going
17 to say something similar and that we -- we need some
18 -- some more detail on that and specify if it's going
19 to be left to an agency medical director, the
20 parameters around that if there are any regulatory
21 ones.
22 **MR. PHILLIPY:** Dr. Doynow?
23 **CHAIR DOYNOW:** Yes, go ahead.
24 **MR. PHILLIPY:** Mark Phillipy, I -- I
25 happen to have that section up and we discussed that






2 in exactly a little bit ago, and as Dr. Cooper points
3 out quite correctly, it is regulated medical devices.
4 So as -- I think we all know, there are probably a
5 fair number of non-regulated devices that are being
6 marketed to us, probably on a regular basis.
7 So that's -- that's probably the more
8 pressing matter at this point is letting our -- our
9 physician colleagues who are at the agency level know
10 what their expectations are.
11 **CHAIR DOYNOW:** Anymore discussion on
12 that? I would just also add, it needs to be within
13 the scope of practice of that particular provider.
14 Okay. We have a motion on the floor, if you would
15 like to read it back for us again, Dr. McEvoy?
16 **MR. ISAACS:** I'm sorry, one other
17 point to that. I just want to get clarification. So
18 you just send the standards for what the equipment
19 list should be or -- because any, you know, any
20 medical equipment, it's likely it would be F.D.A.
21 approved and so on.
22 So I'm still not quite sure, is there
23 a training component to this because I think there --
24 a lot of agencies sometimes like training components
25 to medical devices would be very helpful for all






2 regions or so what is specifically, it's not clear to
3 me what we're voting on.
4 **CHAIR DOYNOW:** Dr. McEvoy, if you
5 would?
6 **MR. MCEVOY:** So it's really voting on
7 developing a policy that would clarify all those
8 questions. And I think the point of the policy is
9 that, really to say that training and Ed, SEMAC,
10 SEMSCO are not the ones responsible for what
11 equipment and devices are used, that that's the local
12 medical director who's responsible.
13 And probably also at the same time,
14 which would be incorporated in the policy,
15 responsible to know what those are that the agency
16 uses and know that the people are trained to use
17 them.
18 **MR. GREENBERG:** I mean, I think in
19 some cases we're looking at it and we say we don't
20 approve stretchers, we don't turn and say, you know,
21 okay, strike, you're approved, for now you're
22 approved, you know, in those aspects.
23 But they have to have a stretcher on
24 board that's, you know, going to be safe. So the
25 other thing is -- is and E.M.S. for children has --






2 has done some work on this related to different
3 equipment and safe transport of a pediatric patient.
4 So they may be a reference for you to
5 look at and how they approached it because I think
6 they also tried to stay sensitive to not endorse or
7 not necessarily approve anything specific, but kind
8 of that concept, and then some resource guides that
9 might be with it. So I'm sure Amy would be happy to
10 help facilitate that as well.
11 **CHAIR DOYNOW:** So Dr. McEvoy, we're
12 going to vote on SEMAC recommending that we put out a
13 policy statement. Would you be by any chance to be
14 able to put that policy statement together for the
15 next meeting? And if so, then we'll vote that you
16 will put that policy together.
17 **MR. MCEVOY:** Why, certainly.
18 **CHAIR DOYNOW:** All right. If we can
19 just have a show of hands, everyone in favor of --.
20 **MR. WINSLOW:** I have one --.
21 **CHAIR DOYNOW:** One more question.
22 **MR. WINSLOW:** Sorry, I was just
23 reviewing Section 3002-A of the Article 30 and it
24 gives REMAC the authority to -- I'll read it to you.
25 Section 30 dash -- 32-A number two, the committee

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2 shall develop and recommend that to the state council
3 statewide minimum standards for et cetera, et cetera.
4 And then it says, medical equipment.
5 Doesn't it -- isn't it that regular -- use of
6 regulated medical devices by emergency medical
7 services personnel it's page fifteen. So I think if
8 the -- the REMAC is supposed to have some say or the
9 SEMAC about using regulated medical devices, because
10 that's what we're talking about, use of regulated
11 medical devices.
12 So I -- I -- I do agree that there
13 needs to be some agency training and education, but
14 in our region of best practices, we then notify the
15 REMAC of this great new device that's being approved.
16 And allows other agencies to see it, share and if
17 they want to adopt it as well, they can.
18 So I -- I do think that before we just
19 say it's only on an agency, do review Article 30.
20 **MR. GREENBERG:** I think that's the
21 point of this working group is to clarify kind of
22 some of those points and -- and what, you know,
23 physicians, medical directors this table would want
24 to see in that, you know, both interpretation and
25 working with, you know, Division of Legal Affairs





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2 within the Department of Health, as well as
3 interpretation of these things.
4 But, you know, I think what the goal
5 was is that not every single medical device or
6 concept that comes up, comes around this body,
7 because I -- from my understanding and feel free for
8 this body to say else wise, they did not want to sit
9 here and approve specific devices along the way.
10 And as we get more -- let me pause
11 there, is -- has that changed?
12 **CHAIR DOYNOW:** No, I don't believe
13 that has change.
14 **MR. GREENBERG:** Okay, just checking.
15 And since it hasn't changed, to have that framework
16 of how we're going to handle that, including, you
17 know, references like that, because it absolutely
18 does. It does reference medical equipment things,
19 both for the SEMAC and the REMAC.
20 So I think that this policy statement
21 and guidance document would work to clarify and see
22 what that role is and involve it and like you said,
23 point out things that might be, hey, report it to
24 your REMAC so they can ask questions and get feedback
25 and give you a study or whatever that might look





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2 like.
3 **MR. WINSLOW:** Yeah, that would be my
4 recommendation is to add the language into it that
5 although it doesn't need to be approved by the REMAC,
6 that it should be shared with the local REMAC for
7 also knowledge of neighboring agencies of this new
8 possible device.
9 **CHAIR DOYNOW:** Okay. Thank you, Dr.
10 Winslow. We do have a motion on the floor. Can we
11 have a show of hands? All in favor of Dr. McEvoy and
12 his group putting together a policy statement. Okay.
13 Anybody against? Any abstentions? Okay, that
14 passes. Let's -- Dr. McEvoy, are you -- are you
15 done?
16 **MR. MCEVOY:** Yes.
17 **CHAIR DOYNOW:** Okay. Moving along,
18 next would be med standards, Dr. Lewis.
19 **MR. MARSHALL:** Yes, hi, good
20 afternoon. Medical standards met early this morning
21 and we bring forward two seconded motions for the
22 committee's consideration and then a few items of
23 discussion and moving forward.
24 So the first protocol coming forward
25 as seconded motion is approval of the New York City





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2 protocol change to add tetracaine to the eye injury
3 protocol. Tetracaine is already in the burn protocol
4 in New York City and is also in the eye injury
5 protocol in the collaborative protocols. So there's
6 very little discussion that comes forward as seconded
7 motion.
8 **CHAIR DOYNOW:** Any discussion? Okay.
9 Val, I think we would need a roll call vote.
10 **MS. OZGA:** Okay. Dr. Bart?
11 **MR. BART:** Yes.
12 **MS. OZGA:** Dr. Berkowitz?
13 **MR. BERKOWITZ:** Yes.
14 **MS. OZGA:** Dr. Cooper?
15 **MR. COOPER:** Yes.
16 **MS. OZGA:** Dr. Cushman?
17 **MR. CUSHMAN:** Cushman, yes.
18 **MS. OZGA:** Dr. Dailey?
19 **MR. DAILEY:** Dailey, yes.
20 **MS. OZGA:** Dr. Doynow?
21 **CHAIR DOYNOW:** Doynow, yes.
22 **MS. OZGA:** Dr. Isaacs?
23 **MR. ISAACS:** Yes.
24 **MS. OZGA:** Dr. Kugler?
25 **MR. KUGLER:** Yes.



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2 **MS. OZGA:** Dr. Lynch?
3 \MR. LYNCH: Lynch, yes.
4 **MS. OZGA:** Dr. Markowitz?
5 **MR. MARKOWITZ:** Markowitz, yes.
6 **MS. OZGA:** Dr. Marshall?
7 **MR. MARSHALL:** Marshall, yes.
8 **MS. OZGA:** Dr. Olsson?
9 **MR. OLSSON:** Olsson, yes.
10 **MS. OZGA:** Dr. Talbot?
11 **MR. TALBOT:** Talbot, yes.
12 **MS. OZGA:** Dr. Walters?
13 **MR. WALTERS:** Yes.
14 **MS. OZGA:** And Dr. Winslow?
15 **MR. WINSLOW:** Yes.
16 **MS. OZGA:** Motion passes.
17 **CHAIR DOYNOW:** Okay, thank you. Dr.
18 Marshall?
19 **MR. MARSHALL:** Yes, thank you. So
20 this -- the next motion that comes forward is about
21 aligning the New York State B.L.S. protocols with the
22 collaborative protocols. A document was in Boardable
23 which outlined differences between the state B.L.S.
24 protocols and the collaborative protocols.
25 And as pointed out by one of our





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2 members, most of these changes are not medical in
3 nature. So that discussion happened and then this
4 comes forward, the committee recommended to accept
5 all these changes and bring that forward as a
6 seconded motion and then I'll have some other
7 information after the vote.
8 **CHAIR DOYNOW:** Okay. Any discussion?
9 Okay. Val, another roll call vote, please?
10 **MS. OZGA:** Okay. Dr. Bart?
11 **MR. BART:** Yes.
12 **MS. OZGA:** Dr. Berkowitz?
13 **MR. BERKOWITZ:** Yes.
14 **MS. OZGA:** Dr. Cooper?
15 **MR. COOPER:** Yes.
16 **MS. OZGA:** Dr. Cushman?
17 **MR. CUSHMAN:** Cushman, yes.
18 **MS. OZGA:** Dr. Dailey?
19 **MR. DAILEY:** Dailey, yes.
20 **MS. OZGA:** Dr. Doynow?
21 **CHAIR DOYNOW:** Doynow, yes.
22 **MS. OZGA:** Dr. Isaacs?
23 **MR. ISAACS:** Yes.
24 **MS. OZGA:** Dr. Kugler?
25 **MR. KUGLER:** Yes.





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2 **MS. OZGA:** Dr. Lynch?
3 **MR. LYNCH:** Yes.
4 **MS. OZGA:** Dr. Markowitz?
5 **MR. MARKOWITZ:** Yes.
6 **MS. OZGA:** Dr. Marshall?
7 **MR. MARSHALL:** Yes.
8 **MS. OZGA:** Dr. Olsson?
9 **MR. OLSSON:** Olsson, yes.
10 **MS. OZGA:** Dr. Talbot?
11 **MR. TALBOT:** Yes.
12 **MS. OZGA:** Dr. Walters?
13 **MR. WALTERS:** Yes.
14 **MS. OZGA:** And Dr. Winslow?
15 **MR. WINSLOW:** Yes.
16 **MS. OZGA:** Motion passes.
17 **CHAIR DOYNOW:** Thank you, Val. And
18 Dr. Marshall.
19 **MR. MARSHALL:** Yeah, thank you. So as
20 -- as a result of that discussion this morning, we
21 had the discussion about the establishment of this
22 New York statewide B.L.S. protocols many years ago,
23 approved by this body.
24 And some of the regional changes that
25 have occurred over the years based upon region's





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2 specific needs. And so what we agreed to do is put
3 together a working group to look at the statewide
4 B.L.S. protocols, the collaborative protocols and the
5 unified protocols to see how we can get to one set of
6 protocols.
7 The concern was is that where do you
8 refer a provider to when they want to look at B.L.S.
9 protocols. And I believe it was Dr. Olsson said it
10 should be the same regardless of which document you
11 look at when you're looking at the B.L.S. protocols,
12 not the A.L.S. protocol.
13 So this -- this taskforce -- this
14 working group will work on that and bring information
15 back for the next meeting. Other items that we
16 discussed were the protocol approval update process,
17 which will also be worked on again and brought
18 forward. There was some data request from the
19 committee to the department which we will have for
20 the next meeting.
21 We did have a discussion based upon
22 length based pediatric resuscitation tape and
23 conflict with our existing protocols. And that
24 there's at least one medication that conflicts
25 between the tape and the protocols in one region.



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2 And so E.M.S.C. has volunteered to
3 look at that and come back to medical standards and
4 SEMAC with their recommendations on how to move
5 forward with that. Continuing the pediatric
6 discussion, we talked about pediatric CPAP and high
7 flow nasal cannula, especially with the viral
8 respiratory surge that we're seeing and the -- the
9 challenge for some areas is how do you transport
10 these critical pediatric patients long distances when
11 you can't, you know, maintain high flow oxygen on an
12 -- on an -- on an ambulance, so that will also be
13 looked at by E.M.S.C.
14 And lastly, we had a discussion on an
15 article from last month on defibrillation strategies
16 for refractory V-fib which showed that -- I think
17 double synchronize -- double defibrillation and
18 vector change defibrillation resulted in improved
19 hospital discharge and outcome of patients and
20 refractory V-fib.
21 We didn't have any -- there was no
22 motions on that but it did come up for discussion and
23 we should probably further discuss that because
24 there's at least one state that's already implemented
25 that process. And apparently, we had that in our





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2 protocols years ago and took it out so more to come
3 on that. And I'll answer any questions and that's my
4 report.
5 **CHAIR DOYNOW:** Thank you, Dr.
6 Marshall. Any questions? Okay. Dr. Cooper,
7 E.M.S.C., if you would.
8 **MR. COOPER:** Thank you. As Dr.
9 Marshall mentioned ... excuse me, sorry. As -- as
10 doctor -- is that better? Thank you. I never had
11 that problem before, you know, having myself heard.
12 As Dr. Marshall mentioned, E.M.S.C. has with the
13 assent of the SEMAC tasked itself with review of the
14 pediatric medication determination methodologies that
15 are out there, such as ... Handtevy and so on.
16 With specific instructions from the
17 SEMAC to ensure that there is, you know, synchrony
18 between the various methods that are there so that
19 our providers are not put in a bind, thinking that
20 they have violated protocol if one of these devices
21 suggested a drug dose, which is different from what
22 is currently in protocol.
23 We'll be looking at that our -- at our
24 next meeting, as we will also be looking at the issue
25 of high flow nasal cannula, CPAP and BiPap. And its





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2 potential applicability to pediatric patients,
3 particularly over long distance transports.
4 There are numerous problems with --
5 with that as many of you are aware, the ability to
6 carry sufficient supplies of oxygen and, you know,
7 and to have all the various mask sizes that one would
8 need and cannula sizes that one would need could be
9 very problematic, not to mention that our providers
10 may not have a wealth of experience in dealing with
11 pediatric respiratory conditions.
12 But we will be looking at that at our
13 next meeting. We were tasked by STAC and E.M.S.C. to
14 look at the new American College of Surgeons field
15 triage guidelines, because they are substantially
16 different from the previous version more in -- in
17 construction than in content.
18 But we were tasked to ensure that
19 pediatric issues were appropriately addressed. We
20 will do -- be doing that prior to the next meeting.
21 We were also tasked, as you may recall, with looking
22 at the proposed pediatric and adolescent agitation
23 protocols.
24 We held a -- a joint meeting between
25 the E.M.S.C. folks involved with this project and the





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2 -- the collaborative protocol -- protocol group,
3 which was a productive meeting, no question about it.
4 The -- the upshot of the meeting as -- as many of you
5 are aware, is that there'll be a major focus on
6 developing educational materials to support any
7 potential protocol changes.
8 Dr. McEvoy did briefly comment on that
9 during his report. I might just add that to -- for
10 those of you who are unfamiliar with this,
11 particularly my emergency medicine physician
12 colleagues, you know, in the November issue of ACEP
13 now, there's a large spread on the -- on the issues
14 of pediatric de-escalation, which figure prominently
15 in the -- in the proposed protocol put forward by
16 E.M.S.C. that was modified by the -- by the
17 collaborative group.
18 But it's our hope and belief that we
19 will be able to develop training materials in a
20 fairly proud fashion. If we find in reviewing the --
21 the -- the various educational programs that are out
22 there don't meet the needs of our prehospital
23 colleagues here in New York State.
24 And finally, I just want to comment
25 briefly on the pediatric emergency care coordinator

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2 issue, Director Greenberg did comment on that in his
3 report. But new this -- this time around will be the
4 -- is the need to have a pediatric emergency care
5 coordinator in the emergency department as well.
6 And I'll turn the platform over to Amy
7 Eisenhauer to comment on that fairly briefly before
8 taking any questions, thank you. Amy?
9 **MS. EISENHAUER:** Thank you, Dr.
10 Cooper. And so I believe our last SEMAC and SEMSCO
11 set of meetings I briefly mentioned the American
12 College of Surgeons has made it a requirement to be
13 trauma verified that you have a -- a pediatric
14 emergency care coordinator and talk a little bit
15 about what E.M.S.C. recommends.
16 I have -- well, through Peter because
17 of course I was sick during the meeting, I presented
18 to STAC on what those criteria are. And since our
19 last SEMAC and SEMSCO meeting the ... for the
20 E.M.S.C. grants coming up over the next four years
21 has come out and this plays a large role in their
22 performance measures.
23 So one of the performance measures to
24 meet for the grant is to have an E.D. pediatric
25 emergency care coordinator, and also to have





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2 prehospital pediatric emergency care coordinators,
3 which we already have. And some work has already
4 been done in the national region, so there is a East
5 region for E.M.S. for children. We are a component
6 of that.
7 And they have developed a pediatric
8 recognition slash PECC program for in hospital use
9 called always ready for children. And we hope to
10 avail ourselves of the work already done by my fellow
11 program managers, mainly Mark Mingler (phonetic
12 spelling) from Maine has really fleshed that out.
13 And so I hope soon we will have our
14 first group meeting with the people that have
15 indicated they'd like to be involved. I know that we
16 are waiting on a representative from D.O.H. from
17 hospitals, because this does involve in hospital and
18 we want to include everybody that will play a part in
19 that role.
20 So I think that we're just waiting for
21 a representative and I'll be sending out an email
22 with, you know, some potential dates, so we can pick
23 our first meeting date. And so if anybody else in
24 here is interested in joining us, for, you know,
25 development slash clarification of the program that





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2 has already kind of been working in other states
3 around our region, I will be happy to have you join
4 us. So just let me know. Thank you, Dr. Cooper.
5 **MR. COOPER:** Thank you, Amy. Any
6 questions for -- for me or for Amy regarding the
7 activities of E.M.S.C.? Hearing none, thank you, Dr.
8 Doynow.
9 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
10 All right. Moving along, any old business anybody
11 wants to bring up? Go ahead, Dr. Bart.
12 **MR. BART:** Joe Bart. Just any
13 progress we've had on the submission of the state
14 E.M.S. medical director position and what we've heard
15 about that.
16 **CHAIR DOYNOW:** I'll leave that for
17 Ryan Greenberg.
18 **MR. GREENBERG:** It's literally on my
19 list to discuss.
20 **CHAIR DOYNOW:** It wasn't on your list?
21 **MR. GREENBERG:** No, it is literally.
22 **CHAIR DOYNOW:** Perfect.
23 **MR. GREENBERG:** But we are waiting for
24 old business. So it is progressing through the
25 process on our side, you know, at about the pace that





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2 I thought it would. So my goal is, hopefully,
3 probably this summer to have an idea of -- of really,
4 you know, where that is and what, you know, getting
5 out and stuff like that by the time it gets through
6 the many processes it has to in order to kind of
7 create that new position.
8 **MR. BART:** Was there any feedback in
9 particular? I know several members of this -- this
10 group, put that together as far as the description.
11 But I don't know if there's any feedback at all that
12 you were willing, even offline, to share with us to -
13 - to just try to keep us involved in the process, if
14 we can.
15 **MR. GREENBERG:** Sure, I don't think
16 there was any specific feedback at this point. I do
17 know that the recommendations in that document was
18 moved forward as well.
19 **MR. BART:** Thank you. I had one other
20 thing and I know this has been in the pipe for quite
21 some time here. But is the bureau intending on
22 putting on any specific correspondence for maybe
23 those individual who weren't completely prepared for
24 the A.E.M.T. transition to the loss of the intubation
25 particularly in their scope of practice.



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2 And those medical directors were
3 involved in that process, but there are people that
4 maybe don't -- don't know where that came from. Just
5 wondering if something was coming out from the bureau
6 that we should echo that or if individually as
7 medical directors, we should be creating our own
8 content.
9 **MR. GREENBERG:** Excellent point, it's
10 actually something that came up over these two days
11 in conversations. So we will be working on a policy
12 statement with the other updates. And realistically,
13 that will come out with the February meeting so
14 that's how it will come out.
15 **MR. BART:** Thank you.
16 **CHAIR DOYNOW:** Any other old business
17 before we move on?
18 **MR. GREENBERG:** Do you want the mental
19 health?
20 **CHAIR DOYNOW:** I was going to do a new
21 business but --.
22 **MR. GREENBERG:** Sure, either way.
23 **CHAIR DOYNOW:** We -- we can do mental
24 health now, Jenny, if you'd like to.
25 **MS. SALOMON:** Thank you so much.





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2 Folks, I am really grateful to everyone who has
3 helped us get where we are so far. It's significant
4 I had a recent evaluation -- every student who takes
5 this course submits an evaluation.
6 And one of them recently came back
7 specifically thanking the state and everyone involved
8 for promoting this kind of education. And I think
9 that was huge because support is a massive part of
10 fostering resiliency.
11 So if our providers feel supported by
12 us giving them this education and making these
13 opportunities available, then that in and of itself
14 will help foster the resilience of our providers.
15 The providers that have taken courses have come from
16 many different program agencies, there are still some
17 that have not yet had courses there.
18 I think that speaks to the over
19 saturation of continuing education, the geographic
20 limitations and just some other situations going on.
21 So if you are from the EMSTAR region, I would love to
22 put a class together for someone in there.
23 We do need to reschedule something for
24 Southern tier. They had something scheduled and we
25 had a very low enrollment so that needs to be





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2 rescheduled for hopefully a better time in the year.
3 Central New York as well I'm looking for, Westchester
4 we anticipate in the spring and Suffolk County
5 possibly later on in the year as well, they suffered
6 from oversaturation.
7 Just because we have already done this
8 class in your region does not mean that we can't come
9 do it again, if there is interest. Originally, I had
10 reached out to program agencies to help facilitate
11 this. It turns out program agencies already have a
12 lot on their plates.
13 So what was really great was going
14 directly to agencies and squads and being able to
15 offer this in house and meet their providers where
16 they are. We found that providers responded very
17 well to this and we had some very high numbers of
18 people enrolled.
19 So for instance, Oneida County has
20 already hosted three separate classes. So providers
21 in Oneida are feeling pretty resilient and grateful
22 for this. I also really want to appreciate people
23 speaking towards the de-escalation, because we in
24 that same survey ask providers what else they would
25 like to see and with the time limitations of the





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2 course they get a very one on one sense of de-
3 escalation.
4 But they are in fact actually asking
5 for more of that, so collaboration is huge. I'm
6 happy to lend whatever I have to those of you doing
7 that. And I think that's it. Ryan, is there
8 anything else you wanted from me?
9 **MR. GREENBERG:** Jenny, how would
10 people get in touch with you that are looking to get
11 in touch with you for this program?
12 **MS. SALOMON:** All right. Get ready to
13 write it down, I'm going to give you my -- or you
14 could just email Ryan and he'll forward it to me if
15 that's easier for you.
16 **MR. GREENBERG:** I think -- I think --
17 I think it might be more successful if they emailed
18 you directly.
19 **MS. SALOMON:** I agree, but I think
20 that you -- you're selling yourself short, I think
21 you're totally capable. So if you'd like to get a
22 hold of me, jennifer.salomon, S-A-L-O-M-O-N, it
23 should look like the fish salmon but with an extra O
24 in the middle @health.ny.gov.
25 **MR. GREENBERG:** Thank you very much.





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2 **MS. SALOMON:** Wait one more -- one
3 more -- one more, I did so good. On the back table,
4 Amy has been absolutely instrumental, there is a
5 poster speaking to a universal approach towards
6 mental health. That poster has a QR code, which will
7 link your providers to our resources.
8 Especially if you come from an agency
9 where your folks are too cool for this, then I
10 implore you to put it up because those are exactly
11 who we need to set the standard and model the
12 behavior to be able to access these resources because
13 like I said before, the beginning resources foster
14 resilience.
15 **CHAIR DOYNOW:** And Ryan has a poster
16 up if anybody would like to come up and scan Ryan.
17 **MR. GREENBERG:** This is a big
18 initiative too actually on the posters. The posters
19 are in the back table. But if anybody does need more
20 for their region or want more, these are also going
21 to be sent out to all the E.M.S. agencies so it is
22 really designed and where the Q.R. code goes to is
23 designed for QA -- for an agency.
24 So for a provider who maybe doesn't
25 know who to reach out to or how to reach out to them,





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2 something that they can quickly walk by, see it's
3 there, scan the code. It goes to a web page that we
4 created. Thank you to Amy Eisenhauer for doing a lot
5 of legwork on that one, and we'll continuously update
6 as more resources become available.
7 This is very E.M.S. centric or
8 emergency services centric, I would say. So, you
9 know, the point of this program is to get out to our
10 providers and to let them know if you need help,
11 there are options. And if you need help that are
12 specific to understanding your needs, we have many,
13 many of these posters.
14 Like I said, we're going to send them
15 out to each of the agencies but in addition, please
16 don't be afraid to take a large handful. We didn't
17 bring as many this time, but at the next meeting, we
18 will be plentiful. And please take as many as you
19 think you need. Thanks.
20 **MS. EISENHAUER:** So I also note in the
21 future we're working on having a web form for request
22 for that. But you can email me if you need many of
23 them, I can get them shipped direct to you if you
24 don't want to wait for the next meeting.
25 **CHAIR DOYNOW:** Okay, thank you. Any





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2 other questions for Jenny? Okay, moving along some
3 other new business here. Just to report, this -- so
4 you folks are aware at the STAC meeting Dr. Simon and
5 Dr. Taperman had rather harsh comments about this
6 group's protocol for T.X.A. They were invited to
7 come to this meeting.
8 Or their representatives were invited
9 to come and discuss it with us if they had any
10 questions. And as far as I know, neither of them or
11 their representatives are here. So my assumption is
12 after further review, they found that their concerns
13 were unfounded and put that to rest. Dr. Dailey, do
14 you have anything?
15 **MR. DAILEY:** No, Dr. Doynow, I -- I
16 would actually just like to -- to apologize, I was at
17 E.M.S. World Expo and could not join you for that
18 meeting. And I'm sorry, I could not remind them that
19 -- that indeed the STAC had agreed with -- with the
20 process that was moving forward at that point. So
21 I'm sorry, that turned into a less than collegial
22 experience for you.
23 **CHAIR DOYNOW:** Thank you, Dr. Dailey.
24 Okay. Moving on, E.M.S. wait times. As all of you
25 know we are telling our E.M.S. agencies, they need to





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2 be at the patient side within minutes. Yet, we're
3 getting to the point now where multiple E.M.S.
4 agencies are being tied up in hospital hallways
5 waiting to unload their patients, sometimes for
6 hours, which has presented significant issues for our
7 E.M.S. response times.
8 Some agencies are going to first and
9 second mutual aid in attempting to get an ambulance
10 to the patients. That resulted in a vocal group of
11 E.M.S. providers who met and one agency came to a
12 decision that they vetted through their legal
13 representatives as to what exactly they were going to
14 do if they could not unload the patient.
15 And if they were going to be there for
16 a prolonged period of time, what was going to happen?
17 I won't go into specifics. If anybody wants to see
18 me after the meeting, I'll be happy to give you their
19 contact information. They said that I could
20 certainly do that.
21 That did prompt one of the local
22 hospitals to come up with a pretty reasonable program
23 to get E.M.S. agencies to unload, which they actually
24 started this week. And I was going to ask Dean
25 Romano, who is E.M.S. coordinator for that hospital,



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2 to explain what they did.
3 And I'm sure he'd be happy to ask --
4 answer any questions. My understanding is that
5 specific hospital had seventy-four ambulances over
6 the period of time that they started this and it
7 worked out pretty well.
8 **MR. ROMANO:** Okay. So I -- I'm from
9 St. Peter's Hospital and St. Peter's health partners
10 and at St. Peter's. In Albany med we kind of both
11 have the same problem where we have ambulances
12 stacking up. So at St. Peter's we did a pilot, we've
13 begun this -- we're using it on Mondays and Tuesdays
14 to troubleshoot, try it out, tweak it that week and
15 then modify it for each following week.
16 The very first week on the very first
17 day, we saw a thirty-three percent increase in our
18 ambulance volume. That has nothing to do with the
19 pilot program, it just happens to be that that volume
20 that day was incredibly high.
21 And some of the findings that we found
22 were that -- well, the goal was to build like a --
23 almost like a waiting room for ambulances at the back
24 entrance along with the waiting room for the walk-in
25 patients at the front.





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2 And so we've created a space and with
3 that increase in volume, we quickly overrun the
4 resources that were available. However, it did
5 create an improvement in the flow. The E.M.S. crews
6 definitely appreciated the -- the additional effort
7 and it did actually help the flow through the
8 department a little bit.
9 There's lots of opportunities to make
10 some more improvements, but it is just one effort in,
11 you know, a whole list of problems that we're trying
12 to solve. So we did make some progress and we are
13 going to continue to work through this kind of like
14 an E.M.S. staging, offloading area.
15 **MR. GREENBERG:** Dean, can you explain
16 who's in --
17 **CHAIR DOYNOW:** Thank you.
18 **MR. GREENBERG:** -- how that would work
19 and who's staffing, like what that would look like a
20 little bit?
21 **MR. ROMANO:** No, because actually it
22 is changing. Yes, certainly. So right now I'm going
23 to just talk about the E.M.S. side of it, not the
24 waiting room side of it. So right now, we -- we
25 staffed it with an R.N., we -- we have lots of





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2 different scenarios on how we're going to try this.
3 We're thinking we can staff it with an R.N. who can
4 take the report and move the patient from the
5 ambulance stretcher to the emergency department
6 stretcher and then move the patient into the
7 department and swapping and move around stretchers.
8 We've talked about a model where we're
9 using an L.P.N. in the back and the R.N. will -- the
10 charge nurse R.N. will take report, the L.P.N. can
11 stay there with the patients and move the patients
12 around as needed, you know, the -- the nurse
13 regardless of if it's an R.N. or L.P.N., in the back
14 staging area, is not taking that patient as an
15 assignment.
16 It is kind of a hold area until the --
17 the nurse who can take that patient is, you know, got
18 available bed.
19 **MR. GREENBERG:** And just curiosity, is
20 there a mid level or provider seeing them at all in
21 that offload time or is it not till they get to the
22 back?
23 **MR. ROMANO:** So -- yeah, so this is
24 not yet a treatment. This is truly a waiting room
25 for -- it is not a pit type of a process like we're





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2 using in the front of the house. And I hate using
3 the terms front of the house, back of the house for
4 ambulances and walk ins, but you get the idea.
5 But we have talked about the
6 possibility of using that, a lot of different
7 scenarios and we're, you know, there's nothing out of
8 -- out of the balance here trying to figure out the
9 best process for this.
10 **MR. GREENBERG:** Thank you and thank
11 you for sharing it. Is there any other members that
12 are in their hospitals doing anything similar,
13 anything to help in -- in decreasing this times or a
14 different approach?
15 **CHAIR DOYNOW:** Ideas, I think all of
16 us are open for the -- Dr. Rabrich.
17 **MR. RABRICH:** Thanks so yeah, I
18 commend you for this program and in full disclosure I
19 have some relationship with that health system, but
20 we're seeing this all over the state and all over the
21 country quite frankly. And it's not that, you know,
22 ... want to help our E.M.S. colleagues ... as quickly
23 as possible but as the recent ... journal article,
24 you know, the emergency department Canarian (phonetic
25 spelling) health system eloquently pointed out.

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2 This is really a problem of hospital
3 throughput and hospital efficiency. And I think
4 there's a lot of things we can do beyond this temper
5 rising measures which will help, but for example,
6 during COVID and it's still in effect, the health
7 department requires hospitals to report inpatient bed
8 capacity and that's how they make their decision as
9 if they can continue elective surgeries or not.
10 You know, I would say that that's not
11 the right measure and that there really should be
12 some measure of E.D. in there whether that's percent
13 of E.D. beds occupied by inpatient holds or left
14 without being seen rates or wait times and I really
15 think this body should work with the department to
16 and the incoming commissioner to really try and get a
17 -- a meaningful measure of hospital health and
18 efficiency and that comes from the emergency
19 department, not how many total beds you may have in
20 the hospital whether staffed or not so I think that's
21 one concrete action we can take.
22 And another one is in the -- in the
23 realm of diversion. I -- I really think we need to
24 get a handle on diversion and, you know, hospitals
25 should be required to report diversion to the S.O.C.





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2 or the S.O.C. designee so that we really can have an
3 understanding working with the bureau and with the
4 health department as to, you know, what's the
5 capacity of the system currently and are E.M.S.
6 provider being asked to go sixty, eighty, a hundred
7 miles out of their way with patients to try and drop
8 this off.
9 So again, I applaud these effort and I
10 think a lot of our hospitals are trying to be
11 creative and think out of the box as to -- to how to
12 help offload E.M.S. in a timely fashion, but, you
13 know, this is -- this is a hospital problem and not
14 an emergency department problem and I think we should
15 -- this body should point that out to the department.
16 And, you know, I -- I think we run the
17 risk though with some of these E.M.S. agency and I
18 understand the frustration, but creating an agency
19 specific policy is a challenge for our hospitals
20 because they don't know how each agency is going to
21 act or what their plan is to leave the patient there.
22 So perhaps a -- a regional approach would be better
23 there as well. I know -- I know I threw a lot out
24 there but thank you.
25 **CHAIR DOYNOW:** Is that a motion or is





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2 that just a suggestion?
3 **MR. RABRICH:** I will phrase it in a
4 form of a motion that -- that the SEMAC send a letter
5 to the commissioner or designee asking that the
6 department develop a emergency department based
7 metric to determine hospital status and ability to
8 continue elective surgeries.
9 **CHAIR DOYNOW:** Okay, did you get that,
10 Val?
11 **MS. OZGA:** No.
12 **CHAIR DOYNOW:** Okay. Need to -- need
13 to have it slower, sorry.
14 **MS. OZGA:** I'm sorry.
15 **MR. RABRICH:** I'm from downstate, I'm
16 sorry. Yeah, so a letter to the commissioner or
17 designee because right now we -- we don't know who
18 that's going to be, but the commissioner that the
19 department reevaluate the current criteria for can
20 hospital continue elective surgeries.
21 **MS. OZGA:** Reevaluate the --.
22 **MR. RABRICH:** The current criteria for
23 hospitals to be able to continue elective surgeries
24 and develop an emergency department.
25 **MS. OZGA:** I'm sorry.





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2 **MR. RABRICH:** Uh-huh.
3 **MS. OZGA:** The current criteria.
4 **MR. RABRICH:** To collect -- continue
5 elective surgeries.
6 **MS. OZGA:** Okay.
7 **MR. RABRICH:** And develop criteria
8 that consider inpatient burden on the emergency
9 department and -- and E.D. capacity.
10 **MS. OZGA:** Inpatient burden on the
11 emergency department?
12 **MR. RABRICH:** Inpatient burden on
13 emergency department and available E.D. capacity.
14 **MS. OZGA:** Available E.D.
15 **MR. RABRICH:** Capacity.
16 **MS. OZGA:** Okay. Now what do I do?
17 **CHAIR DOYNOW:** Hold on it for a
18 moment. Do we have a second?
19 **MR. MARSHALL:** Second.
20 **CHAIR DOYNOW:** Dr. Marshall seconds
21 it. As far -- I was going to say at this point Mark
22 Phillipy, would you like to talk about what you have
23 done with this before we vote?
24 **MR. PHILIPPY:** As a point of
25 discussion on this matter but also, I'm just kind of





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2 reporting on some of the things that have been done.
3 Thanks to the effort of Steven Kroll and Dr. Morley
4 from the department, we were able to meet Director
5 Greenberg and I with the principals from the public
6 health and health care policy counsel which is our
7 sister counsel actually predecessor counsel I
8 understand was helpful in formation of the SEMSCO and
9 the SEMAC.
10 The physician leaders there were very
11 interested in what we were talking about as far as
12 emergency department hold times and the offload
13 times. It is a topic that is very concerning to Dr.
14 Morley and -- and by extension I'm sure the
15 commissioner and the staff at the department.
16 We have good information from Director
17 Greenberg that ... is interested in speaking with a
18 delegation from the SEMSCO at the request of Dr.
19 Doynow. I'm going to ask for some physician leaders
20 from this group who may wish to help -- help assist
21 us with forming our -- our thoughts to that and
22 potentially be involved in the -- the presentation
23 but, you know, certainly depending on the outcome of
24 the SEMSCO elections this afternoon, I -- I will be
25 in a different positions. But I'm still willing to -





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2 - to help and -- and facilitate this discussion.
3 And anyways we're trying to do this I
4 would have an ask of this group as -- as physician
5 medical directors to speak with your agencies to try
6 and develop some data and -- and full credit to the -
7 - the bureau's data and ... staff and Chief Brody. I
8 know that agency sometimes have different data and
9 ... platform available to them, they might help us to
10 develop information along the lines of what are your
11 hospital hold times, what is the unit hour
12 utilization are -- are they being involved with hold
13 -- being held up at the hospitals.
14 This is some information we can very
15 much use to -- to make our case, but that's -- that's
16 something that's in the work. I don't have a firm
17 date on when that might be. So that's all I have to
18 report on that, thank you, Doctor.
19 **CHAIR DOYNOW:** Thank you, Mark. Go
20 ahead.
21 **MR. WASHKO:** All right, Jonathan
22 Washko, hospital representative. So I would throw up
23 -- first off NAMSEC is working on this issue and
24 advisory was sent to final last NAMSEC meeting
25 associated with this particular issue. There is





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2 three specific recommendations that the NAMSEC is
3 making to the federal government because this is a
4 national problem.
5 The biggest thing has to do with
6 relationship building and pretty much all three
7 points are associate with relationship building and
8 so potentially it might be worthwhile to consider
9 putting a group together from the SEMAC to
10 potentially engage either HAINES or some other group
11 that we potentially can work with from the state
12 level to see what we can do to help solve this
13 problem, identify what the issues are, share the
14 data, open the dialog, you know, something along
15 those lines.
16 **CHAIR DOYNOW:** Thank you. Go ahead,
17 Steve.
18 **MR. KROLL:** Good afternoon, I get to
19 wear -- Steven Kroll. I get to wear a couple hats in
20 my bureau and I'm going to put on my hospital hat
21 right now. I serve as the chairperson of the board
22 of a hospital in New York state and I want to take
23 something John said and connect it with something Dr.
24 Rabrich said.
25 You know, John talked about how this





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2 is a collaborated process. We have to work his
3 partner with hospitals and we are the regulatory body
4 of E.M.S. and what Mark Phillipy just connected us
5 with is the regulatory body for hospitals. Article
6 30 -- Article 28, meet each other, talk among
7 yourself see if you can come find some solutions.
8 And I think ... like HAINES and to
9 that in the medical society and the emergency
10 physicians associations all make sense. I -- I do
11 want to speak though on your motion, Dr. Rabrich.
12 Hospitals in New York State are losing hundreds of
13 millions of dollars because the cancelation of
14 elective surgeries. That is feeding into this
15 vicious circle of a problem which is we don't have
16 money to hire the personnel that we need, to improve
17 the nurse ratios, to be able to open up more bed to
18 be able to do E.R. throughput.
19 But I think us sending a letter, and
20 I'm not a voting member, I'm a -- I'm a non-voting,
21 but for us to send a vote, to send a letter that says
22 you ought to have a metric as to whether or not we're
23 going to stop doing elective surgery actually feeds
24 into the hospital problem. My hospital system is
25 lose -- has lost somewhere around fifty million



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2 dollars in operations so far this year.
3 And we are one of the ones that is
4 doing better than others. There are some that are --
5 that -- that number in the hundreds of millions now.
6 If we suggest that the metric to suggest is limiting
7 elective surgeries because of the throughput issues,
8 we actually put more pressure on the hospitals, in a
9 place where they -- they just don't have the money to
10 make those hires.
11 So I think your intent is correct that
12 we need to be sitting down with hospitals and talk
13 about what is the right metric, but I don't think
14 this one necessarily is going to get us where we want
15 to go. Because no hospital wants to have these
16 throughput issues. We actually can be part of their
17 solutions as partners, you know, things that are
18 being talked about or like community paramedicine
19 like things, right?
20 How do you keep people, you know, how
21 do we get less people in E.R. that don't belong
22 there, you know, Dean described what one health
23 system is doing. I think we need those collaborative
24 discussions and I think we're not going to get
25 ourselves very far if we put the hospitals in a





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2 position of hearing them say they want you to less
3 surgeries so you can get patients out of the E.R.
4 Now I know that make -- there's a lot
5 of inside hospital politics that this relates to,
6 right? And I don't want us to -- the E.M.S.
7 community sort of set up a fight inside the hospital,
8 right? E.R. versus inpatient, they already have that
9 fight. I don't want us to be making it worse, so
10 that's my thoughts.
11 **CHAIR DOYNOW:** Any other discussion?
12 **MR. RABRICH:** ...
13 **CHAIR DOYNOW:** Dr. Rabrich.
14 **MR. RABRICH:** So I understand what
15 you're saying and I'm fully aware of the hospital's
16 financial situation. I would submit though that we
17 have over the past many years emergency medicine
18 organizations have spoken with the hospitals and, you
19 know, hospitals are driven by certain motivations
20 which -- let's be honest, you know, the -- the E.R.
21 patient waiting in E.R. is not the highest provider
22 of income for the hospital to -- to put it that way,
23 right?
24 So you know, throughput and hospital
25 holds have been an issue before COVID. It's coming





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2 through a crisis level again now, but, you know,
3 we've been having this discussion for thirty years,
4 so you know, I will give you that, you know, maybe
5 canceling elective surgeries might not be the exact
6 way to go about it, but until there is a motivation
7 for this to be fixed by hospitals and health systems
8 beyond let's sit and talk, I'm -- I'm not sure we're
9 going to get anywhere.
10 **CHAIR DOYNOW:** Okay. Let's see, Dr.
11 Walters, I guess, was next.
12 **MR. WALTERS:** Sure.
13 **CHAIR DOYNOW:** We'll move over this
14 way next.
15 **MR. WALTERS:** I just wanted to -- I --
16 I think I echo what Dr. Rabrich said and -- and Mr.
17 Kroll I appreciate what you're saying. I think the
18 intent here nobody wants to see surgeries canceled,
19 right? We know that that affects patients and it
20 affects hospital's bottom line. But we also know
21 that some hospitals are not as good as others at
22 looking at E.D. wait time, E.M.S. offload times,
23 boarding in the E.R.
24 And I think one of the things that
25 we've seen in the last two years through COVID is





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2 that if there is a risk of canceling elective
3 surgeries, all of a sudden hospital administrators
4 pay attention to whatever metric is attached to that
5 every single morning. And I -- and I think trying to
6 put some type of incentive, like Dr. Rabrich
7 suggested, that will get the attention of the
8 hospitals and make it a motivation for them to
9 improve that throughput or look at these numbers and
10 look at the system as opposed to not just their
11 financial incentives, I think that is the goal.
12 It is difficult probably to define a
13 way to do that without punishing someone in some way,
14 however, to be honest, sometimes that stick rather
15 than a carrot has to be put in place to draw that
16 attention of our -- our hospital administrators.
17 **CHAIR DOYNOW:** Thank you, Dr. Walters.
18 Maryanne.
19 **MS. PORTORO:** Maryanne Portoro with
20 New York State Emergency Nurses Association. I'm not
21 a voting member but just what Dr. Rabrich said, I
22 mean, I know elective surgeries canceling them may
23 help some of the problem but the other biggest
24 problem is there is not enough nurses out there to
25 take care of these patients.



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2 So he talked about throughput.
3 Throughput is a major issue so if there is no staff
4 upstairs to take care of the patient on the floors,
5 we're not going to get our patients out of the E.R.
6 because they are not taken them on the floors, they
7 are closing the beds because they don't have staff to
8 staff those beds and to take care of all those
9 patients.
10 So we're backlogged with all these
11 patients and holding them because they think the E.R.
12 is the place to do it. And then E.M.S. comes in,
13 they are backlogged, it's a major throughput
14 situation and I think maybe what we need to look at
15 or this body needs to look at, is how can you help
16 improve the nursing shortage and work together and
17 also with the -- a community paramedicine. I know
18 that's a major thing but it -- it -- that's the key.
19 **CHAIR DOYNOW:** Dr. Dailey, I believe
20 your microphone is on.
21 **MR. DAILEY:** So I -- I very much
22 appreciate what Dr. Rabrich is suggesting, but I
23 think one of the things that our patients in the
24 community are still suffering from you had some of
25 their restrictions on elective cases that were





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2 started through COVID. The idea that if we cancel
3 elective surgeries that somehow increases capacity in
4 a hospital system is false, right?
5 Most elective surgery is same day
6 stuff. The staff that takes care of patients in the
7 same day situation isn't going to suddenly decide
8 that they want to go work on the floors instead. And
9 during that shift and staffing and trying to move
10 patients -- move nursing staff from one place to
11 another during COVID we actually lost a significant
12 amount of nursing capacity within our hospital.
13 I -- the reason that you want to do
14 this is absolutely fantastic. The way to get there
15 is not by limiting elective surgery. The department
16 stick here would be a drastic -- a drastic move. The
17 other thing I'd like to point out is that while ...
18 is indeed the -- the planning for hospitals, right?
19 This is the planning and the committee for emergency
20 departments. We are responsible both for emergency
21 departments and for E.M.S. advising to the
22 commissioner.
23 I think advising the commissioner to
24 look at things like NEDOCS scores in terms of
25 hospital capacity or emergency department capacity,





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2 great idea. They could modify NEDOCS scores so it's
3 based on actual capacity, not reported capacity. But
4 we cannot start impacting elective surgeries in these
5 days of, you know, physical disaster for hospitals
6 when it's not going to ultimately decrease throughput
7 times in our emergency department and increase
8 capacity in our E.D.s.
9 **CHAIR DOYNOW:** Thank you, Dr. Dailey.
10 Dr. Marshall?
11 **MR. MARSHALL:** Thank you. And so as
12 C.M.O. of a large level one trauma center in New York
13 City, I deal with this on a daily basis in terms of
14 what's the balance between the inpatient and the
15 emergency department. We always have patients
16 boarding in the emergency department. We always have
17 patients waiting for surgical procedures upstairs.
18 There -- these is no easy answer but
19 perhaps in considering whether or not a hospital or
20 health system should reduce the elective surgical
21 volume because of a particular reason, they should
22 include E.D. metric in that discussion, not that you
23 have one E.D. metric that determines that, but they
24 should also include the emergency department in that
25 decision making process.





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2 I think that, you know, my problem in
3 my facility is -- is not throughput, it's not nursing
4 staffing, it's anesthesia staffing. And so, you
5 know, some of the things that I've had to decide are
6 -- can I continue to do elective surgery if I don't
7 have anesthesiologists, right? I mean those are my
8 challenges, but I think that adding an E.D. matrix to
9 that whole decision-making process may just help us
10 better understand throughput through the hospitals.
11 Thanks.
12 **CHAIR DOYNOW:** Thank you. Dr.
13 Rabrich.
14 **MR. RABRICH:** Thank you. And -- and I
15 just to -- to your comment, Dr. Dailey, I -- I have
16 mentioned elective surgeries because that currently
17 exist and then we're -- I'm not suggesting that
18 that's the only thing to do or look at and I would be
19 happy to amend the motion or look at other things,
20 but I think there has to be -- there has to be some
21 motivation for hospitals to help fix this beyond just
22 -- we're going to meet and we'll be great if you
23 could work on your throughput. But I -- I hear your
24 concerns about elective surgeries but it's currently
25 what the department is using based on capacity to



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2 make that decision.
3 **CHAIR DOYNOW:** Dr. Markowitz.
4 **MR. MARKOWITZ:** So I think none of us
5 will deny the importance of incentivization. I mean
6 that's what we're talking about, how do we -- how do
7 we -- how do we incentivize the behaviors and that's
8 a real challenge. You know, I think that, you know,
9 we're talking about sticks and I think we should be
10 looking for carrots what -- what can we do within our
11 health infrastructure to incentivize with -- with --
12 positively for hospitals.
13 I don't know what we can do, but I
14 think that that will -- that will support more growth
15 of the health care system which what we -- what we
16 need future state, we need -- we need health care to
17 grow. There is -- is minimum capacity in many -- in
18 many areas from in -- in many ways. Access in
19 general to health care is an issue.
20 So I think that if we can incentivize
21 properly, we'll be incentivizing growth. I mean, no,
22 you know, hospitals are not, you know, making the
23 margins that other players in the health care
24 industry are making. So I agree that with that --
25 that -- that the kind of stick is not -- regardless





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2 of whether it would work and it would likely cause
3 all sorts of other untoward ramifications, you know,
4 we know that when we make decisions.
5 You -- you think you make this great
6 plan to incentivize behavior in a certain way and,
7 you know, --, you know, if you look at three years
8 down the road and you're like why are people doing
9 these weird things and it's because of what -- what
10 you put together. In general, I think when you have
11 positive incentives you have less -- less of those
12 behavior ramifications.
13 **CHAIR DOYNOW:** Thank you. Dr. Cooper,
14 you had comments or not?
15 **MR. COOPER:** ...
16 **CHAIR DOYNOW:** No? Dr. Phillipy.
17 **MR. PHILLIPY:** I think Dr. Cooper was
18 first.
19 **CHAIR DOYNOW:** Dr. Cooper.
20 **MR. COOPER:** Thank you, Dr. Doynow,
21 you know, back in 2005, I believe it was, when --
22 when Article 30B was introduced for action by the
23 legislature at the behest of assembly member ... the
24 assembly health committee several of us were able to
25 convinced him that it was really important to give





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2 this body a role, you know, and -- in advising the
3 department and the commissioner about -- about issues
4 taking place in the emergency department because
5 there was really no other place where those issues
6 were being discussed or advice being provided on a
7 formal basis.
8 Some of them ... saw the wisdom in
9 that as Article 30B explicitly does speak about
10 SEMAC's role, you know, as Dr. Dailey has just
11 pointed out. There was a task force that was -- that
12 -- that was set up. Dr. Marshall may remember he
13 served on it, I believe, back in 2006 or '07 in that
14 thereabouts under Director Ronski a couple of
15 meetings were held, but nothing further, you know,
16 happened after that point.
17 And I -- I think that -- I think that
18 the issue we're discussing today really points out
19 the wisdom that Assemblymember Gottfried, you know,
20 brought to bear about making sure that there was a
21 better interface between the, you know, the -- the
22 emergency department and the -- a pre-hospital end of
23 things and in some ways this mirrors the approach
24 that has always been taken by E.M.S.C., which was
25 envisioned as a -- as a program from the -- from the





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2 get go that focused on the emergency patient through
3 the end -- the fate of the emergency patient through
4 the entire system.
5 You know, the entire course of care
6 from, you know, prevention access et cetera all the
7 way through to rehabilitation, you know, including
8 that, you know, the proviso that this body has a role
9 and advising the commissioner and the department
10 about emergency department as well E.M.S. I think was
11 a fundamentally important first step in that
12 direction. And I -- I do think that -- that, you
13 know, this body is very well prepared to, you know,
14 think about those issues not just about the current
15 crisis but -- but moving forward.
16 Everyone has made great points. I
17 just can't help but remark that if you cancel
18 elective surgeries, I'll have more time to go to
19 meetings talking about why we're cancelling elective
20 surgeries. And so maybe -- maybe with that in mind
21 you would like not to cancel elective surgeries but -
22 - but be that as it may, a lot of good comments made
23 today but, you know, as Dr. Dailey also has widely
24 pointed out most -- most surgeries these days is --
25 is elective and ambulatory.

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2 And, you know, the long haul surgery
3 patients, by which I don't mean long haul COVID, but
4 long haul surgery patients that are in for, you know,
5 for several days, those patients are very, very few
6 and far between now except in our trauma centers and
7 no one's going to deny them access to care, you know,
8 at all.
9 So I will stop there, but I just want
10 to encourage us all to continue and at this level to
11 see if we can't help our colleagues statewide find
12 some reasonable solutions or -- or share best
13 practices, you know, as we're attempting to discuss
14 today. Thank you, Dr. Doynow.
15 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
16 Mark Phillipy.
17 **MR. PHILLIPY:** Thank you. I -- I
18 really appreciate the conversation as I kind of go
19 back to some of the information that I brought
20 forward earlier and -- and to Dr. Rabrich just kind
21 of -- we have a motion on the floor so I don't want
22 to take up too much time from that.
23 But I think at the end of the day what
24 I'm hearing is that we need to kind of revitalize
25 this task force concept that we need a couple of





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2 things to do that one of which is transparency in the
3 information that we're obtaining. Not just from the
4 agency represented here but also from the hospital
5 systems. For example, one of the hospital system in
6 my region has an internal document that someone
7 accidentally shared with me that has some very good
8 information about their E.D. boarding and whole
9 times.
10 So they are self-reporting within
11 their own institution. Their E.D. hold times in
12 boarding and nursing stuffing and to ... point, you
13 know, not to get into the politics of it but how many
14 nurses on the floor are actually handling how many
15 patients and we all know the E.D. nurses are often
16 handling way more patients than a floor nurse would.
17 So what do those -- what do those
18 numbers look like. If we are to incentivize this in
19 some way, I think part of that is getting information
20 that may require a demand or at least a polite
21 request from a -- a governing body and I think that
22 we could potentially influenced that by joint venture
23 between us and FIBBIC (phonetic spelling) but again,
24 I -- I know this is kind of off Dr. Rabrich's motion,
25 I just want to throw it out there that I -- at some





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2 point I think that's where we need to head.
3 **CHAIR DOYNOW:** Don, go ahead.
4 **MR. HUDSON:** Sorry, I'm not a member,
5 but Don Hudson. So in -- in acknowledgement that we
6 need to work within what we can control as the -- the
7 regulatory body in this case SEMAC, SEMSCO and
8 whatnot and in acknowledgement to all the problems
9 that our in hospital partners are encountering that
10 are far beyond even their control if not ours.
11 What could we do as E.M.S.? Is this -
12 - is this the springboard issue that really should be
13 used to drive committee paramedicine E.T. three and
14 alternative destination in an effort to work with our
15 in hospital partners to decompress their facilities.
16 We keep feeding this machine that we
17 know is breaking and then we're amazed to the poor
18 product that comes out. In this case meaning people.
19 So what would the true E.M.S. role be here and I
20 don't want to stop feeding our hospitals patients,
21 but we need to get the right patient, the right
22 facility as we all know. And how do we do that and I
23 think that is a topic that has somewhat stalled due
24 to other political and misconceptions both within our
25 own community and outside so I would just say strike





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2 while the iron is hot.
3 **CHAIR DOYNOW:** Thanks. Yes, go ahead.
4 **MR. GREENBERG:** So I just want to say
5 thank you for all the feedback and even just the --
6 the concepts, the ideas and different things and, you
7 know, in thinking through different ideas and, you
8 know, conversation that I've had, you know, one of
9 the other conversations this weekend was also about
10 just transparency and transparency on a number of
11 different things. And so maybe it's not the, you
12 know, elected surgeries that stop and we all
13 understand, you know, that the pain and that the
14 things that happen with us.
15 But it's also we're living in an
16 ecosystem. It all affects one another, Maryanne
17 spoke about it, you know, one backs up the other. We
18 all know that one. But, you know, step one in Dr.
19 Rabrich in -- in reporting and maybe having to post,
20 you know, how long your offloads times are, how long
21 your average offloads times are because comparing to
22 different sometimes competition, you know, around it
23 does help and or at least it makes it recognized when
24 you look and say, you know, fill in the blank Steve
25 ... hospital, you know, has ten minute offload times

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2 and, you know, Greenberg's hospital down the block
3 has sixty minutes offload times, I'm walking over ...
4 going, how did you do that.
5 Maybe St. Peter's depending on how
6 that program goes. So, you know, maybe some of that
7 transparency is a recommendation that doesn't have
8 the same other impact and financial impact, but has,
9 you know, a step in the direction of at least having
10 someone look at something on a regular basis. Again,
11 just ideas for steps.
12 **CHAIR DOYNOW:** Don.
13 **MR. KROLL:** This has been a great
14 dialogue and there are a lot really motivated people
15 around the table and -- and Dr. Burke (phonetic
16 spelling) what you mentioned both the carrot and the
17 stick, you know, there is a combination of things we
18 can do. A transcript that this should feed right
19 into the conversation that the SEMSCO and SEMAC have
20 with the public health council planning committee
21 which we now know is going to happen.
22 They occupy the same role, they're our
23 sister body. So if we can take this energy and
24 conversation and -- and the point Dr. Dailey made
25 that we are not just E.M.S. where E.M.S. and E.R.





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2 advisory body to the commissioner, you know, you all
3 met Dr. Morley who is here at the last meeting who
4 has sort of been the facilitator of this. He's --
5 he's a heartbeat away from, you know, he's -- he's on
6 the -- he's a -- he's a deputy commissioner, right?
7 He is part of that commissioner's executive team.
8 We can make this into all of -- you
9 know, dimension, you know, some other things that
10 play into this right, the community paramedicine. We
11 really do have an opportunity as a body here and I
12 would say the SEMAC should reach out to the SEMSCO
13 which should be together to make this public health
14 council thing not just one meeting, but make this,
15 you know, here is the regulator of one side of the
16 equation and the regulators of the other side of the
17 equation, let's make it as three months, six months,
18 nine months project.
19 What are we going to come out with and
20 do because I think that -- that the transparency is
21 important. I mean I think you raise a good point
22 about one of the matrix you got to look at. The
23 other thing I mentioned is the public health counsel
24 because they're the hospital system, they got a
25 pretty big staff of people, you know, you take that





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2 stuff of people and you combine them with our staff
3 of people that work here.
4 There is a lot of data to be mined and
5 there is a lot of public policy to be built and I
6 think that, you know, Ryan ... and if Ryan and his
7 counterpart at the public -- at the public counsel
8 side are able to work together, they really could
9 facilitate great conversations. So -- so I mean, I
10 think that we should bother whatever happened here
11 today when that meeting happens with the public
12 health council, folks.
13 **CHAIR DOYNOW:** Thank you, Steve. Any
14 other comments? So I would recommend that anyone
15 that's interested in working with Mark Phillipy, let
16 him know. That being physicians and E.M.S.
17 providers, if that's okay with your Mark.
18 **MR. PHILLIPY:** Okay.
19 **CHAIR DOYNOW:** And they can meet with
20 you I guess after the meeting, share information.
21 Dr. Rabrich, did you want to modify your motion?
22 **MR. RABRICH:** I'd actually like to
23 table it to the next meeting if I could and hopefully
24 this can happen before then and we can get some
25 progress.





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2 **CHAIR DOYNOW:** Okay. So we will table
3 that motion until the next meeting. Okay, any
4 further discussion, Dr. Cooper?
5 **MR. COOPER:** ...
6 **CHAIR DOYNOW:** ... is not here today,
7 unfortunately. Okay so we'll -- we'll table it from
8 Dr. Cooper.
9 **MR. GREENBERG:** I apologize for the
10 stenographer, can you just repeat that on your mic,
11 turn on your microphone and repeat it? I just want
12 to make sure she was able to record.
13 **MR. COOPER:** Thank you, Dr. Greenberg.
14 I commented that I don't believe under parliamentary
15 law that -- that a maker of a motion can table his or
16 her own motion. He or she can withdraw it certainly,
17 but since the motion has been made, I don't even know
18 if it's been seconded formally, but I'm assuming that
19 it has been formal -- formally seconded and I will
20 therefore move to table to the next meeting which is
21 a non-debatable motion.
22 **CHAIR DOYNOW:** Okay. I will second
23 and yes, we'll table it till the -- the next meeting.
24 Okay, that being said, next is Quality Metrics.
25 **MR. REDLENER:** Thank you, Mr.



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2 Chairman. Now if you could put up a presentation. I
3 was asked to -- to deliver a brief presentation on
4 where we are, but the Quality Metrics committee we
5 talked about this last time as well. I have to give
6 a huge shout out and thank our committee, they have
7 done just a tremendous amount of work.
8 I appreciate all that work that they
9 have done. We have a Q.I. manual it's about forty
10 pages long that really is pretty detailed as more of
11 a reference document, a quick start guide that's
12 about four pages long and that really details the
13 things that folks can do at their agencies.
14 These are all sort of the how to
15 measure what we're doing with data and this is all on
16 Boardable as draft documents for everybody here to
17 see. And so what I'd like to do next is hopefully,
18 if these will all work, give a brief presentation of
19 what we've got now as a quality measure. We looked
20 at the ability to measure blood glucose on stroke and
21 T.I.A. patients and so, Val, if we go to the next
22 slide.
23 **CHAIR DOYNOW:** I think maybe just give
24 it a minute to --.
25 **MR. REDLENER:** Sure okay, we're going





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2 to get it lined up here.
3 **MS. OZGA:** Yeah, I know, the projector
4 had to be restarted.
5 **MR. REDLENER:** Got you, sorry about
6 that. And so as we move through this, I just want to
7 highlight what's possible and what we can all do.
8 And so these are the items that we want to quickly go
9 through in this presentation here. Next slide. The
10 manual itself has quite a number of different areas
11 to it. Great, thank you for making that larger on
12 there.
13 Next slide. Manual has all these
14 different areas here and so this really is more of a
15 detailed reference document. I can't imagine that
16 everybody is going to read through this manual unless
17 it's late at night and they'd like to get to sleep,
18 which I appreciate, but there is a ton of good
19 information in here that this team really looked at
20 that's nationally vetted data and reference material.
21 Next slide. The quick start guide
22 here has a little bit of a briefer approach to it.
23 I'm going to take you through that process very
24 quickly and so these are the components of the quick
25 start guide. Again these are all on Boardable. Next





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2 slide. So we're looking at the state measure O six
3 and this is a stroke or a T.I.A. patients receiving
4 blood glucose monitoring. The denominator of this
5 are the people that responded on nine one one call
6 for a stroke or T.I.A. patient, the numerator are
7 those who received blood glucose measurement.
8 Next slide. It's fairly easy to do on
9 a state bridge and if you -- this looks a little
10 scarier than it actually is, but we're taking a look
11 at all of the potential data points and funneling
12 them through the state site to come up with this
13 measure. The top pieces of this are some of the
14 larger components of it and then the smaller
15 individual data points are below.
16 Next slide. And so we look back at
17 2020 quarter one across the state and we came up with
18 the numerator, denominator and measure and it looks
19 like eighty percent of all nine one one stroke or
20 T.I.A. patients received a blood glucose check. And
21 so when we look this ... well, how can we improve
22 this? Where do you want to improve to and -- and we
23 looked at a date point of ninety percent of all
24 patients, we think should have blood glucose
25 monitoring in the stroke or T.I.A. category.





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2 Next slide. So this is what it looks
3 like on the run chart and we're taking a look at data
4 points over time. We can't just take one data point
5 in time and decide what to do with it. It's kind of
6 like looking at one piece of film from a movie and
7 deciding whether a movie was a good one or a bad one.
8 And at this point in the run chart, we don't have any
9 measures that are implemented either, but we can look
10 at our goal which is the red line and we can look at
11 the data points which is the blue line.
12 Next slide. So we did that, and here
13 is the data from the state that thank you, a huge
14 shout out to the D.I. team in putting all this data
15 together, and if you can look down on the bottom line
16 that's the percent of E.M.T.s that perform blood
17 glucose monitoring for stroke and T.I.A. patients
18 from quarter one 2020 and then it marches on to 2022.
19 Also in there are A.E.M.T.s, C.C.s and paramedics
20 which I think are the purple line.
21 Only at one point in there did we
22 reach our goal, but again this chart doesn't show any
23 kind of relevant interventions and going through a
24 P.D.A. cycle what that might look like. Next slide.
25 So here is other reasons why we may not have made

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2 that -- that mark, right. So it could be knowledge
3 about what we need to do engagement of personnel and
4 the equipment. Do we have the equipment, do we not
5 have the equipment? These gives us the opportunities
6 from our primary and secondary driver to make
7 improvements in the system and look at outcomes after
8 that.
9 Next slide. Here is that plan due
10 study act cycle and we have to come up with we
11 decided ninety percent was the goal, we're going to
12 measure, we're going to implement, we're going to
13 measure again and we're going to continue this cycle
14 through and through. Next slide. So here's finally
15 what we would expect a run chart would look like over
16 time. The first section, the first third there cycle
17 one where we've measured then we make an
18 implementation, we measure again, we make an
19 implementation, we measure again and we continue down
20 the cycle and ongoing way.
21 And so this is what our committee has
22 been working on for the past year. We've got the
23 manual, we've got a guide and -- and we've got a
24 measure, that's a state measure that we're looking at
25 that also happens to be a national measure. So as





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2 things usually go, I am passing on a ... to this
3 group for a pilot data study for February.
4 We're going to ask every physician on
5 SEMAC, every program agency and every SEMSCO member
6 to try this process with your home agency. We'll
7 give you a login, the D.I. team has already put
8 together documents, templates and we'll have written
9 and video instructions on how to do this. It will be
10 nothing more than logging in and pressing a button to
11 see the data from your agency.
12 Come up with the run chart and then
13 report back on this measure of blood glucose and
14 stroke and T.I.A. So what do we get out of this?
15 We're actually considering this as a gateway measure,
16 if you would. First one's free, it's on us and you
17 may be able to see the power of the data and what's
18 happening at your agency with -- with the press of
19 the button. Then you can decide what you need to do
20 with your agency in trying to improve this and -- and
21 we'll move forward with -- with other pieces.
22 We also like to -- and we really don't
23 care about what the data shows as much as the process
24 is -- the process working. As we move forward, we
25 are looking at about twenty other data points then to





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2 share out that you'll have a button to press and
3 figure out what to do with that information in a run
4 chart over time.
5 We really want to be collaborative
6 with this, we want to be inclusive with this. This
7 is not just our process and data, this is everybody's
8 process and data and -- and we want it to work for
9 you. Once this process gets tweaked and we see what
10 the other numbers are, then we can roll it out with a
11 slew of reports and we'll make it available for you
12 with timeframes and even an auto delivery process, so
13 you can get a report in your in -- inbox every Monday
14 for the past week or however you -- you want to set
15 it up.
16 So that's my pitch, I appreciate that,
17 we'll have everything sent out by Boardable with
18 directions, videos, lengths, et cetera, and ask that
19 folks really try this and get back to us so we've got
20 a good working document moving forward from February.
21 Thank you, Mr. Chairman for your time, I'll take any
22 question if you have any.
23 **CHAIR DOYNOW:** Any questions? Anybody
24 has?
25 **MR. GREENBERG:** I would just -- you





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2 know, just to add on to that ask, you know, this
3 isn't asked to all the council members both SEMAC and
4 SEMSCO and if not directly by you by who, by who you
5 feel the appropriate person is in your agency to
6 initiate something like this and, you know, what this
7 will really allow even more than and -- and I don't
8 know if you spoke this part -- it's -- we're not
9 looking necessarily at the metric or how well your
10 agency is doing or something else.
11 This is really the test of the system
12 through about sixty people and hopefully sixty
13 agencies that are testing it for seventeen hundred
14 agencies so that we put out a good policy manual. So
15 we put out a product that, you know, that -- that
16 people can engage with so we can get the feedback and
17 tweak it on a smaller scale and have hopefully to be
18 the champion, you know, of the goal of quality
19 metrics and moving forward on some state initiatives
20 and -- and understand exactly where those are coming
21 from.
22 And thank you to all the work that you
23 and your committee has done, Dr. Redlener, really
24 just outstanding, thank you.
25 **MR. REDLENER:** Excellent, thank you.





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2 **MR. GREENBERG:** Thank you so much.
3 **DR. MCEVOY:** Will there be a penalty
4 if we don't do this like canceling three elective
5 transports?
6 **MR. REDLENER:** I think the number is
7 under discussion at this point.
8 **MR. GREENBERG:** Transparency, your
9 name will go on the website.
10 **CHAIR DOYNOW:** No, actually you'll
11 have to come up with more policy statements. Anybody
12 have anything else for the committee before we close?
13 **MR. LYNCH:** Josh Lynch from Buffalo.
14 Just a quick -- a quick plan of information about a
15 free resource available to E.M.S. providers across
16 the state for the assessment and referral for
17 patients with substance use disorder, particularly
18 opioid use disorder.
19 So this is a program called the
20 matters network that's available for free to E.M.S.
21 providers across the state. It's app based, it
22 doesn't include using or making any phone calls and
23 it's a process that can be done in just a few minutes
24 on scene. So typically E.M.S. providers may make get
25 frustrated by going to the same house over and over





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2 again for the same problem.
3 And often times that frustration is
4 because we really don't have much to offer patients
5 with opioid use disorder except for bringing them to
6 the hospital which often times as we all know they
7 don't want to do and maybe they don't want to do that
8 because the hospital doesn't really have much to
9 offer them either.
10 So that's really where kind of the
11 premise of the matters programs was built and really
12 what that is, is a free app matters network as you
13 can search it in the Google Play store or on the
14 Apple store. Basically what that allows you to do is
15 to enter some information in about the patient and
16 the patient will see a -- a map of -- of treatment
17 organizations that can accept them.
18 So we've built relationships with
19 about two hundred treatment organizations around the
20 state and have solidified about eighteen hundred
21 weekly treatment slots for patients, so they
22 typically get their first choice appointment usually
23 the next day. That turns the -- kind of turns the
24 tone of the interaction with the patient that's just
25 overdosed, has gotten naloxone, is in withdrawal and





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2 is frustrated because there is really no option for
3 them. In doing interaction where hopefully the
4 E.M.S. provider and the patient both leave a little
5 bit better off with an appointment real -- really
6 happening, you know, happening the next day.
7 So the few other resources on the app
8 including access to naloxone, fentanyl test strips,
9 requests that are all free that can be sent to the
10 E.M.S. agency. So I hope that you will find -- find
11 that helpful. In 2023 we will include referrals for
12 mental health resources also so you can refer
13 patients to mental health treatment right from the
14 scene of the 911 call.
15 I will put this information up on
16 Boardable. There are a few handouts just one page on
17 the program in the back with the Q.R. code to get to
18 the app. And then just one other piece, Dr. Dailey
19 and I have been working on an E.M.S. initiation of
20 buprenorphine or suboxone program for New York State.
21 There are a few agencies that are
22 ready to do that. We're waiting on B.N.E. approval
23 for us to move forward to do that which we think
24 really -- really will save lives. So thanks again,
25 it's matters network is the name of the app and we





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2 encourage you to distribute that out to the agencies
3 in your regions, thanks.
4 **MR. GREENBERG:** Just two questions.
5 **CHAIR DOYNOW:** Thank you, go ahead.
6 **MR. GREENBERG:** Is it limited to any
7 particular parties, I know you said you had a pretty
8 big network, but you know, if E.M.S. providers were
9 to try and use that and, you know, fill in the blank,
10 they'd be like okay, there is nothing here verse, you
11 know, if you were to use it in Buffalo or Syracuse
12 there's a --
13 **MR. LYNCH:** Yeah.
14 **MR. GREENBERG:** -- lot of options.
15 **MR. LYNCH:** So if you look on the
16 Apple or on the website or on the little map that's
17 on the one pager in the back, you will see where we
18 are geographically distributed. We have pretty good
19 coverage across the state admittedly in pieces of
20 kind of central New York and up in the north county
21 where resources are fair -- are fairly limited. You
22 will see that those partners are also fairly limited
23 but I assure you we're -- we are working every single
24 day on growing the network.
25 There is also some capacity to refer



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2 someone. They can pick an ongoing tally addictions
3 care, so if there is another brick and mortar place
4 anywhere close really -- like reasonably to where
5 they live, they could choose to receive their care
6 via telehealth.
7 **MR. GREENBERG:** Mr. Chair, if it's
8 possible -- by the way amazing work and thank you.
9 Would it be possible maybe to have a four or five
10 slide PowerPoint or something just to see what it
11 looks like and what that interaction would be or
12 presentation at the next SEMAC meeting?
13 **CHAIR DOYNOW:** Yeah, that -- that
14 would be excellent. Would you be able to put that
15 together?
16 **MR. LYNCH:** Yeah, absolutely, we'll
17 keep that brief, and I -- I just -- I wanted to throw
18 that out there today because New Yorkers continue to
19 die from opioid overdoses and I thought if we can get
20 this into the hands of E.M.S. providers now, we can
21 do that. But I'll have something prepared for
22 February.
23 **CHAIR LYNCH:** Okay, great, thank you
24 very much. Any other discussion items before we
25 close? Okay. I want to thank everybody, we have a





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2 great discussions and thoughts on E.M.S. overcrowding
3 and E.D. –- yes, Ryan.
4 **MR. GREENBERG:** Just the last thing
5 for this committee. So their next meeting is in
6 February and -- the first week in February which
7 means we need all presentations, agendas, anything
8 else for the next meeting by January 9th and I know
9 that, you know, with the holidays and everything
10 else, it's a tight time period that's why I'd like to
11 put it out here to everybody and everyone in the room
12 who also needs to know that. January 9th, that's a
13 Monday, close of business everything need to be into
14 Val for -- or Theresa, for the next council meeting.
15 Thank you.
16 **CHAIR DOYNOW:** Thank you. Okay, that
17 being said, can I have a motion to close? Dr.
18 Cooper, second?
19 **MR. COOPER:** Second.
20 **CHAIR DOYNOW:** Dr. Markowitz. Anybody
21 against? Okay, I'll give you a few minutes back till
22 the next meeting, thank you all. Have a good
23 holiday.
24 (Off the record, 01:40 p.m.)
25





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2 STATE OF NEW YORK
3 I, DANIELLE CHRISTIAN, do hereby certify that the
4 foregoing was reported by me, in the cause, at the time
5 and place, as stated in the caption hereto, at Page 1
6 hereof; that the foregoing typewritten transcription
7 consisting of pages 1 through 102, is a true record of all
8 proceedings had at the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 22nd day of December, 2022.
11
12
13 DANIELLE CHRISTIAN, Reporter
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