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NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA EMERGENCY MEDICAL

ADVISORY COMMITTEE MEETING

DATE: September 13, 2023

TIME: 11:33 a.m. to 1:27 p.m.

CHAIR: Donald Doynow

LOCATION: Hilton Garden Inn

235 Hoosick Street

Troy, New York

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APPEARANCES:

ALEXA COPPOLA
ARTHUR COOPER
BRIAN CLEMENCY
BRIAN WALTERS
CHIEF ED MAJOR
DANIEL OLSSON
DAVID KUGLER
DAVID MARKOWITZ
DONALD HUDSON, Nassau REMSCO
DOUGLAS ISAACS

DR. JASON WINSLOW
DR. JEFFREY RABRICH, Nyack Hospital

JENNIFER GOLDMAN
JEREMY CUSHMAN
DR. JOHN MORLEY
JOHN WASHKO
JONATHAN BERKOWITZ
KATERINA GAYLORD
LEWIS MARSHALL
MARK PHILIPPY
MICHAEL DAILEY
MICHAEL MCEVOY
DR. MICHAEL REDLENER

RYAN GREENBERG, Bureau of EMS
STEVEN KROLL

THERESA ALLEN
TIFFANY BOMBARD

VALARIE OZGA, SEMSCO
WILLIAM MASTERSON, Suffolk REMSCO
YEDIDYAH LANGSAM

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

CHAIR DOYNOW: Good afternoon everyone. We're going to be starting in about two minutes so please stand for the Pledge of Allegiance.

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

CHAIR DOYNOW: Before everyone sits, if we can have a moment of silence for Earl Evans. He was one of the founding executive directors of the REMO Region. My kids used to know him as Mr. Remo. He'd been around for years and unfortunately, he died this past week at 89.

Okay. Thank you. If everyone could be seated. If we can have approval of the previous meetings of minutes, if somebody wants to make a motion for that?

MR. MARSHALL: So moved.

CHAIR DOYNOW: So moved. Thank you. Second?

MR. MARSHALL: Second.

CHAIR DOYNOW: All in favor, raise your hands. Well, that wasn't -- that wasn’t overly

enthusiastic. Anybody opposed? Okay. Any abstentions? It passes with a minor majority.

All right. Ryan, are you ready for your report? You're next up.

MS. ALLEN: Do you want to do roll call first, Dr. Doynow?

CHAIR DOYNOW: Okay. We can do -- we can do roll call first, sure, why not? I was hoping to avoid that but go ahead.

MS. ALLEN: Okay. Dr. Bart. Dr. Berkowitz.

MR. BERKOWITZ: Here.

MS. ALLEN: Dr. Barry. Dr. Bombard.

MS. BOMBARD: Here.

MS. ALLEN: Dr. Cooper.

MR. COOPER: Here.

MS. ALLEN: Dr. Cushman.

MR. CUSHMAN: Cushman here.

MS. ALLEN: Dr. Dailey.

MR. DAILEY: Dailey here.

MS. ALLEN: Dr. Doynow.

CHAIR DOYNOW: Here.

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

MR. ISAACS: Isaacs here.

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MS. ALLEN: Dr. Kuglar.

MR. KUGLAR: Here.

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

MR. MARKOWITZ: Here.

MS. ALLEN: Dr. Maynard. Dr. Marshall.

MR. MARSHALL: Here.

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

MR. OLSSON: Olsson here.

MS. ALLEN: Dr. Talbot (phonetic). Dr. Walters.

MR. WALTERS: Walters here.

MS. ALLEN: Dr. Wizlinski and Dr. Winslow.

MR. WINSLOW: Winslow here.

MS. ALLEN: Oren Barzilay. Aidan O'Connor. Mark Philippy.

MR. PHILIPPY: Philippy here.

MS. ALLEN: Marianne Porturo. Dr. Rabrich.

MR. RABRICH: Rabrich here.

MS. ALLEN: Mike McEvoy.

MR. MCEVOY: McEvoy here.

MS. ALLEN: Steve Kroll.

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MR. KROLL: Present.

MS. ALLEN: And John Washko.

MR. WASHKO: Present.

MS. OZGA: How many?

MS. ALLEN: Thirteen.

MS. OZGA: Thirteen. We have a quorum.

MS. ALLEN: We have a quorum.

CHAIR DOYNOW: Excellent. Ryan, are you up?

MR. GREENBERG: I'm up. Chief Major, if you can come up as well. It's not just so you can pay attention. I have one thing in our report that I think you're best to speak on. All right. Good morning, everyone, and welcome. Thank you for joining us today. I'm going to try and get through a couple of things here in our report.

On the operation side within bureau, we are moving forward in surveillance and investigations. I know many of you have seen us at your local agencies as we continue to do our full-service inspections and getting back on target. Just a reminder, those are on target to be about every two years. So the goal is that we'll be there every two

years.

For co-sponsors as well, we're getting to an educations to those. Site visits are also going to start back up again as we continue to add some additional staff on that side. So we've had some questions on that as well. So a reminder, when we are there, a reminder for all of our E.M.S. agencies. All the paperwork needs to go in through the portal. We've really moved towards paperless submissions to the point where we're even starting to return paper that shows up in our office. So if you start some things in via paper, there are times now where we are going to start sending back to you and say please send this electronically.

The -- or -- we tried the pathway of just saying, we'll send you a nice note, you know, don't send it to us this way again the next time. It doesn't seem to be as effective as maybe returning the paperwork that needs to be done. So just a reminder, almost everything comes in electronically now.

So there's something new and this is what I've asked Chief Major to -- to come up with us. We have started for our full service inspections, an

E.M.S. self-assessment survey. And this is something we're happy to share the link so that everybody, you know, here, can see it and we can put it up as -- as a P.D.F. or share it that way. But there's an E.M.S. self-assessment and in -- and in all fairness, this actually came in from another state who was trying to improve E.M.S. sustainability, and foster good conversations, and things like that. And these E.M.S. assessments are sent out when a full service inspection is happening at an agency. And the goal that is actually really just to foster good conversations both while the investigator is there but as well as within that agency, to recognize what is -- how the agency is doing, what they're focused on, and maybe some opportunities for the future on what to focus on in the future.

So the reason why I asked Chief Major to step up and -- and talk about this a little bit is there is, you know, a number of these things that talk about quality assurance and talk -- talks about medical directors and talks about medical director involvement, you know, at the agencies. So I don't want it come as a surprise to anybody on here or any other colleagues that you're working on your REMACs,

hopefully, we'll go back and share this with them as well, related to well, what is a survey, I've never heard anything, who's asking the question.

All these things aren't necessarily related to a regulatory obligation of, you know, we're going to come in and say, oh, well they didn't do this so they're going to get an S.O.D. This is more about improving your system, strengthening your system and fostering positive conversations.

So with that, I'm going to pass to Chief Major, a little bit about the history of where those survey came from, what it touches on, and where some of the results are going to.

MR. MAJOR: Is side this okay? Thank you, Director. My name is Ed Major. I'm from the Western Branch. I'm a branch chief. You want me to say my name, you got that, right.

The -- the survey actually came from the state of Michigan and -- and there's a couple others that we had looked at. And the coordination from an E.M.S. sustainability standpoint, organization internally from the processes of medical direction, what the recruitment and retention standards were, what the community involvement was.

All sorts of activities related to the Board of Directors make -- make up, what the strengths, weaknesses, opportunities for improvement are, sort of a self-assessment from the perspective of E.M.S. sustainability, funding, agency capability.

Looking at the -- the quality of -- of patient care and evaluating the futuristic objectives related to equipment and the ability to -- are they looking at regionalization and some other quality components that are -- that are in this particular survey. So far we've got about fifty to sixty responses back. And some of the information that we've got is -- is pretty eye-opening related to not only medical director involvement and system improvement and what is -- what is identified as -- as strengths. And we're looking at this from the perspective of we're going to share this data. We don't have enough to quantify and to really give a quality assessment of what the individual responses are.

But if the -- the method that we're using is -- is forms, it's Microsoft Forms, so it does break the data down and gives us graphs and some -- some capabilities to sort of evaluate the

responses so then we can sort of quantify it, look at opportunities for benchmarking. And our objective will be to share that data and get some real quality initiatives that are going because it goes in conjunction with E.M.S. sustainability, quality metrics, and also other components related to not only the medical director involvement but what activities individuals are doing to strengthen recruitment and retention which is really a big push to this too. So I could -- I could talk further but I think that those are really the highlights as director of that and we're going to -- oh, I forget the recap, we will share it with E.M.S. agency briefing and we'll get that link up and I think we could email it out with the correspondents here, if that's okay. Anything else you want me to say? Thank you.

MR. GREENBERG: Any questions? All right. Perfect. Thank you so much, sir. Again, I think you'll start to see possible some questions coming from your agencies so we thought it was really important for each of you as the medical directors to understand that. So continuing on, on the operation side, like I said, the inspections are out there.

And one of the big things that we're finding is the way that the oxygen tanks are secured. Both portables and the main tanks are not being fastened. They're not using the straps correctly or they're not using the correct straps. So please make sure, if you are involved in an agency to make sure that they're securing that appropriately for the safety of everybody involved.

On the administration side, we continue to finalize some contracts. A big one on this one for your REMSCOs, your REMACs, your program agencies, please make sure that when they fill -- when they submit their invoices so that we can spend the money that they're submitting everything appropriately and on time. There's a new pilot program. You heard about four of them at the last meeting. But there's one additional one that's being included this time which is the new recruitment and retention pilot program that came from feedback from the last meeting. And so what this program allows for and their policy statement should be up by the end of this week, if not already. But what this policy allows for is for people who became an E.M.T. and paid for themselves to go become an E.M.T. for

them to work for an agency for a year and to be eligible for reimbursement for the course that they took.

So the reason for this and that feedback that we got is, we do a lot of programs where people are becoming E.M.T.s but then they never work on a truck. We are trying to say okay, but the people who took the initiative to get the training ahead of time and maybe paid for it, now they're worked on a truck for year, can they get paid back for them and there is a nod coming from Sean over here that, you know, gives them another opportunity. So this is another great opportunity to make sure, to let your agencies know about a way to get back to one of the members. The agency does have to submit it. The provider can't submit themselves so the agency is submitting for that reimbursement.

On the education side, a lot of stuff going on education. We're really excited to have Kevin Lynch join as one of our newest unit chiefs in the education branch. He is out of the Marrow office. Kevin is a paramedic and an A.I.S., C.I.C. He is currently dealing with all reciprocity applications and P.S.I. issues. I know there's no

P.S.I. issues so he's very slow on that part. But no, he's anything on that side so you'll see communications coming from him.

We have two new administrative support staff coming starting tomorrow out of the -- the Albany office. so we're excited about. That hopefully some of the timelines and things will be reduced in what we're able to get processed out there. We also just received information that we are going to be able to post for John McNolan's back first for so we have another grade eighteen unit chief that will be posted in the near future that would be based out of, I believe, the central office. But I'm waiting on final confirmation.

The paramedic or the online testing with P.S.I., there's been a slight cost increase. It has moved from twenty-eight dollars to thirty-one dollars and that was effective September 1st. If you had vouchers or anything prior to that date, or you're scheduled prior to that date, it won't affect your change and your vouchers should still work. If you have any problems regarding that, you can reach out to Kevin Lynch and he'll be happy to help you on that side to coordinate that side.

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We know there's been some issues with P.S.I., with testing, and we know that there's been some issues in scheduling and things of that nature. We're looking at about a thousand complaints a year related to that when we test anywhere between twenty and twenty-five thousand tests a year. So we're -- you know, in the ballpark, we're somewhere around that five percent. We want to make sure that we are capturing all the issues that are happening. We think there's a series of issues that might be happening that we're not told about. So please, if you do have an issue with testing, and you get to a site, they tell you that they can't test or whatever that might be. Please make sure to -- to let us know, put in a -- a communication so that we can track that even if it's been resolved already. So thank you for that side and letting us know.

We have a large amount of stream exam so -- so just in finding exams, so sometimes there's some issues with the upload. So the exam results coming in. If for any reason that the exam results come in and you don't see it up on the -- on health commerce site or you don't see or you haven't gotten the communication on it. Please make sure again to

reach out. We process those I think two to three times a week right now so, you know, realistically you shouldn't be longer than seven to ten days after you've taken your exam for that to be shown up and to be on our system and to be on the health commerce system. If anybody is having issues related to any of these things, related to testing, they can reach out to us at ems.testingissues@health.ny.gov and we're happy to take a look into those.

There's -- again in the transparency side and one of the things we've heard is it took me a really long time to get a duplicate card request or it took me a really long time to -- to hear back about my core sponsors. So we have started something new. On the bureau website, if you click on E.M.S. forms and you click on either of the E.M.S. education pages, dropdowns, it will show you a chart. And the chart shows the function of education, the average time that we think it takes to process, and what our current processing times are.

And so we know we're ahead in certain processes. We know we're behind on certain processes from our averages. But that is available to everyone now. Please take a look at the date on the bottom.

It will show you when it was the last updated. Our goal is to keep this, you know, every two to four weeks, we'll update that chart or if there's something that's really an outlier, we'll update that chart. But you can give this to your students. You can give this to your agency leaders, your core sponsors, your C.S.E.s so that they know when to expect to hear something.

So if something on there says average processing time is two weeks and it's actually week three or four for you, that's the time to reach out to us. If on there says average processing time is -- or current processing time is six weeks and you're at three weeks, understand it still then takes us a little bit longer to get there. Any questions on education or operations? Yes.

MR. OLSSON: Olsson. Could you just reiterate? I missed what that website or webpage was to look at process in times?

MR. GREENBERG: Sure. So if you go to that then the bureau of E.M.S. webpage. On the left hand side, second button down, it says E.M.S. forms, and then in the E.M.S. forms page, there's a dropdown if you go to education and certification or the other

education button, that chart will be there on both of those.

MR. OLSSON: Okay.

MR. GREENBERG: And then the rovers are all the forms system at your staff. Any other questions on education or operations? Wonderful.

So there's a lively discussion yesterday about NEMSYS data and three point five and the what the process will be. We talked about reducing some of the standards until three point five was initiated. I think the outcome and I'm going to look towards Peter on this one to get a nod. The outcome is most likely were going to be, we're going to move towards three point five. That standard will be released in the early part of November. And then agencies will be able to transition to three point five on the standard that's released between January and July of 2024 so no later than July of '24, 2024. But preferably closer to January if possible.

This is really beneficial for your providers. This reduces the number of mandatory fields. This makes it to where -- I don't want to say it's easier to chart but that they can chart in a manner hopefully that doesn't take as long. I will

tell you personally, as -- as I ride the truck, this summer, Peter got a series of text messages with all sorts of hours when I was frustrated writing my chart. And so we are working to reduce those frustrations and to ease into, you know, a new charting pathway. I know there's been some discussions from the working group who works on these standards to also have them really kind of refresh and look at this from a new way. There were a lot of standards. Just for those who don't know, there were close to nine hundred standards or requirements in the current, in the old standards. The new one will be probably close to two hundred and fifty, so a big reduction in mandatory fields.

Stack, our next meeting is the second week in October for anybody who would like to join and the four zero five regulations had an -- an emergency regulatory change in order to allow us to go to the new A.C.S. playbook standards and that just went into effects last week. E.M.S. for children, our next E.M.S. for children's meeting is in December here at the Hilton Garden Inn. They are working on the pediatric education group. I was working on producing some videos and some education and -- and

working on some protocol recommendations. There's a ped stroke group that's gathering data related to peds strokes and discussions is further coming. The grant had some carry-over funds. So we have some additional projects that we'd be working on, excited about that part.

We have started on the -- the new ready for Children E.D. Peck Recognition Program. So this is a Peck program for emergency departments. So slightly different than the Peck program that's for E.M.S. agencies. We have a little bit of sad news, is one of our E.M.C. members is departing us, Jacob in the front, wave Jacob, sitting up there. He has been a tremendous part of the bureau. He is taking a -- a fabulous new job but we're sad to see him leave. So hopefully he'll be working on backfilling. His position provides us with a lot of data analysis and data that comes in.

The E.M.S. for Children's Program Manager, Amy Eisenhauer is actually working right now on the safe transport pediatric testing standards. And is actually at an E.M.S. for Children's Conference right now and that's why she's not here today.

We're excited about the Vital Signs Peds classes that are being offered for safe transport, de-escalation, as well as disaster planning. And we also are continuing on our peds focus on Vital Signs Academy online. Speaking of Vital Signs, Vital Signs is October 18th to 22nd in Syracuse, New York. Registrations are going up and increasing and really excited about that, hopefully, we're going to start to see some pre-COVID numbers there. The Hotel block closes soon. I don't know when soon is. But I know it closes soon, so if you are joining us there, please get inline. Go on to our website and make sure to book your hotel sooner than later. Sorry, just catching up here on things.

The vehicle equipment regs, so these are the regs that are able to -- these are gone here. We were hoping to have emergency reg packet presented to SEMSCO while we're here in order to push forward many of the things that were in place or -- or looking to be in place because they were in place for Executive Order Four and now they are no longer. Unfortunately, timing did not allow, although I think we're really close to the finish line, so much so that there may be an emergency meeting or a -- there

may be a short SEMSCO meeting between now and the December meeting to discuss, review, and approve those emergency regs, if they do come through the approval process. We'll obviously make sure to keep everybody aware if that's happening and when it's happening if that does occur.

The equipment regs are in the final process to go out to public comment. So they will go directly out the public comment because they are not under the emergency process. When those go out to public comment, we encourage everybody to take a look at them and also to comment both in the positive or any areas of concerns. We encourage you to do that one. And just a giant thanks to both the education committee and the education -- at the safety committee for helping put those together. And the rural health taskforce meets tomorrow -- the rural health ambulance taskforce meets tomorrow and I know some of our members are around this room. There is a rural health ambulance task force survey that is out right now. It's available on the E.M.S. forms page dropdown to E.M.S. provider surveys. And please feel free to fill that one out. That is based on recommendations that they are working on, what they

think will be some of the things to really help the rural health side of things. We ask everybody to please take the time, take a look at it, and provide your feedback.

In addition, on the E.M.S. forms page, there been a lot of surveys lately. So we've sent out a number of surveys. We tried to put those all into one place. That one place is now in the E.M.S. forms page. So on the E.M.S. forms page under E.M.S. provider surveys and feedback, there are currently four surveys that are open. We'd like everybody in this room to spend some time filling those out. Each are probably in the ballpark of eight to twelve minutes to complete. But it allows so many of these working groups that are so active and, you know, under Chairman McEvoy and -- and the work that's been done by the SEMAC and SEMSCO and other working groups. It really allows all providers to have a say in this. So there's one out there on diversity. There's currently one out there in rural health. There's one out there on feedback from Part S. Please take a few minutes and take a look at this. This is how your voice is heard.

Last but not the least, we're excited

on some new staff members. As was mentioned, Kevin before has joined us in education. We have new staff member in Vital Signs, really excited about that part. We have Jacob who is unfortunately leaving us but for good things. Gina is -- who is our policy fellow before is our newest district chief investigator, very excited on that. She'll be in the emergency preparedness and response side of things. And in addition, we're excited to report that the bureau is -- is growing.

When I first got here, we were just in the mid-thirties or so. We are now north of fifty-five staff in our bureau. And we are charted over the next twelve months or so to add probably between twenty and twenty five positions to the bureau. It does come with some added responsibilities, duties, and assignments so there are not all just things that -- that will help us to support our current functions so there's some new ones. But we're excited to see the growth. We're excited to see the focus, you know, on E.M.S. and -- and things in that. And we're excited to be able to provide additional resources to the SEMAC and the SEMSCO to be able -- to carry out the functions that each of you are doing.

So that is the end of our report. Happy to take any comments, questions, or concerns, and thank you for everything.

CHAIR DOYNOW: Okay. Any questions for Ryan? All right. Moving along, Dr. Marshall.

MR. MARSHALL: Good afternoon, everybody, well, almost afternoon, sorry. We still got a couple of minutes. So Medical Standards met this morning and we have two action items to bring forward so the first one is the collaborative A.L.S. protocol, update, and changes. And they did a lot of work so we'd like to thank Dr. Cushman and -- and everybody who participated. They had looked at the protocols. They simplified language, reduced inconsistencies, and made it more readable without actually changing the medicine. So a couple of things and everybody should be able to have seen the version twenty-four protocol change log which I would also like to thank them for putting together because this makes it very easy to see what changes were made.

Two things came out of the discussion, one is the anaphylaxis protocol was changed to allergic reaction and anaphylaxis which would enable

A.L.S. practitioners to administer Benadryl or steroids to a patient who is not in anaphylaxis. And the second item that came up or that was discussed was that they also looked at scope of practice and removed any inconsistencies and the one that was removed was C.F.R. administering oral glucose and that was removed.

There were also some wordsmithing that made it more readable. And this comes forward as a seconded motion and it is protocol change so it will require a roll call vote.

CHAIR DOYNOW: Any questions for Dr. Marshall? Okay, none seen. Now, we're going to have a roll call vote.

MS. ALLEN: Okay. Dr. Berkowitz.

MR. BERKOWITZ: Berkowitz, yes.

MS. ALLEN: Dr. Bombard.

MS. BOMBARD: Bombard, yes.

MS. ALLEN: Dr. Cooper.

MR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Cushman.

MR. CUSHMAN: Cushman, yes.

MS. ALLEN: Dr. Dailey.

MR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Doynow.

CHAIR DOYNOW: Dr. Doynow, yes.

MS. ALLEN: Dr. Isaacs.

MR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kuglar.

MR. KUGLAR: Dr. Kuglar, yes.

MS. ALLEN: Dr. Markowitz.

MR. MARKOWITZ: Markowitz, yes.

MS. ALLEN: Dr. Marshall.

MR. MARSHALL: Dr. Marshall, yes.

MS. ALLEN: Dr. Olsson.

MR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Walters.

MR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow.

MR. WINSLOW: Winslow, yes.

MS. ALLEN: Roll call complete.

CHAIR DOYNOW: Okay. Motion passes.

MR. MARSHALL: Thank you. So the next item that comes up is revision of the alternative medication formulary policy. So over the years, we've had different medications that have been on shortage and it varies from time to time and sometimes from region to region. So Dr. Winslow and

-- and his team and I thank them for that, put together and updated alternate medication formulary policy which the original one was policy thirteen zero four.

This new policy will allow us to continue to use alternative medications. And there's also provisions for notification to the department when these alternative medications are being implemented and when the alternative medications are being terminated from use. The actual list of medications and the alternative medications will not live in the policy as it does now. Will live in -- in an appendix so that we don't have to change the policy when we run out of a -- a different medication. So thanks again for putting this together. And I'll answer any questions but this comes forward as a seconded motion as a policy.

CHAIR DOYNOW: Any questions. Okay. We'll also need a roll call vote on this, please as well.

MS. ALLEN: Dr. Berkowitz.

MR. BERKOWITZ: Berkowitz, yes.

MS. ALLEN: Dr. Bombard.

MS. BOMBARD: Bombard, yes.

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MS. ALLEN: Dr. Cooper.

MR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Cushman.

MR. CUSHMAN: Cushman, yes.

MS. ALLEN: Dr. Dailey.

MR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Doynow.

CHAIR DOYNOW: Doynow, yes.

MS. ALLEN: Dr. Isaacs.

MR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kuglar.

MR. KUGLAR: Kuglar, yes.

MS. ALLEN: Dr. Markowitz.

MR. MARKOWITZ: Markowitz, yes.

MS. ALLEN: Dr. Marshall.

MR. MARSHALL: Dr. Marshall, yes.

MS. ALLEN: Dr. Olsson.

MR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Walters.

MR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow.

MR. WINSLOW: Winslow, yes.

MS. ALLEN: All right. Motion passes.

CHAIR DOYNOW: Okay. Motion passes.

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Dr. Marshall.

MR. MARSHALL: Okay and thank you. Those -- those are the only two action items. There were some discussion about that Chem Pack and the process so more to come from that. It's probably the shortest Medical Standards Committee meeting in history. So thank you for that as well. And that's my report.

CHAIR DOYNOW: Okay. Thank you, Dr. Marshall. Don from Education.

MR. HUDSON: Yes, good afternoon, everybody. Don Hudson. So I'll just hit the pertinent points for the SEMAC. The bureau is currently working through a new funding policy which will continue to increase the funds available to our co-sponsors for E.M.S. education so we thank them for that and continue to look towards the future or ex -- further expansions in fundings. Instructor certifications for both C.L.I., a continuation on some discussions regarding certified instructor coordinator C.I.C., and then also probably more importantly some cross profession from our fire service healthcare and education compatriots about what some sort of reciprocity process may look like

is ongoing. A new prerequisite policy is forthcoming from the bureau involving not only HAZMAT awareness clarification about what it -- what classes are acceptable and what are not. But also to try and roll up some of the other policies for C.P.R. incident command, incident management system training into one policy rather than the two or three or more that exists today.

Current discussions about mentorship or field training officer programs around the regions and around the State so if an agency or region or otherwise has a functioning field training officer program that they think other agencies could benefit from, please let us know and we'll continue to work towards that. There's been an ask of a number of different committees but ultimately it may fall back to training at Ed about looking at some sort of standards for inter-facility transport or critical care paramedic certifications. So that's one of the ongoing discussions just for your awareness. And then most importantly probably to this body is the E.M.T. C.C. to paramedic bridge. We have some numbers crunched from the bureau and from Northwell from the Bridge Program enrollment itself. The two

current bridge programs, Bridge Nine and Ten, each have Statewide about twenty people in them. And in talking to Northwell yesterday, the current Bridge number Eleven which will kick off in October has four applicants Statewide. So I know a number of the physicians have rightfully so wanted a discussion about that and know that discussion is ongoing and we want you involved in that. So those charts and data is posted on Boardable for you to review so that we can make some educated decisions about sunset and timeframes moving forward.

Board of Director Ryan mentioned the thirty-one dollar increase for P.S.I. testings so just to again to reiterate that, there's -- it is an increase so that is effective today or as we speak. And then lastly, we do have a seconded motion that comes forth to the SEMAC for I guess, Theresa, can you put that up?

This is related to the discontinuation of the primary practical skills exam for paramedic originals and it's to move in concert with the national registry as, you know, the -- the State of New York currently utilizes the national registry format and more specifically the national registry

exam for paramedic originals. As they're going to sunset their exam, we should follow suit and explore what that looks like moving forward. So there are two letters that are put forth to the bureau through the E.D.C.C. process for the next SEMSCO meeting for actual action. I just wanted to bring it up as the committee did as a seconded motion here to keep it on the record and to continue pushing that conversation as we believe sooner to formulate a plan is better than later. We don't want to find ourselves at midnight, the night before, and go when did -- when did this happen? So the motion is, motion to recommend to SEMSCO to eliminate the paramedic practical skills exam by July 2024.

CHAIR DOYNOW: Any discussion on that?

MR. CUSHMAN: Don, just a question, fully support the motion to -- to align with the national. However, the C.M.E. recertification process still requires skills verification which are fundamentally obsolete. How -- is this or should this be tied to that recertification process?

MR. HUDSON: So myself and Chief Chesney me from -- and Michael Bagozzi from education have had and will continue to discuss both paramedic

refresher and C.M.E. with Mr. Myers. The committee felt that the most pressing need and -- and the easiest lift right now is to deal with the imminent paramedic original knowing that shortly thereafter, this group and others needs to struggle with the skills validation exam testing that, you know, not only affects paramedic refresher on C.M.E. but quite honestly, why stop there. Look at everything across all levels of care would be a natural continuance of that conversation. They are tied a lot to the pending emergency education regulations which as Director Greenberg said, we were hoping we would be able to, you know, codify and -- and push forth here. Unfortunately, that didn't work out. So we're on it, just not yet.

MR. CUSHMAN: Appreciate it.

MS. BOMBARD: Hi, it's Bombard. Why -- I'm still unclear as to why we can't do both at once if we're getting rid -- rid of the original, why -- it's -- it's the paramedic level across the board. Why are we not just taking it away? And actually, your proposal is written the paramedics skills exam. And it's not really written explicitly that it's the original only. So why can't we just get rid of it

all at the paramedic level and we'll deal with the other levels later?

MR. GREENBERG: When you say both, are you referring to both original and recertification or original in C.M.E.?

MS. BOMBARD: Original and recertification.

MR. HUDSON: So thank you for being so astute to pick that up. That was actually one of my recommendations to the committee. And as a committee, we discussed that, step one is the original, step two and three, you know, probably bear a little bit more discussion and planning simply because, you know, as you state, not to speak for anyone else. But my own opinion and my own experience as a co-sponsor has been that we have providers that are now five years without seeing a State written or practical skills exam. And there may be concerns about a student's level of preparedness to once again take those exams and what that might mean from a patient care perspective.

So as you continue to read between the lines of what I'm saying, I think we need to have that discussion sooner than later. This is the first

lift and once the emergency regs kick in, then the bureau and -- and ourselves have a lot more flexibility as far as, you know, some wordsmithing of an exam versus an evaluation or a processes or what that may look like. I -- I agree, why not rip the band-aid off all at once but I also, you know, stand with my compatriots who -- who then suggested, no, step one comes first, so. I'll leave to the committee. I mean, it's a -- -- either one's --

MR. GREENBERG: I'll bring up one thing --

MR. HUDSON: Okay.

MR. GREENBERG: -- to think about and we don't want one to delay the other. So I think, you know, and especially in timeline, and between now and July, there might be more work that can be done that -- that could advance this at the same time. But one of the things that -- that comes up and why P.S.E.s on the original are disappearing is because students create a portfolio while they're going through their paramedic program. They are performance skills. They're being validated by someone, they're, you know, with the field training office or preceptor, or whatever that term might be.

And so in some cases and in the -- the new regs or the proposed regs change it from what's called a practical skills exam to a practical skills assessment, whatever that might look like. And the -- the tools and the -- the systems in place today for that original paramedic student to have that paramedic skills assessment, their portfolio that they had built over the course of time. They're not necessarily in place and even if it just means creating what that would look like for the person who's taking a refresher class and during that refresher class, are they doing any clinical time? Are they documenting any assessment? Are they looking at any of those other things that we're using as the validation tool for the original one? And so I think that's just something that needs to be thought about. I think -- I think you can get there but it's not as quick as here's the switch, you know, because the question would then be, well, what is that practical skills assessment because for that original paramedic, it's their portfolio.

For the refresher, what would it be and we just don't know today. That doesn't get there. We just -- it's not something that's in

place.

MS. BOMBARD: I'm just concerned because the first P.S.E. somebody might take is the one at their refresher is the way we're setting it up which would be a little -- I mean, it just doesn't make a lot of sense to me.

MR. GREENBERG: So I would give you a different timeline. Let's say the regs go through in the way that they're written. That person would be certified then for three to four years. This would go into effect in July of 2024. And if by July of 2028, we've determined that the P.S.E. shouldn't be eliminated then there's probably a different issue that we have to address.

The others who may be affected by this would have taken a P.S.E. prior to because they would have taken it during the original. So I think this -- you know, it gives up a -- a pretty wide buffer span and again, you know, depending on the work of the committee or anything else, that could be eliminated between now and when this would go into effect. But that needs to be determined on what that assessment is, how it is, and also how it affects our programs that are doing refresher programs. We have

co-sponsors who may turn and say no, leave the P.S.E. because we don't have the bandwidth for a refresher student to do these other things to create a portfolio. There could be co-sponsors who turn and say no, we have a solution for that. Here's what it is. They just need to do it at their home agency and, you know, to perform this.

And then the question also becomes, well what about the person who's taking a refresher who doesn't practice in E.M.S. or maybe doesn't even practice as a paramedic at all. They work using their skill set doing something else. How do they get assessed for this?

So I think those are many of the questions that would have to be answered, that I think could be. But I think the primary goal of this one is to align with National Registry for that original and to get there from that point and then to determine how to handle the others.

MR. DAILEY: Mike Dailey. So Don, you talked about ripping off the band-aid. Allow me to give it a slightly different rip. Why do we still have a contract with E.S.I. for testing? Why haven't we just not moved to the registry and do we have a

timeline to just move New York State to the registry?

MR. GREENBERG: So no, there's not a timeline to move to the registry. But there is the option again based on standards and regulatory changes to have a registry be an option for an exam. And then if every student chose to take that one versus something else, and they go look at it, there's a financial cost that is significant compared to that of that's administered by the State. The average cost for an exam with registry is anywhere from a hundred dollars to, I think, a hundred and seventy dollars. The exam for New York State is thirty-one dollars.

MR. HUDSON: But it was twenty-eight so we are getting closer.

MR. GREENBERG: Yes. By like 2050, we should be caught up.

CHAIR DOYNOW: Any other questions? Okay. Well, we do have a -- a seconded motion on the floor here so we need to vote on it. This would be a roll call vote as well. Go ahead.

MS. ALLEN: Okay. Dr. Berkowitz.

MR. BERKOWITZ: Great conversation, thank you, Berkowitz, yes.

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MS. ALLEN: Dr. Bombard.

MS. BOMBARD: Yes.

MS. ALLEN: Dr. Cooper.

MR. COOPER: Yes.

MS. ALLEN: Dr. Cushman.

MR. CUSHMAN: Cushman, yes.

MS. ALLEN: Dr. Dailey.

MR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Doynow.

CHAIR DOYNOW: Doynow, yes.

MS. ALLEN: Dr. Isaacs.

MR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kuglar.

MR. KUGLAR: Yes. Kuglar, yes. Sorry. I'm all choked up.

MS. ALLEN: Dr. Markowitz.

MR. MARKOWITZ: Markowitz, yes, I'll see to it.

MS. ALLEN: Dr. Marshall.

MR. MARSHALL: Dr. Marshall, yes.

MS. ALLEN: Dr. Olsson.

MR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Walters.

MR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow.

MR. WINSLOW: Winslow, yes.

MS. ALLEN: The motion passes.

MR. HUDSON: So Mr. Chair, just in closing a question, does this come to the SEMSCO from SEMAC or do I do it from education and training? And forgive my ignorance.

CHAIR DOYNOW: And it will come from SEMAC to SEMSCO but we'll probably will be answering questions there, I suspect.

MR. HUDSON: Ditto.

CHAIR DOYNOW: Okay. All right. Moving along, Dr. Cooper, E.M.S.C.

MR. COOPER: Thank you, Dr. Doynow. Director Greenberg I think touched on most of the points that I'd planned to make in the E.M.S.C. report. What I will do at this point is very briefly remind you of the key issues that he raised and give you an opportunity to ask any questions you might have about any of these issues.

First, with respect to the pediatric agitation workgroup, that work is ongoing. We had a very fruitful meeting with the E.M.S.C. community last week and the several conference calls before

that and we are in the process of developing potential scripts for -- for videos that may be produced as part of an educational program in pediatric de-escalation techniques which as you all know really the verbal de-escalation really forms the -- you know, the -- the key in the pediatric world to management of -- of agitation with a lesser emphasis on the medication domain.

It's come to our attention of course that the safety workgroup of SEMSCO is also dealing with this issue on a brighter level including adults as well as children. And Amy Eisenhauer, our outstanding E.M.S.C. coordinator is going to get these two groups together. So we can plan out a -- a joint program that will serve the needs of everyone, adults and children, as well as folks from all parts of the State.

The time of triage education group also met. They have made a good deal of progress towards the development of a -- of a guidance that will be used to or to assist various regions in -- in updating providers to the new time of triage protocols, the length-based resuscitation tape group had several meetings over the summer as well. But

due to logistical concerns, these issues were not able to be brought forward at our meeting last week and will be dealt with in the very near future. The additional matter of other methods for determining drug doses in kids such as the Home Tele method and others have also been raised as potential alternatives to a length-based resuscitation tape. That's part of what held up the process because these issues also need to be discussed and we plan to have if you will a final approach on both of these, excuse me, at our December meeting so that they will be ready for the next meeting -- meeting of SEMAC which I believe is in February.

We continue to focus on the issue of pediatric stroke and how would the management in field here will differ from that of adult stroke. And there's no formal designation process at the present time for pediatric strokes centers. Pediatric strokes are few in number and they're generally managed in pediatric I.C.U.s, you know, mostly sickle cell anemia related as I'm sure you're aware. So data is being collected to guide our thoughts on that particular area.

As Ryan also -- also mentioned, the

pediatric emergency care coordinator program has -- has been expanded under federal mandate from the -- the pre-hospital room to the emergency department realm, more about that as we go forward. And, of course, Amy Eisenhauer continues to be deeply involved in the safe transport issues, both locally and nationally, doing a terrific job of representing New York State in that venue and in fact, that's where she is today, at the National E.M.S.C. Grantee meeting focusing on many of these issues.

I just wanted to highlight again as Director Greenberg mentioned there's a robust pediatric program at the Vital Signs conference this year focusing on safe pediatric transport, de-escalation techniques for kids, and pediatric disaster planning and, of course, I hope that all of you will be able to attend the Vital Signs conference. I do myself plan to be there and we're hoping that it will be the success that it has always been in the past and will continue to be in the future so thank you for the organizers -- to the organizers of that conference. And thanks to Amy for putting together everything with respect to the pediatric programs at the conference.

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I'll stop there and I'd be happy to answer any questions folks might have. Thank you.

CHAIR DOYNOW: Does anybody have any questions for Dr. Cooper? Okay, Doctor.

MR. COOPER: Thank you, Dr. Doynow.

CHAIR DOYNOW: Thank you. Thank you for the report. Moving on to old business, Dr. McEvoy.

MR. MCEVOY: I just want to let people know I'll discuss this more at SEMSCO but a motion that originated here couple meetings ago to allow REMACs to credential providers came back to SEMSCO through D.L.A. with some concerns. So at SEMSCO this afternoon, we'll address the concerns and -- and form a group to resolve that issue.

CHAIR DOYNOW: Thank you, Dr. McEvoy. Any other old business that anybody wants to bring up?

MR. WALTERS: Excuse me, Dr. McEvoy. Just because that discussion happened here at SEMAC, could you elaborate on that a little bit for us?

MR. MCEVOY: Let me find my note here. So essentially, what happened with Division of Legal Affairs is to tell us that the motion has no standing

in statute or regulation. And the responsibility for credentialing belongs at the agency level. Which our perceived solution to that is that this body and/or people from Systems can create some templated credentialing requirements for agencies to use. And like anything else that we create here, regions would then have the capability of enhancing those with the approval of the SEMAC and SEMSCO. So my intent this afternoon would be to put together a -- a working group that would consist of people from here and people from Systems to start to resolve that issue.

Does that answer your question?

MR. WALTERS: Yeah. Yes. I guess my question is, I thought that that discussion originated from SEMAC, so I guess I was just curious why it's coming up at SEMSCO but not SEMAC.

MR. MCEVOY: The process of how motions move through the system is that it comes from here, which is the subcommittee of SEMSCO, and then SEMSCO gets told once they vote on something whether that's acceptable or not or when it is not acceptable we hear from D.L.A. about it.

CHAIR DOYNOW: Any other discussion? Any other old business before we move to new

business? Okay. All right. New business just for SEMAC members, if you have interest in subcommittees, please see Dr. McEvoy. We would like to get some folks involved in some of the subcommittees if we can. We do have a presentation from Dr. Jennifer Goldman, who's a psychiatrist, on mental health issues and you know, are now affecting E.M.S. and I'm not sure where she is at the moment.

MS. ALLEN: Over there to the right.

CHAIR DOYNOW: Huh, over there. Hi. And I believe you have presentation we need to put up on the screen.

MS. GOLDMAN: Yes. Hi. Thanks, everyone. Yes. My name is Jennifer Goldman. I'm a psychiatrist with the Office of Mental Health. And I'm here with my colleague, Alexa Cappola. And we really appreciate your time today and the opportunity to tell you a little bit about this new program that O.M.H. and Oasis are working together on developing throughout New York State. I'll turn it over to Alexa to say a few words and we'll walk you through the -- the basics around this new program and then talk a little bit about where we see the touch points between these new centers and E.M.S. Thank you.

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MS. CAPPOLA: Thank you. My name is Alexa Cappola. I also am with the New York State Office of Mental Health within the Bureau of Crisis Emergency and Stabilization Initiatives. I do want to give a quick shout-out. We also have someone else here today, Katerina Gaylord who is our Deputy Director within our bureau. And just a shout-out, she does have some stickers for 988. This isn't about 988. But if you would like to see them and if you would like some 988 materials, you can also use the email at the end of this slide to request those as well.

If you can go to the next slide, please. And on this slide, we just have a few of our agency representatives who have also been working very diligently on the development of these centers and who have assisted in the development of this presentation. So as Jen said, with the permit -- with the primary part portions of our discussion are going to be the core components of the crisis stabilization centers and how they impact E.M.S. providers or how they may impact E.M.S. providers. And I'll pass it over to Jen just to talk a little bit about how they're connected to the comprehensive

crisis response system. Thanks. Next slide.

MS. CAPPOLA: Thanks.

MS. GOLDMAN: So the development of these new centers, the crisis stabilization centers falls within an overarching vision that O.M.H. has been working on for New York State. O.M.H. and Oasis together are trying to develop a Statewide crisis system for behavioral health crises, rather than kind of siloed services or programs throughout the State that come together based around 988. So you have the telephonic triage through 988. We are developing and expanding mobile crisis response throughout the State, crisis residences, CPEPS, Comprehensive Psychiatric Emergency Programs, which many of you are probably familiar with, and then a new program, Crisis Stabilization Centers, which is what we will discuss today.

Next slide. And this slide just touches on the overarching vision that O.M.H. has for the future of behavioral health crisis system development with the idea being someone to call.

So having those ninety-day -- regional ninety-day crisis call centers available, soon to come. Ideally, that's mobile crisis teams and then

somewhere to go. Seven Crew is a crisis residences, comprehensive psychiatric emergency programs. And then the new program that we're going to discuss today, Crisis Stabilization Centers. Next slide. And, you know, if we build out this system in the way we're envisioning, ideally that hopefully will be less burden on ambulances because if you look at studies and it's probably really hard to see here the -- the fine print. But -- so easy of showing it, approximately eighty percent of crisis calls end up being able to be resolved over the phone when answered with a crisis line, with a trained crisis counselor. Of those that get an in-person response from the mobile crisis team, seventy percent of those -- on those calls are responded in the field and don't need further referral to a hospital or to a higher level of care. Of those that -- of those individuals that are treated in a crisis facility, so that would be like our crisis residences or potentially these future Crisis Stabilization Centers, approximately sixty-five percent of those individuals are discharged into the community and eighty-five percent are then stable in the community.

So our goal is really to be able to

build out the full continuum of behavioral health crisis services. So that E.D.s are no longer kind of burdened as the default provider for individuals that are experiencing behavioral health crises. So I'll turn it over to Alexa who will go into some greater detail about these centers.

MS. CAPPOLA: Thank you and you go to the next slide. So as -- as Jen noted, these are completely new programs in New York State. There are no currently licensed Crisis Stabilization Centers. We're in the process of reviewing licenses to provide operating certificates. But it's important to note that this is a joint authorization and certification between both the Office of Mental Health and the Office of Addiction Services and Supports.

And this is a completely joint effort so we do have a joint -- joint regulations which are under part six hundred and a joint program guidance. Both of these documents encompass two types of Crisis Stabilization Center. So there are supportive centers and there are intensive centers. And we'll talk a little bit about the differences between the two. But before we do that, I just want to talk about the similarities that everything that they both

encompass before we talk about the separation in their services. Thank you.

So it's important to note that these are completely voluntary programs. So you could access a Crisis Stabilization Center through a walk-in depending on the partnerships with law enforcement. Law enforcement may be able to transport somebody to these facilities. There is a requirement for these facilities to have a separate triage and entrance base for law enforcement, for privacy of that individual. But it is a completely voluntary program. And with the goal is to provide person-centered services with a strong emphasis on peer and recovery-oriented supports. They provide rapid intervention to individuals across their lifespan. So they are all required to serve both adolescents, families, and adults. They also serve individuals experiencing both mental health and substance use crises.

So we're looking at a very overarching umbrella of services that can be provided. Essentially, what these centers looks like, we are not -- the -- the intent was not for them to be emergency room programs or emergency like programs.

So we're really focusing on having these spaces look safe, therapeutic, and be very welcoming. They are an outpatient service or considered an outpatient service so recipients can receive services for up to twenty-three hours and fifty-nine minutes ideally. And they operate 24/7 and also, the biggest part of these is that we hope that they will assist with diversion from higher levels of care as Jen noted.

And in many communities, in the emergency department is the only twenty-hour crisis option for individuals. And in many cases, individuals who are seeking services may not meet the requirements for an inpatient stay. So this is an option for those individuals in their communities.

Next slide. We're going to skip over that slide. But it will be available -- it will be -- it will be available on the website. So we'll talk about the primary differences between the supportive and intensive services. So on the left-hand side, you'll see all of the services that every Crisis Stabilization Center supportive and intensive must provide. So this is from triage, screening, and assessment all the way to discharge after -- and aftercare planning. This is also inclusive of a

follow-up component in order to connect individuals to make sure there's a direct connection with their wrap-around services. And everything on the right-hand side, these services are what intensive Crisis Stabilization Centers will specifically provide. So really the only differences between supportive and intensive is obviously community planning based on the provider needs and the area needs if you need assist -- if the provider is looking to open a supportive or intensive based on the crisis that they're experiencing in their communities but also what partnerships are available. So an intensive center will offer this -- these additional subset of acute services. So that spans from psychiatric diagnostic evaluation and planning all the way to mild to moderate detox services as well as medication management.

And it's important to note here that the support of Crisis Stabilization Centers, while they're not offering those specific services onsite, they are required to have partnerships and linkages to those services or providers who offer those services within the community. So if somebody presents and it's assessed that they will need one of

these services, that there's a direct immediate connection to those services. Do you want to add anything to this? You aren't the only --?

MS. GOLDMAN: The only thing that I add is just that we see this as a very important piece of the puzzle that does not currently exist, which is that an individual that is looking to seek treatment at whatever intensity of a crisis can walk in the door of one of these centers and get help. They don't have to wait until business hours. They don't have to, you know, walk into an E.D. if all they need is to be able to be connected to resources in the community. If they need more urgent help or they need medication started right away especially if they're experiencing withdrawal from substance use. The goal is these centers will be able to start, you know, 24/7, initiate buprenorphine, be able to address mild to moderate withdrawal symptoms. There will be, you know, resource in such a way. There will be a nurse onsite 24/7. The intensive programs have prescribers available 24/7. So that, you know, this is openly accessible to individuals at the time that they need it.

MS. CAPPOLA: Thank you. You can go

to the next slide. So I just -- I'll touch upon the importance of the peer services here and I won't go through the -- the next slide and we'll probably skip over. But you'll have it for your -- accessible to you. This is really important to the vision and philosophy of these programs.

And essentially really to differentiate them as well from emergency room programs is the focus on peer support and utilizing individuals with lived experience to not only provide direct services in these centers but to build out the programs themselves. So we've been having these conversations ongoingly with the providers on the importance of peer specialists and looking at our peer network across the State. But ultimately, peers have this shared lived experience with individuals and families across the lifespan who are experiencing both mental health and substance use crises in their various disciplines. And we really do think that they are the leading experts on the resilience and recovery-oriented support services. So like I've said, part of this philosophy is building in individuals with lived experience throughout the program model to ensure that the vision and

philosophy of these hold true. Thank you.

And another important component that I touched upon is that all Crisis Stabilization Centers will provide services to individuals across their lifespan. So there is an expectation for there to be staff available with expertise and training in child and adolescent development. And we are expecting these staff to be available 24/7. And we've also been talking about -- with providers about how to build out this space. We -- there's -- will not be commingling of adults and children. But how do you create a space like this without separating into two separate spaces. So we've been talking about this. But ultimately, utilizing different methods within the premises to limit commingling as much as possible. And that's what we've been talking about. So there's also an expectation to collaborate with providers in the community who provide services to adolescents including younger adults. So this includes schools, pediatrician offices, and whatever is available in the community in order to make those direct linkages to care. As we all know there -- there is a shortage of services for -- for children so that'll be important. Thank you.

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Okay. If you can go to the next slide. So I'll just quickly touch upon the staffing requirements. And I think Jen touched upon this a little bit. But in it -- for an intensive Crisis Stabilization Center, there will be oversight of a medical director and as well as twenty-four access to a prescriber. For all crisis stabilization centers, they are required to have a program director as well as at least one psychiatrist -- psychiatric or a psychiatric nurse practitioner as well as a KSAC and a certified peer specialist. And these individuals are required to be onsite or have the ability to come onsite as needed. And as well, they must have a registered nurse available 24/7. So these are the minimum requirements. And we continue to talk about the build-out of the multidisciplinary team within these settings really looking at what the community needs in order to make these projections for how many staff will be needed in their various disciplines. So looking at the population that these centers are planning to serve and so on. And a very large component of a Crisis Stabilization Center in order for it to be successful is very strong community partnerships and collaboration which is why we're

very thankful that you're having us here today because part of the requirements of the crisis stabilization centers are not only to have partnerships with the local government units. But to reach out to all providers within their crisis response continuum. And to establish partnerships with law enforcement as well as emergency medical services in order to discuss how transportation may happen and how drop-off may happen. But also to understand where this service fits into the larger community system.

Next slide, please. Thank you. Can you go to the next slide please? Thank you. So just so that we can talk more about the larger impacts this will have on E.M.S. providers, I will just note a little bit about the development across New York State. We have provided funding for the development of -- of supportive and Crisis Stabilization Centers across New York State. Specifically, at this time, twenty-two Crisis Stabilization Centers are -- are in the full swing of development, and at your leisure, in your time, we do have the specific providers included on these slides and the counties that they plan to operate in. If you can go to the one that's

like the (inaudible) slide. Okay. Thank you. All right. Thank you. I'll pass it over to Jen.

MS. GOLDMAN: Thank you. So we just want to take a few minutes to discuss a little bit more about where this fits in to sort of the -- the crisis system emergency medical services which we recognize will vary regionally throughout the State. But generally speaking, there'll be a potential variety of touchpoints. One of which is ideally if we are messaging this out to the community, though it would be, you know, ideally clear to individuals, and to providers, and to agencies that, you know, when someone should be going to an emergency, you know, department versus when -- when someone might seek treatment at a Crisis Stabilization Center. One major differentiating factor as -- as Alexa had mentioned, these are voluntary settings.

So individuals that are voluntarily seeking help for a condition, you know, and are not at an imminent risk to hurt themselves or others would very well be served in a crisis stabilization center. And there are going to be times likely where if someone may present to a Crisis Stabilization Center and -- and start in that condition and then

something may change. Maybe they end up getting, you know, having -- experiencing a complicated withdrawal or maybe there's an unrealized medical condition. So we're -- there may be touch points which an E.M.S. and these centers is a medical emergency or an issue arises at one of the centers. And it turns out the center realizes this person needs to be referred to a hospital for a higher level of care. And I mean, in which case they would be calling 911 and they would be activating that response. It -- we think it'll be great though for E.M.S. to be familiar with these centers to know what their, you know, responding to, what staff is on board. And -- and ideally as Alexa had mentioned, the providers of these services are going to be expected to be reaching out to their local emergency medical service providers to be able to build those relationships prior to even opening.

You know, we hope that in the year or years ahead, we can partner with all of you here to discuss other ways that there might be connections potentially to help foster this goal of where diverting individuals away from that default, kind of going or calling 911, going to the -- going to the E.D. to receive support for a behavioral health

crisis. There -- you know, the potential for there to be E.M.S. transportation to a crisis stabilization center when appropriate we think would be a great option. It might be the case that these centers are closer than, you know, in neighboring hospitals. It may be the case that it can offset some of the burden for those E.D.s. So that's sort of -- we just wanted to have this introductory discussion to open the door. We -- we look forward to collaborating with you in the future and getting feedback about how you see this potentially developing, how this can be most helpful to all of you. And, you know, potential future directions from there.

MS. CAPPOLA: Thank you.

CHAIR DOYNOW: Well, thank you for a very interesting presentation. Does anybody have any questions?

MR. MARSHALL: I have a question. Thank you very much. Hi. My name is Lewis Marshall. So this is a -- a voluntary program so a person would voluntarily say I'm -- I'm in crisis and I need to go there, right? As opposed to, you know, being -- calling 911 and being picked up. And then 911 services having to decide where they should go,

correct? Is that --?

MS. GOLDMAN: Thank you. That's exactly right. So an individual that would not be appropriate for this setting would be, for example someone maybe that's agitated in the community and a passerby is saying this person needs help. And the person is not interested in, you know, receiving help. And there's concerns for things escalating or violence or an acute medical condition or intoxication where they think, you know, that the person needs a full medical evaluation before determining the etiology of what this crisis is. That would be someone that would -- would continue to go to the traditional so -- sort of process.

MR. MARSHALL: Okay. Yeah. And I think one of my concerns is that because of the overlap of symptoms caused by medical conditions and those caused by behavioral health conditions that patients may wind up in the wrong place but, you know, so. Okay.

MS. GOLDMAN: Yeah. I think that's where we really want to proceed slowly before we consider, for example, having ambulance drop off to these centers. I think that to start, this would

mostly be voluntary, people walking in of their own volition and seeking care, potentially police drop off, if there's a police touch point, and police, you know, as a diversionary option ideally to move away from arrest or other things, to be able to drop them off to the Crisis Stabilization Center. I think we feel, when it comes to that decision of potentially am -- you know, E.M.S. or ambulance involvement. I think that that would have to be very thoughtful discussion because it's a very -- you know, there's a snippet of what you're seeing in the field to then determine whether someone does need that full hospital evaluation verses a community-based voluntary program. So I think that that would be a great future direction. But I think to start, we see this more as what -- you know, and you're just walking in, being dropped off by loved ones. There still likely could be situations where, you know, as -- as the C.S.C.T. is assessing and triaging an individual, you know, the vital signs are concerning or, you know, someone gets agitated and that's why we really want them to have strong relationships with neighboring hospitals in the event that there has to be an escalation and a referral to a higher level of

care.

MR. MARSHALL: But I think that we would all appreciate anything you can do to help reduce the burden of behavioral health in our emergency department so thank you for that.

MR. MCEVOY: Could I -- I ask a few questions. So this seems like a really good referral source where there's many times when we refer people rather than transporting them so this seems like a really good program. Do you have an anticipation of making more than twenty-two of them?

MS. GOLDMAN: At this time, the funding that was available was for the development of twenty-four. And at this time, twenty-two providers had interest in opening them and were awarded and had some competitive funding for it. But the certification process is open to any provider who would like to operate a Crisis Stabilization Center. The twenty-two who are -- who are developing just happen to be providers who were provided some State aid to open these.

MR. MCEVOY: Is there a place to get a list of where they actually are?

MS. GOLDMAN: I did include them on

the slides so the slides will be available. But they're not publicly available anywhere else. So if you have access to these slides which I know will be public facing that has the list of providers and counties they're willing to operate in.

MR. MCEVOY: Okay. Is it just like there was listing of counties, not really location specifically?

MS. GOLDMAN: As they get closer to opening, I think we're going to be doing a lot of -- trying to do a lot of -- outreach to communities and providers to make sure that everyone is aware. The other thing is that there is -- that these services are billable -- are Medicaid billable services. So the hope is that they've been designed in a way that can be self-sustaining so that even providers that may not have been awarded these -- that start-up funding, you know, if they decide they want to pursue this, that there's the opportunity for -- for additional centers to develop over time.

MR. MCEVOY: Okay. And then I guess down the road, important to us, is are any or all of these Article Twenty-eight facilities?

CHAIR DOYNOW: You may want to explain

that to them, Larry.

MR. MCEVOY: Licensed under Article Twenty-eight of Public Health Law.

MS. GOLDMAN: New license under Article Thirty-six.

MR. GREENBERG: What's the capacity of these centers? Are we talking they would see ten patients a day or are we talking they'd see a hundred patients a day?

MS. GOLDMAN: It's going to devout -- depend on the region and the other I think available services. We, as part of the R.F.P., the providers were asked to include a projection of what they anticipated they would have -- you know, the number of individuals they would anticipate to serve. But we do -- though this will be a learning process. I mean, this is the first time that this service has been developed. And so I think we want them to be developed in a way that can grow depending on the need. And I think it'll -- it'll also depend on how well we do to messaging to communities that they exist and to providers to make sure that they're actually being utilized to the maximum that they could be.

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CHAIR DOYNOW: Do you have a timeline as to when you're going to be up and running and --?

MS. CAPPOLA: Based -- based on the provider and where they are in the process, it's at various stages. We do expect a number of them to be fully operational by quarter three of 2024.

CHAIR DOYNOW: Anybody have any other questions? Go ahead, guys. Dr. Cushman.

MR. CUSHMAN: Oh, Jerry, oops, sorry. Brian, would you -- okay. Jeremy Cushman, we just met. Yeah. A -- a couple of things just having -- having been a part of a -- an O.M.H. pilot that will soon become a Crisis Stabilization Center and frankly that's going to disappointment me because right now they are receiving Nine forty-ones which is -- which is incredibly important for our community given -- given that status. With -- with all of that being, I -- I fully agree with -- with Dr. Marshall. Anything that we can do to identify more patient-centered sources of care for those with mental health, substance use, or other crises is really imperative. But always based on my experience and -- of a good friend down the table here of navigating this process for the last four or five years. I am really happy

that you're here. I do think however that whatever O.M.H. can do to frankly force these C.S.C.s to engage and at least notify the program agencies within the communities, within -- that they operate in the E.M.S. agencies within -- which they operate. So that we actually know that they even exist. Because its -- its frankly a little concerning that if they need to go the hospital, they're going to call 911. That -- that's not good continuity of care and many of these patients don't need an ambulance at all particularly if they are voluntary going in for an in-patient admission. And that -- that is not a problem unique C.S.C.s. It is a problem everywhere. But the vast majority of these individuals should not be in the back of an ambulance for a lot of different reasons. Medical needs notwithstanding, I think there's some opportunities there. I, personally look forward to working with you in the hope that we can bring things back here to identify what are clinical standards that are reasonable and appropriate for individuals going to this, if you will, class of facility, just as this body makes those decisions for strokes, STEMIs, and any other clinical indication, understanding that there's a tremendous heterogeneous

and difficult to diagnose population within there. You also mentioned the ability of law enforcement to potentially bring these, you know, again as the System's E.M.S. Medical Director, that falls to me too. And they're going to be looking for guidance. So the more -- the more consistency in the -- the guidance that we can provide Statewide and understanding that there maybe some regional variations is going to be absolutely critical. Because the other thing that can very well happen is that the cop calls E.M.S. to get an eval for medical clearance before they take them to the crisis center which frankly maybe completely appropriate. But I don't think we have much guidance across most of our systems as to how to do that and that gets into a resource allocation issue that none of us have the resources to be able to do to begin with.

So, you know, kind of with -- with all that being said, alternate destination is also huge. E.M.S. gets a lot of voluntaries. They're not all nine forty-ones and nine forty-fives that are getting transported by an ambulance or nine fifty, whatever it happens to be. We get a lot of voluntaries. So again, the -- the sooner, we can look and maybe it's

at a community level decision based upon the capacity of that -- that facility because frankly, I don't want to lose the ability to have -- its not huge numbers. But have small numbers of our patients that are either voluntary or actually under nine forty-one going to our future C.S.C. Sorry. It was more of statements but just like yeah, we got to work together on this one because its --.

MS. GOLDMAN: Very, very helpful statements. You might have noticed all of us jotting things down as you were saying them. But I think you bring up very good points. And also, you know, important lessons learned from the work that you have done, you know, it would -- the center that you're working with. And I think that as you had described, we -- we really are looking to make some statewide standards, guidance around who would be the appropriate, you know, and -- and what type case or what type of individual would be most appropriate for this setting and those that would not. And really try to distill it down in a way that knowing in an emergency response setting, you know, you're not going to go through twenty different questions to try to streamline. And you're really trying to, you

know, distill it down, ensure that that person gets to the safest, most appropriate, you know, receiving center as quickly as possible. I think you bring up a good point also about the regional variability. And I think that's where we do see a lot of this work hopefully over the course of the year is then thinking about what is potentially currently working in one region. You know, our goal is not to undo systems or processes that are working, it would only be to augment or to add to. So I think that while there might be some standards that we have put forth already about, you know, the -- the types of individuals that these centers are receiving. If there's a system that is working, I think that O.M.H. and Oasis will be very open to thinking creatively around how to, you know, support that system to continue to work.

MS. CAPPOLA: And I just -- I just want to note and bring back Jen's comments about this being a learning experience for providers who are opening them as well. So and I -- I want to second your last comment that there will be -- if there -- if there is something that is happening and its working well that providers are very open to looking

at that as well. We have started a monthly learning collaborative with these providers who are in development. And we're still talking about the early phases of what -- what did they want to see come to these discussions in order to have these conversations. So this is a great point and they are also looking for what's working well across the State to have ideas. So at this point, having them all in a space to be able to collaborate is good. And I think being able to incorporate various E.M.S. providers and law enforcement officers who are doing some of this work currently to come in and have these open discussions is -- well, it sounds like the providers are looking for and what we're definitely hoping to facilitate.

CHAIR DOYNOW: Dr. Walters.

MR. WALTERS: Just real quick. I was going to say many of the same things that Dr. Cushman had mentioned so I appreciate that. Thank you. But I guess I would just come back to the point of a lot of people, no matter how you roll this out and how much education you do, a lot of these patients or their families at the time of crisis will still access healthcare through the 911 system, right?

Because it's familiar and it's what they know. And whether that -- that patient then encounters law enforcement or E.M.S., I guess, you're -- you're talking about taking -- having law enforcement potentially drop them off to these C.S.C.s but not E.M.S. And I know -- I understand the slow rollout in wanting to try to put systems in place before you kind of start accepting all these ambulances. But I guess from a medical director perspective, I'm not sure a lot of times if it matters whether its law enforcement or E.M.S. that first encounters that patient and/or transports that patient because they've accessed this system the same way. And I don't know if differentiating and parsing those out clinically makes a lot of sense from the types of people that we see in the community. I do agree patient selection becomes hugely important to make sure we're getting the right patient to the right resource because they -- some of them will need more in patient, longer stay, psychiatric hospitals, right, as supposed to a C.S.C. But I guess those are just things that I would consider looking at a little more closely or implementing in short order because I think that would directly impact and offload both

E.M.S. and the overcrowding we see in the emergency departments.

MS. GOLDMAN: Thank you. And I mean, I think that this -- the development of this program is in parallel with some of the other work that O.M.H. is doing and nationally around the development and expansion of 988 as alternative call center. I think, you know, ideally over time the needle moves and people are calling 911 less for a behavioral health crisis and calling 988 more especially as we can build out that mobile crisis response. So there is an alternative sort of response entity that will go assess the scene and then potentially bring the individual to a Crisis Stabilization Center, if that's appropriate. I think that what you described is absolutely correct, you know. When you think about someone calling 911, it may be police responding or police plus E.M.S. Its then -- then it's sort of no different if they're then going on to the center. I think where at least locally in New York City where we've seen some of the police drop off has been more about touch points in the community where there may be, you know, it's not through 911 activated response. It's more of police is engaged

with an individual. They -- they feel it's possible that there's a mental health component to this. They don't want to necessarily pursue the criminal justice route. But they also want -- don't want this person staying in the community without having some sort of an evaluation. So I think that's more of where we see the police drop off piece. But for a 911 call with a response, I think you're exactly right, like whether that ends up physically being the police or E.M.S., it's still that same question that there was a crisis that raised to the threshold of 911 being called and wanting to really do your due diligence before you're not taking the person to the hospital. So yeah, I think that's a very good point. And -- and as I said, I think, you know, there's work being done for -- you know, between 911 and 988 as well to be thinking about how to potentially, appropriately, and safely move or divert some of those calls that are coming into 911 over to 988 at the start. So that, you know, because at this -- at this time in most locations, if someone calls 911 and you've got just a few options, you know, you have police response. You've got a police and E.M.S. -- E.M.S. response. So I think that if you can divert from the

top over, then you have more ability to then utilize those other options without and always having to, you know, fall on E.M.S. to be bringing someone to a hospital.

MS. GAYLORD: And Jen, do you want to say something?

MS. CAPPOLA: Yes.

CHAIR DOYNOW: So -- I'm sorry. Go ahead. Any other questions?

MS. CAPPOLA: I just wanted to add on to that, if I can. Okay. Thank you. There have been ongoing conversations as well with the 911 Coordinators Association for about two years just trying to understand the nuances of what it is for them to receive behavioral health calls into 911 and how that can coordinate with the 988 system. And we have some contact centers who have started pilots, if you will, with their 911 locations where they're co-located. And so that there are some protocols that have been developed for these certain centers to do some triaging of calls from 911 to 988 and then 988 to 911 based on what they have seen for their volumes and presentation of callers. So we continue to assess this as part of the developing comprehensive

crisis into one system. This is all information that will be shared for the other components as well.

CHAIR DOYNOW: Dr. Winslow.

MR. WINSLOW: Yeah. I just want to say thank you for your presentation. In Suffolk County, we've had one of these since 2019. And they filter out hundreds of calls that otherwise would end up in the 911 system. But the way we separate it is between 911 and 311. So if 311 is called for someone who has an issue of depression, mental disorder, substance abuse, they're directed if they may, self-direct to this facility. It works quite well, also schools because a lot of these are adolescent and -- and young adults. So school and colleges also have programs where they can refer to this program and it's been very successful.

CHAIR DOYNOW: Go ahead.

MR. WASHKO: Yeah, Mr. Chair. Jonathan Washko. So thank you guys for this work. This is -- this is awesome. Its fan -- it's great to see the State catching up. Really the issues that were discussed here, these -- these programs exist in many other states already. Ambulances are taking patients to these types of facilities in other parts

of the country. I don't think we need to reinvent the wheel. I would ask as you guys were building these facilities out, that you consider the intake process and the logistics associated with an ambulance coming to a facility to drop a patient off like that. And -- and how their -- you're -- you're -- whatever the requirements are for your facility and one of the things we noted in E.T. Three, you know, in our participation of that and working with alternative destinations. Those were some important things, you know, to consider as well as the ability to communicate with the E.M.S. system if their dropping patients off and things like that. Like I said, I think -- well, in -- in Innovations and Research Committee, we made a motion that hopefully will be coming to this body today about building a framework for alternative destinations because ultimately we need something. This would be I think a subset of that whether its, you know, taking patients to an urgent care or taking patients to a crisis facility like this is clearly going to be part of I think the future for E.M.S. as well as, you know, the -- the movement of 911 calls over to the 988 centers and vice versa. I mean, it's all good

stuff. I think we should be ahead of this or working in parallel. And like I said, I will ask this body to consider putting, you know, either tied together or a special group to be able to start working on what does that protocol look like from an operations perspective, from a clinical perspective. You know, some guidance maybe for the regions because ultimately I think we would want have a standardized approach to -- approach to this versus, you know, variability all over the place, so thank you.

CHAIR DOYNOW: Dr. Cooper then Don Hudson.

MR. COOPER: Thank you, Dr. Doynow, and thank you for the presentation. I have the honor of chairing the Emergency Medical Services for Children Advisory Committee to the State Department of Health. I know you did mention that you're incorporating planning for pediatric patients and -- and -- and in these -- you know, in your process. I think, first, that as has been suggested, patients who are significantly agitated are -- are going to constitute, you know, a large percentage of the -- of the patients that E.M.S. will be called to -- to see. And of course, as I'm sure you're aware as a

psychiatrist that the issues are, you know, a little different for the kids than they are for the adults. But not, you know, entirely different but different enough. But I -- I -- given that we are embarked on a major project to develop both adult and pediatric de-escalation, not protocols exactly but guidance's in terms -- and education as to how to deal with agitated adults and children. I -- I wondered if in addition to speaking here, we could invite you to come to the December Emergency Medical Services for Children Advisory Committee meeting and layout your plans. And I think you may get some -- some good feedback from some of the pediatric critical care and emergency medicine physicians who serve in that committee. And I think that may help all of us, you know, come to a place where we can ensure that -- that kids are fairing well within the system particularly with respect to the individual staffing at those centers that may not be as familiar with pediatric issues as they may or may not be familiar with adult issues. Thank you.

CHAIR DOYNOW: Don Hudson.

DR. HUDSON: Yeah. Two minutes, I promise. So just to put some color to this from the,

you know, E.M.S. coordinator or the program agency perspective as Dr. Cushman mentioned. So literally two weeks ago in the office the phone rings and I answer it. And the first thing they say is hi, how wide at the doorway can your ambulance stretcher get through, and, you know, obviously, hi, who is this. What are you asking for, you know. And it turns out it was Central Mesa Guidance who just got a ton of money through a grant that they're renovating one of their facilities for this. And in doing so, they want to make sure that for future, you know, years down the road, reception of ambulances that their facility is commensurate with our logistical needs. So thank you for coming here and thank you for putting us together in the infancy of this. And those questions are going on. And I just want to make sure we get the right people together to continue those and building out this thing for the benefit of everyone, so thanks.

CHAIR DOYNOW: Any other comments? Well, thank you very much for your presentation. Oops. Dr. Dailey.

MR. DAILEY: No. I was -- I was going to say thank you. That was actually my follow up

was to Don just to say how exciting that was to have someone reaching out asking about ambulance stretcher dimensions because municipal building codes still does not require -- municipal building codes still does not require ambulances to fit in the stretchers for multi-story buildings. That would be nice.

CHAIR DOYNOW: As well as the elevators and --

MR. HUDSON: And, you know, just to plant the seeds so they literally on a hunch did a Google search to try and find that out. And then, you know, this E.M.S. coordinator, they came across my phone number. So, now is a nice time -- if the -- if somebody hasn't reached out to you and then there's a place on your list, you know, or in your county that is being built out maybe introductory hi, who are you. This is who we are. Its -- its time.

MR. GREENBERG: I got to take this moment to ask -- or ask how did they figure out that you were the E.M.S. coordinator or even to look for an E.M.S. coordinator position?

MR. HUDSON: Well, the same way I never heard of the 911 Call Center Association or anything. I mean, just by sheer happenstance,

literally a Google search. So, you know, people are at least mindful that E.M.S. exists. And we have a stake in this game which I don't know if it's -- has ever really happened before, so. I guess I'm just excited that they figured out what an E.M.S. coordinator was. And is there more things that we can do to kind of promote that. So when people have questions or trying to make that link, they know a person to go to in each county. And they're even more excited when I just sent them the product specifications from the stretcher manufacturer, they go oh, we'll show this to our contractor. Thanks.

CHAIR DOYNOW: Okay. Thank you. We appreciate the presentation. Before I move on, any other new business anybody wants to bring up? Go for it Mike.

MR. GREENBERG: Mr. Chair, just two things. One, the funding policy and the new pilot program policy are up. They're on the bureau's website for anybody who would like to as well as also I'll put the plug back out there for anybody who wants to do a survey. It's on the E.M.S. forms page. And the E.M.S. advisory related to equipment selection, that has to be approved by the medical

director at the agency. It's also up. That is under the -- on the -- and bureau of E.M.S. page, under protocols and advisories, under SEMAC advisories. It is 23A and it is that protocol or that advisory as well.

CHAIR DOYNOW: Thank you, Mike. Dr. Dailey.

MR. DAILEY: So there's a paper that's recently written that I want to bring the attention to this body on, unless because of our role in advising the Commissioner about E.M.S. and more about our role in advising the Commissioner on emergency departments. But it was a paper written by Jeff Kamta, et.al and the folks in Rochester including our own Dr. Cushman and Dr. Dorset who have been extremely valuable obviously as we've discussed. And this paper actually was really interesting because what they focused on was information transfer between ambulance crews and the physicians and providers caring for patients in emergency departments. And the title, improving emergency medicine clinician and awareness of prehospital-administered medications. And what they did is they looked to see how many people that received dexamethasone pre-hospitally,

received additional dexamethasone in the hospital. And they found out that about thirty or thirty-five percent of people receive the same medication again without any clinical indication for a second dose. So they went through a series of P.D.S.A. cycles, exactly the way you're supposed to do, a really good quality initiative, and tried a couple of different solutions to try to improve the process of information transfer so that the ordering clinicians wouldn't re-order a medication the patient had already received. And after two very well structured P.D.S.A. cycles that they described very nicely in here, they still had thirty to thirty-five percent of the patients getting dexamethasone again. And the problem is something that I think that we have the potential to start considering solutions to. We are moving towards electronic health records. We are moving -- moving towards actually rather robust electronic health records but we're doing that in a silo. In some cases, its agency silos when ambulance agencies decide they will just randomly have their own medical record. In some, it's just a silo within E.M.S. itself. And we have our image trend bridge that ultimately brings these siloed records together.

But those siloed records don't ultimately become discrete information at the hospital end. In many cases, they still remain flat P.D.F. files somewhere hidden within a record system. One of the things that we're doing locally right now is building out EPIC across one of our health systems. That health system is looking to integrate E.M.S. data as real data as opposed to flat files. And that gives us the opportunity then for those medication administrations to be actionable information in the hospital. So that while I understand that with an EPIC build, you have the potential for lots of little pop ups all over the place. This would give you the opportunity to get a pop up when you order dexamethasone for someone who already received it from E.M.S.. I bring this up as new business just because I think we can do things better. Dr. Goldman and her team came here to give us new ideas about how to handle crisis, which is fantastic and some of the things that are being done there. This is something where our -- our hospital systems are implementing new electronic health records. They are very frequently choosing to save money in that implementation by not integrating E.M.S. records as discrete data but as flat files.

And we can as a body recommend ultimately to the Commissioner that we encourage our hospital systems as they look to improving their delivery of care through electronic health records, that they make sure that E.M.S. data system or E.M.S. data is included within the patient's record because at the end of the day, it's not the hospital's record. It's not the E.M.S. agency's record. It's the patient's record so we can care for the patient as optimally as possible. So I bring that here just for us to start thinking about to see how we could impact that within our -- within our mandate to advise the Commissioner on emergency department integration for E.M.S. And just to keep out there as an idea we'll consider.

MR. GREENBERG: Just a quick question on that one. I -- I honestly don't know the answer. When information goes through a RHIO, does it come to the hospital as flat or does it come as dynamic?

MR. DAILEY: So one of the problems with the Regional Health Information Organization is that that is information you actually have to go and seek. It's not information that automatically integrates. As long as you have to pull things rather than it being pushed to you, it is less

actionable at the time of -- of care unless you did make a volitional decision to go and seek that out.

MR. GREENBERG: But if you don't seek that, does it come across as flat or does it come across as dynamic?

MR. DAILEY: It can come across both ways depending on the information itself. Usually, it's a flat file.

MR. GREENBERG: Usually it's a flat file, okay. I was trying to figure out if maybe some of the work for what you're referring to has been done and we can look at it from that point of view.

MR. DAILEY: Actually, most of the work has been done already. Other EPIC builds in other parts of the country already have these integrations done. In the trend, E.S.O. and -- and E.M.S. charts for three examples I know of, all have robust systems that can actually bring discreet data across into hospitals themselves rather than just flat files. It's a question more of how the hospitals are recording this information and how they are choosing -- more accurately, how they are choosing to consume that data. And the easiest way to do it is as a -- as a flat file because it's just like any

other facts.

MR. GREENBERG: Sure.

MR. DAILEY: But the more we can get that information to be actionable, real data that can fit in to the hospital systems, the better off we'll be.

MR. GREENBERG: Who do you think your recommendation or component would be for that? I'm not saying to make it -- or, you know, automatically how do we get here from here to a finish line. But what do you think that first step in discussion or things that, you know, from others around the table have done in order to help results data get pushed up?

MR. DAILEY: I think the first step is what Maya and her team and Jeremy's team out in Rochester did which is study the problem and see that we really do have a problem and what that potentially could mean. I think the next step after that is for some of the E.M.S. leaders at this table and particularly the emergency medicine leaders from their hospitals take this back home and look at how their systems are -- are using this. And then for us to come back together usually at the break between

meetings. And talk about how this ultimately can impact us. This may have to be something that the Public Health Planning Council deals with more than we do. But we actually have a mandate to work on emergency departments. And it maybe something that needs to fall to this stack, into the cardiac advisory committee for STEMI and stroke and all the other places this information becomes extremely valuable in the hospitals themselves. But I think we just have to start thinking about it and talking about it.

MR. GREENBERG: I'd be happy to have a first conversation either in between meetings or schedule a meeting in between, actual meeting dates to see what we can do to -- to kind of push that forward. If you think that's an important one, then I think it's something that, you know, reality isn't -- won't happen overnight. But if we don't start the conversation at some point, it's not moving the process forward either. I would also say that, you know, we strive just to get the flat file over and let alone that dynamic file and that's challenging in itself in each region, you know. And then like the 17 P.C.R. run -- E.P.C.R. vendors that we have in New

York State today, hospitals have a similar issue of, you know, well, what -- you know, electronic health record are they using granted fifty percent being on EPIC. But -- so I think there's some dynamics. But no, I think it's a great thing. And I think we should move forward on that.

CHAIR DOYNOW: Dr. Cooper.

MR. COOPER: Thank you, Dr. Doynow. I think Dr. Dailey in citing Dr. Cushman's work has really touched upon an issue that I think has, you know, concerned all of us for many, many years which is, you know, the -- the weakness of the interface between E.M.S. and emergency departments, you know, across the board. We all know that there is a provision in regulation that -- that emergency departments are required to have interface with E.M.S. on a -- on a regular basis. There's also a provision in Article Thirty that gives the SEMAC a role in helping to develop appropriateness review standards for emergency departments and one of which could be focused on -- on the issue of, you know, the interface between -- between pre-hospital and -- and in-hospital emergency care. There was a workgroup that met briefly, maybe fifteen years ago now when

Mr. Ronski was the director that began to think about these issues and Dr. Marshall may remember that workgroup. I think he was part of it and it might even have been before Dr. Doynow's time. I don't know. But -- but it is an issue that has never been really addressed as well as it could be. And -- and I certainly do think that the better integration between pre-hospital and in-hospital care is a -- an important facet of the, you know, the -- both the original and the follow up E.M.S. agenda for the future and at a national level. And I think it's something that -- it really behooves us to try to, you know, focus on in some way or in the future. I think that focusing explicitly on the interface, I think is a -- between the two phases of care is a really good way to -- to -- to start. And I would urge that the bureau consider pulling together a workgroup to start thinking about these issues. Thank you.

CHAIR DOYNOW: Thank you, Dr. Cooper.

MR. WASHKO: So John Washko again. There is a project going on Downstate in New York City where the hospitals are working together with Health Fix and C.N.C.R. or Health E.M.S. in order to

try to bring X.M.L. level data and not just C.C.D. or a flat file data into the actual E.M.R. systems. We're been going through an EPIC build. We'll be doing the same thing as Dr. Dailey mentioned, trying to bring E.M.S. data in. These -- these exchanges already exist. Ultimately, like you said it's a -- often times, it's a budgetary issue on the hospital side and then, you know, I think -- I think that the technology is there and it's easy to get done. The hard part is finding the dollars to do it. We already have a standard. It's NEMSYS, right? So it's easy for us to get, I think, our data to other places. Other places like, you -- you know, while H.R. Seven and some of the -- and was it Fire I think are the other -- other languages on the hospital side. I've seen that it's a lot more challenging to get hospital data out in a discreet and structured way than it is. You know, E.M.S., I think we've done actually a really good job. And we're actually kind of ahead of a -- the power curve when it comes to our ability to move data and have it in a structured way. And -- and its one language across all E.M.S. entities. So I think we're well on our way. And but, you know, it will require some funding as well.

CHAIR DOYNOW: Any other discussion? Doc -- thank you. Would you be willing to form a workgroup maybe with Dr. Cushman and New York City and come back to the committee maybe in -- in December and at that point have a motion that we can send up to the commissioner. It's certainly an excellent idea and it certainly can be built in. I'm a long term user of EPIC. I know all the pops up that come up, so this would be a great pop up to have to know that the medication be given if you're trying to order it and its already been given.

Okay. Any other questions now before we move on? Any other new business? Okay. Our next meeting is December 6th. And just one thing I do want to mention to the physicians who have attended today, thank you for coming. We do have an attendance issue. Please remember that we are one of the four meetings a year. And -- and also that we try to help everyone out by moving the physician meetings to one day rather than two days. Whose -- who's come? I mean, we have -- we need thirteen people for a quorum and we had that today. There are only really a couple of physicians who do not show up on a routine basis. So I will talk -- I will reach

out to them. But we do publish the dates for the meetings now a year in advance and we really need you to come. Missing a meeting can potentially give us a -- a problem with having a quorum which is -- is a problem. So please, please come to the meetings. All right. On that note, I will adjourn the meeting. Oops, Dr. Cooper.

MR. COOPER: I would like to -- like to make a motion to adjourn, please.

CHAIR DOYNOW: Thank you. Any second, anybody a second? All right. Anybody against? Good.

MR. COOPER: I'm against it.

(The meeting concluded at 1:27 p.m.)

9/13/2023 - SEMAC Meeting - Troy, N.Y.

STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription consisting of pages 1 through 97, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 10th day of October, 2023.

DANIELLE CHRISTIAN, Reporter

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