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10/30/2025 - STAC - Saratoga, New York

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: October 30, 2025

TIME: 1:06 p.m. to 2:13 p.m.

CHAIR: MATTHEW BANK

LOCATION: Holiday Inn, Saratoga Springs

232 Broadway

Saratoga Springs, New York

Reported by Annette Lainson

1 10/30/2025 - STAC - Saratoga, New York

2 APPEARANCES:

3 ABENAMAR ARRILLEGA

AMY EISENHAUER

4 ARIEL GOLDMAN

ARTHUR COOPER

5 CRISTY MEYER

DANIEL CLAYTON

6 DEREK WAKEMAN

DR. EDWARDS

7 DR. VOSSWINKEL

ERIC KLEIN

8

FRANK MANZO

GEORGE AGRIANTONIS

9

GEORGE STATHIDIS

10 GUZMAN CURTIS

JERRY RUBANO

11 KATE MAGUIRE

KERRIE SNYDER

12 KIM WALLENSTEIN

LYNN FARRUGGIA

13 MARK GESTRING

MATTHEW CONN

14 MEGHAN MILLEN

MICHAEL DAILEY

15

ROBERT CURRAN

ROBERT VELLA

16

ROBERT WINCHELL

RYAN GREENBERG

17

SHELDEN TEPERMAN

18 SRIHIVAS REDDY

TOM BONFIGLIO

19 WENDY PATTERSON

WILLIAM FLYNN

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2 (The meeting commenced at 1:06 p.m.)
3 DR. BANK: Okay, if I could call the
4 STAC to order. First business is to do the Pledge of
5 Allegiance, which Dr. Winchell will lead us through.
6 ALL: I pledge allegiance to the Flag
7 of the United States of America, and to the Republic
8 for which it stands, one Nation under God,
9 indivisible, with liberty and justice for all.
10 DR. BANK: Okay. Next order of
11 business is going to be attendance and roll call.
12 Mr. Clayton.
13 MR. CLAYTON: And for the
14 Stenographer, we can go on the record. Dr. Bank?
15 DR. BANK: Here.
16 MR. CLAYTON: Dr. Gestring.
17 DR. GESTRING: Here.
18 MR. CLAYTON: Dr. Doynow. He's
19 excused. Dr. Winchell?
20 DR. WINCHELL: Here.
21 MR. CLAYTON: Dr. Goldman?
22 DR. GOLDMAN: Here.
23 MR. CLAYTON: Dr. Cooper. Dr. Dailey?
24 DR. DAILEY: Here.
25 MR. CLAYTON: Dr. Guzman-Curtis?

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2 DR. CURTIS: Here.
3 MS. CLAYTON: Melana King?
4 MS. KING: Here.
5 MR. CLAYTON: Meghan Mullen?
6 MS. MULLEN: Here.
7 MR. CLAYTON: Dr. Flynn?
8 DR. FLYNN: I'm here.
9 MR. CLAYTON: Francis Manzo?
10 MR. MANZO: Here.
11 MR. CLAYTON: Kerrie Snyder?
12 MS. SNYDER: Here.
13 MR. CLAYTON: Dr. Edwards?
14 DR. EDWARDS: Here.
15 MR. CLAYTON: Dr. Prabakaran is
16 excused. Kate McGuire?
17 MS. MAGUIRE: Present.
18 MR. CLAYTON: Dr. -- Dr. Angus? I
19 believe he's excused. Dr. Klein?
20 DR. KLEIN: Present.
21 MR. CLAYTON: Dr. Arrillaga?
22 DR. ARRILLAGA: Present -- present.
23 MR. CLAYTON: Dr. Vosswinkel?
24 DR. VOSSWINKEL: Here.
25 MR. CLAYTON: Matthew Conn?

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2 MR. CONN: Here.
3 MR. CLAYTON: Dr. Agriantonis?
4 DR. AGRIANTONIS: Present.
5 MR. CLAYTON: Dr. Reddy?
6 DR. REDDY: Present.
7 MR. CLAYTON: Dr. Teperman?
8 DR. TEPERMAN: Here.
9 MR. CLAYTON: We have twenty-one. We
10 have more than a quorum.
11 DR. BANK: Okay, great. The next
12 order of business is approval of the previous meeting
13 minutes. The minutes are on the website if anyone
14 wants to review them. Can I have a motion for the
15 approval of the previous minutes from the May, 2025
16 STAC meeting?
17 MR. AGRIANTONIS: Motion.
18 DR. BANK: Dr. Agriantonis has a
19 motion. Do we have a second?
20 MR. TEPERMAN: Second.
21 DR. BANK: Dr. Teperman or Dr.
22 Vosswinkel both second it. Any discussion? Great.
23 Minutes are approved. Next order of business is the
24 Division of State E.M.S. report. Our Director, Ryan
25 Greenberg, is here next to me.

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2 DIRECTOR GREENBERG: Hi, everybody.
3 Thank you for attending today. I think, you know, in
4 this particular report, just want to talk about some
5 of the transitions that you've seen. We have moved
6 from the Bureau of E.M.S. and Trauma Systems to the
7 Division of State E.M.S. with three bureaus
8 underneath us. There's now the Bureau of E.M.S.
9 Administration, the Bureau of E.M.S. Licensure and --
10 and Oversight. And the Bureau of E.M.S. Emergency
11 Management.

12 The middle bureau is kind of what
13 you've always known, our Bureau of E.M.S. and Trauma
14 System. So a lot of the same functions, licensure,
15 oversight, investigations, trauma systems would all
16 still fall in that domain. The leadership for the
17 parts that you interact with will remain the same. A
18 couple of titles will change, a couple things in that
19 sense, as well as some additional resources. So we
20 are expanding our data team, we're expanding our --
21 you know, our ability to -- to look at different
22 things in addition to the amazing work that Wendy and
23 her team does.

24 So you know, we're excited to be able
25 to have the additional resources, to be able to work

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2 on many of the projects that this group has come
3 forward with to be able to provide additional
4 resources and -- and different initiatives that are
5 coming forward. So we're really excited, you know,
6 on that front. And I think at the next meeting we'll
7 have even more to report out on the new Bureau Chiefs
8 for each of the bureaus and to provide more
9 information on that.

10 You know, in addition, I just want to,
11 you know, put out there, we know that you know
12 there's been some challenges recently, with different
13 software platforms and different vendors and -- and
14 flow of information and that we do continue to
15 monitor that. But we appreciate everybody's
16 feedback. And Cristy Myers and her team has been
17 excellent in sharing information along the way, as
18 well as some of our RTACs who shared information and
19 things like that.

20 It's important for you to please
21 continue to share that information with the division,
22 as that helps us navigate the system, navigate the
23 verification process with the American College of
24 Surgeons and navigate, you know, any challenges that
25 might be coming up in the process. And so I just

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2 want to, you know, say we appreciate that in that
3 feedback.

4 We know that transitions sometimes
5 have bumps in the road. I think Cristy and I were
6 talking about, kind of that. And you know, be
7 patient with some of it, but at the same time,
8 recognize that, you know, if there are specific
9 things that the State needs to be aware of that can
10 help with and everything else to please, you know,
11 let us know.

12 And then, I know I said it in the
13 committee, but I -- I just want to say it here too
14 because I think there are a lot of people here who
15 weren't here before. Those challenges and bumps in
16 the road, probably one of the biggest effects is to
17 our registrars. And our registrars are really a
18 tremendous component of the -- the -- you know, the
19 backbone of the trauma system and the quality and
20 being able to look at data and improve things and
21 improve outcomes.

22 And so, I just want all the registrars
23 out there to know that, you know, the State does
24 recognize this is not you, that you're doing great
25 work, that we appreciate the work that you're doing,

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2 and that you know, we'll be working through those
3 challenges and you know, work for solutions with you.
4 And so I just wanted to say thank you to all of our
5 registrars. And you know, we appreciate everything
6 that you do.

7 So I think that's it for my report for
8 today, unless there's any questions or anything
9 specific I can answer.

10 MR. CONN: I have a couple of
11 questions. So I -- I'm -- I'm excited for the State
12 Division of E.M.S. for the growth and transformation
13 that it's undergoing. I think it's needed expansion.
14 I think it's long time coming and much needed, the
15 straightening out of things is definitely noticeable.

16 The bureau that trauma falls under,
17 the bureau formerly known as E.M.S. and Trauma
18 Systems, I -- Matt Conn's personal opinion, is that
19 Trauma Systems should be identified in one of those
20 bureaus somehow in the title. I think that that
21 gives more credence to what we do as a state, as a
22 state trauma system and the work that the trauma
23 centers and the trauma programs do on a daily basis
24 in collaboration and conjunction with the
25 collaborative services that we work with. And I -- I

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2 think it deserves its own recognition within those
3 titles.

4 DIRECTOR GREENBERG: Totally
5 appreciate and understand that. Go back and take a
6 look at that, I think if you saw the entire
7 organizational structure too, there is an entire
8 trauma systems unit that falls into it and that's
9 part of where things fall. And you know, the other
10 big part of that one is -- is that, you know, where
11 before and it currently still is, you know, kind of a
12 unit of one at the moment. But we have other
13 positions that are now designated into it that
14 hopefully we'll be looking to fill in, you know, the
15 near future, truly taking that unit to the next
16 level.

17 But happy -- like I said, in -- I
18 think in, you know, when we come to February and
19 things like that, you'll start to see more of that.
20 You'll see, you know, the name and -- and this is
21 part of those changes, right? So you'll see a trauma
22 systems unit, which we've never had before. It's
23 within the bureau. But it's -- you know it's
24 something that -- that truly becomes another piece
25 with it.

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2 MR. CONN: Thank you.

3 DR. BANK: Any your questions for
4 Ryan? Okay. The trauma unit update, Dan and Tom,
5 anything to say?

6 MR. CLAYTON: As emergency licensing
7 server -- Emergency Services Licensing Branch Chief,
8 I have nothing to report. And I defer to Tom on a
9 trauma specific report.

10 MR. BONFIGLIO: Nothing in particular
11 for the Trauma Systems Unit.

12 DR. BANK: Okay, great. Going into
13 the subcommittee reports, I'm going to go a little
14 out of order because there's some people they need to
15 make trains. Dr. Winchell did a trauma center needs
16 assessment before.

17 DR. WINCHELL: Sure. Thanks very
18 much. So the trauma center needs -- pardon me,
19 trauma center needs subcommittee spent a fair amount
20 of time talking about the request from the State
21 Department of Health to look at how to improve trauma
22 resources in the Far Rockaway region.

23 We talked about this in our last
24 meeting as well. We had an extensive discussion
25 about options in different ways around going around

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2 this. We're working on a draft document, which we
3 should have ready before the next STAC meeting. We
4 had a little bit of discussion about a couple of
5 changes in designation, which are following our
6 standard guideline and our plan to work on updating
7 the guideline and make it a little more accessible on
8 the state website. That's all we have to report,
9 unless there are any questions.

10 DR. BANK: Any questions for Dr.
11 Winchell?

12 DIRECTOR GREENBERG: I just want to
13 say thank you to you and your committee for the work
14 that you're doing and -- and the discussion on the
15 Far Rockaway side. You know, in looking really, you
16 know, from many different angles, I think the
17 discussions really took it in -- in different ways,
18 and we look forward to seeing what the reports once
19 they come out.

20 DR. BANK: Okay. Going up to the top
21 of our agenda here, Executive Committee just wanted
22 to talk a little bit about some new members and or
23 members moving to new positions. We have Dr.
24 Gestring, who was previously the Finger Lakes RTAC
25 rep, he's going to be leaving that position and

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2 become the new -- he's been vetted as the Vice Chair
3 of STAC, so congratulations.

4 Dr. Eric Klein will be the new
5 representative of the Nassau RTAC and Melana King
6 will be the new representative of the Central New
7 York RTAC. So thank you very much.

8 Some people who are leaving their --
9 their vetted positions is Matt Conn. Dr.
10 Wallenstein, who is no longer representing the
11 Central New York STAC, but will still be very
12 involved with the staff as the Chair of the PED
13 Subcommittee, and Dr. Ullman is leaving her role
14 representing the New York State Neurosurgeon. Any
15 questions about that? Okay. Moving right along.
16 Registry committee. Cristy.

17 MS. MEYER: Cristy Meyer, Subcommittee
18 Chair for the Registry. Good afternoon, everyone and
19 thank you really for recognizing the registry efforts
20 that have gone on across the State over the last
21 year. More or around fifty percent of trauma centers
22 have changed vendors, updated to the A.I.S. 2015
23 dictionary. So on top of new languages, we have new
24 software and new challenges. So thank you to
25 everybody's efforts.

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2 We had a good deal of discussion this
3 morning about some of the ongoing data submission
4 challenges and data collection challenges across the
5 state. We see about fifty percent of centers
6 continue to have difficulty submitting data for the
7 first two quarters of 2025. We did have
8 representation from E.S.O., the vendor E.S.O., who
9 led a very robust discussion of overcoming some of
10 the challenges in mapping and transitioning into the
11 new registry space. We will look forward to updates
12 as they work to fold in a lot of more resources to
13 their field team.

14 Also just to highlight that the
15 registry is vital for verification and re-
16 verification prep. And really, we rely on the data
17 for performance improvement but also for that prep
18 for our visits. So we'll be very carefully
19 monitoring the impact of these challenges as we go
20 forward. We're hoping to correct some of these data
21 submission lags by the first part of the year, so
22 stay tuned. We will certainly have ready updates.
23 And as Director Greenberg said, please keep everyone
24 updated on ongoing challenges.

25 In addition, we had discussion of the

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2 2026 data dictionary updates. There's one pick list
3 change and then a lot of changes to help standardize
4 data collection in New York State. So, whether it be
5 definitions or a little bit of clarifications in
6 additional information, we hope to continue to
7 standardize data.

8 We are working on a data request
9 process for trauma centers who are performing
10 education or maybe research efforts and -- and try to
11 mirror some of the processes for data requests across
12 other divisions of the Department of Health.

13 And then we will form our annual
14 technical advisory group, for creating a frequently
15 asked question document and resource for trauma
16 registrar and trauma teams across the state. So if
17 you would like to volunteer, please email myself or
18 any of the Department of Health designees, and we
19 hope to have a robust group starting off in the
20 coming weeks. And that is the substance of the
21 report today. Thank you.

22 DR. BANK: Thank you very much,
23 Cristy. Any questions about the Registry
24 Subcommittee? Okay moving right along with the
25 Injury Prevention Education. Mr. Conn?

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2 MR. CONN: Good afternoon, everybody.
3 We had a meeting this morning. In the past
4 discussions, a lot of it focused on National Injury
5 Prevention Day, which is November 18th. One of the
6 things I'm very proud to announce is that, we've had
7 a -- a deal with a national movie theater chain,
8 which is going to display fifteen second videos in
9 lobbies throughout New York State.

10 And just very briefly, let me give you
11 a couple of ideas. This is Staten Island, the Bronx,
12 Bayside, Fresh Meadows, Poughkeepsie, Hampton Bays,
13 Astoria, Levittown, Lynbrook, Portchester, Buffalo,
14 Orchard Park, Queensbury, Waterbury, Webster and
15 Vestal. So, throughout New York State, these will be
16 in lobby ads -- well, P.S.A.s to be specific, about
17 injury prevention as well as a lot of different
18 things. We are committed to having some type of
19 representation activity or awareness in every -- at
20 all the sixty-two counties. No motions to present.
21 No further information. I -- I thank you.

22 DIRECTOR GREENBERG: Can you tell us
23 more about the videos?

24 MR. CONN: What more do you want to
25 know? I'll send that -- I'll send that video to --

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2 to the members later on today, if you don't mind.

3 DIRECTOR GREENBERG: But how were they
4 -- like, how were they produced? Or like, what --
5 what's some of the messages that's going to be sent
6 out?

7 MR. CONN: It was all in-house. Yeah,
8 sure -- sure. It was all in-house. This was a not
9 an official STAC presentation, obviously went through
10 -- but it went through with Safe Kids Worldwide and
11 Injury Free Coalition for Kids. And so we focused
12 on, you know, five different topics: always safe in
13 the water with drowning pictures, always safe in the
14 car with buckled up and child safety seats, always
15 safe with gun locks. So, we took a variety of images
16 with some overlying text.

17 DIRECTOR GREENBERG: That's great.
18 Congrats.

19 MR. CONN: Thank you.

20 DR. BANK: Any questions about the
21 Injury Prevention or Education Subcommittee? No.
22 Okay. Moving to the P.I. Committee, Dr. Vella.

23 MR. VELLA: Good afternoon. We don't
24 have any motions. We had a couple of good
25 discussions. The first, Kerrie Snyder from Albany

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2 gave a nice update on standard seven, eight and non-
3 surgical admissions after some clarification from the
4 A.C.S.

5 So, just to reiterate for those who
6 weren't there, basically all non-surgical admissions
7 need to be reviewed in a primary review. And then
8 the -- the main question was what cases need to be
9 taken to the next level of review? And the
10 clarification we got are cases with opportunities for
11 improvement is sort of an obvious one, cases with
12 injury severity score greater than nine and then case
13 -- cases with a Nelson score less than or equal to
14 five, with the caveat, if you're not using a Nelson
15 score, you don't need to use that to adjudicate non-
16 surgical admissions. So take from that what you
17 want.

18 MS. SNYDER: Can I ask -- it was
19 greater than nine without a surgical consult.

20 MR. VELLA: Without a -- sorry, I -- I
21 didn't read that. Yes. Without a surgical consult.
22 So we have some clarification there, although there
23 probably is a little bit of room for interpretation
24 for some of those.

25 Dr. Sam Hawkins gave a nice

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2 presentation on proposed screening for alcohol use.
3 And then I presented some TQIP data from the most
4 recent state collaborative on TQIP. We did see
5 improvements in morbidity mortality as it relates to
6 treating trauma patients and patients with shock,
7 which I like to think is in part at least based on
8 some of the discussions and collaborative work we've
9 done over the past couple of STAC meetings. And then
10 we got some ideas for future presentations. Thank
11 you.

12 DR. BANK: Any questions for Dr. Vella
13 about the P.I. Committee?

14 MR. TEPERMAN: Yeah -- yeah. Shel
15 Teperman, New York. So there was a -- a really good
16 conversation between Sam and the rest of us about
17 tertiary survey. It's interesting that tertiary
18 survey is not a standard. It's one of the things
19 that the college that hasn't mandated. And I think
20 there's -- Mike and I have been talking, there's a
21 little bit of room in this space for us to maybe, you
22 know, teach and educate and maybe standardize how
23 tertiary surveys is done in this state.

24 You know, we rolled it out at my
25 center. It definitely catches missed injuries. In

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2 the case of Sam, his place is using it to -- to make
3 sure escort is done properly and some other things.

4 So it's a -- it's an opportunity for
5 the future, Mike, for us to -- to do some general
6 protocoling tertiary surveys.

7 MR. VELLA: Yeah, I think that's
8 great. I think the plan will be to have some
9 presentations on different ways to do tertiary
10 surveys next time. And then Dr. Hawkins brought up a
11 point of maybe sending out a survey to members about
12 how they do their tertiaries. I think maybe we can -
13 - designing a -- a study --

14 MR. TEPERMAN: That's great.

15 MR. VELLA: -- for the next STAC
16 meeting to get approved and then distribute that in
17 some capacity so --

18 MR. TEPERMAN: Great.

19 MR. VELLA: -- we'll -- we'll work on
20 that.

21 DR. BANK: Any other questions for Dr.
22 Vella? Okay. Next, moving on to systems, Dr. Rubano
23 and Dr. Teperman.

24 MR. RUBANO: Sure. I'll start us off.
25 So the system subcommittee had no motions to make.

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2 We had a very pleasant conversation about a very
3 unpleasant topic, which is what to do in the setting
4 that you failed your A.C.S. site visit. I think good
5 work was made there progressing to how we'll respond
6 to those situations, and there'll be further updates
7 to come on that. We also discussed some -- utilizing
8 the assistance committee for some research projects.
9 And we had to talk about some vascular injuries and
10 what we would do from there. And then I'll turn this
11 part over to -- to Dr. Teperman with some thoughts
12 from the New York City RTAC on some other topics.

13 MR. TEPERMAN: Yeah, just the systems
14 committee received information from the New York City
15 RTAC regarding the E.S.L. registry. And I'd just
16 like to ask Dr. Agriantonis, who's the chair of the
17 New York City RTAC twenty-two Trauma Centers just to
18 update us on that.

19 MR. AGRIANTONIS: Thank you, Dr.
20 Teperman. Yeah, the New York City RTAC, at their
21 most recent meeting on October 6th had a discussion
22 about challenges that many of the centers have had
23 with the new registry product from E.S.O. The
24 challenges include issues with data quality and
25 validation, issues with report writing in order to do

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2 performance improvement and measure compliance with
3 performance metrics, challenges with workflow and
4 also customer service for the end user. A lot of
5 issues with not getting the appropriate help at a
6 timely -- a timely manner for issuing that's brought
7 up with the vendor. So it was moved at the RTAC to
8 draft a letter and send it to the State in -- for
9 information purposes to review the challenges the New
10 York City RTAC is experiencing at this time. And
11 this letter, has been sent to the State to Director
12 Greenberg.

13 MR. GREENBERG: Thank you. So we did
14 receive the letter. We've spoken to the trauma
15 systems unit staff. And the -- we have -- and then
16 today, we appreciate E.S.O. for coming to -- in
17 person today. I know it's not always the easiest
18 task to be the person that gets designated to come
19 when there's an issue, but we appreciate you being
20 here. So we have our setting-up meetings next week
21 to just have a conversation with E.S.O. to see if
22 there's anything from the State side and any issues
23 that the State possibly can help in facilitating or,
24 you know, getting to a resolution on. And then as
25 well as we're going to have a meeting with the

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2 American College of Surgeons to see if this is, you
3 know, unique to New York or if it's a more global
4 issue and then, you know, discuss that with them of
5 how that affects their processes as we know that if
6 the data isn't flowing and isn't flowing correctly,
7 that there are challenges in, you know, the
8 verification process that need to occur. And then
9 obviously, we'll also be talking with -- with Wendy
10 and her team, you know, internal to Department of
11 Health on -- on how that data is coming in, where
12 there are any challenges. But unfortunately, you
13 know, that's something that happens, you know, three
14 or four steps in. So you know, we are normally in
15 that regard that, you know, towards the end of
16 knowing where -- you know, where those data issues
17 are. We just noticed that there's a delay, but don't
18 know what the purpose is. It could be a registrar,
19 it could be a -- you know, a system not getting
20 information out, whatever that is. So we're -- we're
21 going to do a little bit of a deeper dive on our side
22 to -- to check on that and make sure that there's any
23 barriers. In addition to that, I think it is
24 important to, you know -- and this -- this is why I
25 say to all registrars, please always tell us when --

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2 when there's issues. But you know, when we need to
3 facilitate discussion sometimes to help bridge gaps
4 or things like that, we are happy to do that. So I
5 think, you know, in the near future, you -- I was
6 talking with Lynn Farruggia, who is our -- you know,
7 our bureau chief in regards to administration who
8 oversees a lot of our contracts and a number of
9 things with respect to things like that, that we'll
10 facilitate those conversations. We will bring, you
11 know, the different vendors to the table, you know,
12 with our data teams and with everyone else to make
13 sure that the data can flow and flow correctly. So I
14 -- I think first steps will be the other two meetings
15 and then we will flow into, you know, possibly bring
16 together some of the different vendors in order to
17 see what we can do to, again facilitate anything that
18 we can to -- to make this as seamless as possible.

19 MR. TEPERMAN: And just to -- just in
20 closing, I want to thank the director for the praise
21 that you gave to the registrars. They are us and the
22 program officers are us. There is no -- and I'll --
23 I'll repeat what I said this morning in systems.
24 They're the -- they are the best in the country.
25 They're the best in the nation. We couldn't do this

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2 work without our program officers. It's difficult
3 work. They sometimes toil in obscurity. This is a
4 very challenging time and I appreciate the -- the --
5 the fact that Ryan, you took the time to praise their
6 work. And I appreciate the fact that you're going to
7 be helping us get through this difficult time. I
8 think we're good, right? Jerry. And I want to thank
9 Jerry, by the way, for -- for doing the hard work in
10 the committee. Thank you, Jerry.

11 DR. BANK: Okay. Any other questions
12 for the assistance subcommittee? We good? So moving
13 right along, Dr. Wallenstein from Pediatric Trauma.

14 MS. WALLENSTEIN: Hi, I'm Kim
15 Wallenstein. So pediatric trauma subcommittee has
16 one motion I'll get to in just a minute. We did talk
17 briefly about pediatric readiness. We were happy to
18 find that there are now fifty centers that are
19 participating that -- on that and those are all
20 listed on the site. So we're making good progress
21 there. We then had a presentation regarding Stop the
22 Bleed and teaching -- and the challenges of teaching
23 that to children at schools. That leads a little bit
24 to our motion that we'll bring up on the screen. So
25 we are -- our intent is to provide a letter to the

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2 Commissioner of Health to support the concept of Stop
3 the Bleed, both containing kids in schools, and also
4 teaching within the schools on this important topic.
5 And without mentioning specific legislation, we have
6 carefully drafted a letter. So our motion that we
7 wanted support from the wider staff group to send to
8 the commissioner is as follows. State Trauma
9 Advisory Committee's Pediatric Subcommittee support
10 sending a letter to the commissioner of the New York
11 State Department of Health, N.Y.S.D.O.H., supporting
12 efforts to require all private and public schools in
13 New York State to stop bleeding control kits and to
14 train school personnel in basic leading control
15 techniques. We also recommend that the commissioner
16 if N.Y.S.D.O.H. shared this letter with the State
17 Education Department Commissioner. And that last
18 sentence was one that came up this morning, which is
19 a great suggestion to add weight to this. Are we
20 showing the letter as well?

21 MR. TEPERMAN: It's on the screen.

22 MR. VELLA: I was going to second her
23 motion while they're working on putting it up there
24 so we can discuss it.

25 MR. TEPERMAN: We'll get the letter up

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2 in a second.

3 MR. BONFIGLIO: It's page nine of our
4 slides. If you have the slides.

5 MR. GREENBERG: Okay. I knew the
6 letter was shared as one of the documents for the
7 meeting. If you feel that it needs to be read or
8 things like that, we can do that. If you want to
9 maybe summarize what the letter said in a highlighted
10 component, I think that would suffice, unless anybody
11 here didn't get their appeals, it needs to be put up.

12 MS. WALLENSTEIN: I think a summary is
13 acceptable rather than read the entire thing. It
14 basically is what the motion says. It encourages the
15 support for stop the bleeding kits in schools and
16 teaching as a -- as a preventable way to -- as a way
17 to treat these children who will have bleeding for
18 many different reasons. We talked a little bit in
19 the subcommittee about how this isn't just for mass
20 casualty type of events, but also for any reason that
21 a child would be bleeding in the classroom and that
22 it's important for the staff to be familiar with this
23 concept. And so I think it has a pretty wide
24 audience. I don't think that it should be very
25 controversial to have this supported by the

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2 commissioner.

3 MR. GREENBERG: And just wanted to
4 touch on -- thank you, you know, for the efforts in -
5 - in putting this together. You know, this board
6 obviously is, you know, State Trauma Advisory Council
7 -- you are the subject matter experts of the trauma
8 community. And I know the commissioner appreciates,
9 you know, all of the kind of input and forth -- that
10 you put towards this committee, but also things like
11 this that help him stay well informed on different
12 things that might be happening or different comments
13 that are going to come up and stuff like that. And
14 so, I -- I think this letter and reading through it
15 really offers a precise, you know, amount of
16 information. And also, you know, should he be
17 addressed on any questions or things like that so he
18 knows, oh, well, you know, I -- well, I can go back
19 to another subject matter for the time being. So
20 thank you for your assistance in putting this
21 together.

22 MS. WALLENSTEIN: Thank you.

23 DR. BANK: So we have a motion four.
24 Do -- did I hear a second earlier? Dr. Gestring
25 seconded? So this is the motion. So we have to, I

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2 think, take a vote. So for today's STAC members,
3 everybody who is in favor, of this motion, please
4 raise your hand. Okay. I apologize. Any further
5 discussion for Dr. Wallenstein?

6 MR. CURRAN: I did not -- can I ask?
7 I think it's a great letter. I just -- one of the
8 questions that I get when I'm in schools is, okay,
9 how many should we have and where should they be? As
10 part of the expert panel and the expert consensus, I
11 know we -- one of our best projects that we did in
12 Manhattan was to one of our students who had a family
13 member survive the Marjory Stoneman Massacre in
14 Florida had a grant and put a kit in every classroom
15 so that students who were in the classroom that we're
16 talking about wouldn't have to leave the classroom to
17 go to get the kit. So if -- if it just happened,
18 like typically we present the thing and then the
19 principal says, yeah, we have a kit in the
20 principal's office or in the nurse's office. But
21 when you're in lockdown, it doesn't really help
22 anybody. So before, I just want to put that out
23 there.

24 MR. GREENBERG: So I think something
25 like this and -- and by all means and -- others

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2 comment. But I think, you know, something like this
3 in a letter -- in a form of a letter is step one,
4 right? So this is information to the commissioner.
5 I think if the committee wanted to continue to do the
6 work and maybe come up with some advisory or best
7 practice documents, you know, related around it,
8 might be supplemental to it, or there might already
9 be other things out there and I just don't know, you
10 know, precisely, you know, kind of where that falls.
11 But that -- this group can also point people towards,
12 Hey, this is where some of the recommendations are.

13 MS. WALLENSTEIN: Yeah, I agree. I
14 think that this is a sort of just the first step. I
15 think that we have a lot of work to do in order to
16 get best practices in place and to standardize this
17 in the school systems. I think that there's a lot of
18 variability in the way people approach this, even
19 those that have these kits already in their schools.
20 So we're going to have to do some significant work on
21 that.

22 MR. DAILEY: So one of the things that
23 -- that's come up a couple of times and then several
24 of us have had discussions about some of the concerns
25 around the Stop the Bleed kits, is the significant

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2 expense that comes from hemostatic dressings and the
3 relative unlikely benefit from wound packing in a lot
4 of situations outside of active tactical
5 environments. I know as something like this begins
6 to approach school systems, they're going to be
7 really concerned about the potential for things that
8 will expire, which all of the hemostatic dressings do
9 with some regularity. They're incredibly expensive
10 by the time you look at them and not -- not involved.
11 So I don't know that this letter is a place where
12 this needs to be. But I think that this group really
13 should start to think about some of the impact of the
14 things that we are saying and how that can best be
15 brought to the public because in some settings, for
16 example, law enforcement individual first aid kits,
17 we have now gone in many cases to replacing
18 hemostatic dressings with -- with Z-folded gauze so
19 that we're not in a position where we have expiring
20 things going out. But our tactical officers are
21 still carrying the hemostatic dressings because of
22 the increased chance that they will be in position to
23 use them. Certainly, Dr. Gestring and I have -- I
24 have talked about this at length a couple of times.
25 So I'd just like for us to start to consider that.

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2 MR. GESTRING: So I just wanted to add
3 on that and by -- by saying that this was a -- a
4 significant effort by the staff several years ago.
5 Actually, Dr. Dailey made a lot of progress with the
6 school nurses. So that's -- I think, through the
7 Department of Education, right? It's school nurses.
8 So what you guys are talking about is educating the
9 students, which we are a thousand percent in favor
10 of. But this effort does dovetail on another one
11 just before COVID, maybe five years ago or so that
12 had the buy-in from the school nurses union
13 organization. I don't know exactly. I don't
14 remember who we were talking to. But -- but they
15 represented the State and it was through the
16 Department of Education. And I remember drafting a
17 document that this group, I'm sure saw five years ago
18 that would -- that dealt with the professional side
19 of teaching the nurses how to do this and giving the
20 nurses permission to do this. Mike, maybe you
21 remember it better than I do.

22 MR. DAILEY: Yeah. That was actually
23 working with the Center for School Health, who is the
24 contractor to the Department of Education
25 specifically for health-related programs in the

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2 schools. And it was changing the document that they
3 had written to assure that nurses would not be
4 concerned about the potential for not following a
5 patient's specific order for the placement of
6 hemostatic dressing. And the complexity there was
7 they were reading into -- they're reading the F.D.A.
8 -- F.D.A. guidance -- guidance behind the -- the
9 hemostatic dressings incorrectly. They're
10 identifying them as medications, when indeed they
11 were medical devices, not medications. And the
12 level, I want to say it was a type two medical
13 device, which made them exactly the same as a tampon
14 and had nothing to do with a restriction that
15 required a -- a medical order. So we got through
16 that very well. They were -- they were actually
17 fantastic partners, Mark, I think they worked well
18 with us.

19 MR. WAKEMAN: Derek Wakeman,
20 pediatrics co-chair. Within our own pediatric
21 subcommittee, nobody actually knew that had been
22 changed. We have found it, thank you for your work,
23 we found that we are now circulating it for all the
24 injury prevention people out there. The school
25 nurses can place hemostatic dressings.

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2 MR. DAILEY: One of the challenges was
3 the fact that the documents that they had that said
4 they could or they could not and then that they
5 could, didn't actually get a change in number and
6 weren't dated. So both were circulating all over the
7 place and it was really tough to figure out which was
8 which. You had to go to page seven, paragraph four,
9 or whatever, each time just to check and see what it
10 was.

11 DR. BANK: So can I ask the pediatric
12 subcommittee outside of this motion, maybe stay
13 involved in this -- in this topic and maybe a -- a
14 staff continues to see if we can have some guidance
15 for contents of the kit for where the kits should go
16 in schools and eventually bring that back to the
17 staff.

18 MR. COOPER: Thank you. I -- I want
19 to, just support the requests just made by Chairman
20 Bank and earlier by Director Greenberg regarding the
21 PED sub-committee continuing to discuss this issue.
22 This is a far more complicated issue than -- than --
23 than anyone really realizes. I'm just going to cite
24 one specific example within the context of run hide
25 fight. Okay. When, where, and under what

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2 circumstances are -- you know, are first aiders in
3 schools to be, you know, utilizing these -- these
4 techniques. Clearly there's, you know, if -- if you
5 can get away from the scene, you're supposed to get
6 away from the scene to minimize the number of
7 casualties, you know. If you're hiding, you're
8 probably going to make some noise as you pull out of
9 all the -- all the equipment and someone will do what
10 needs to be done. You know, I'm just saying that as
11 one specific example. It's not as simple as what's
12 in the kit, even where the kits are placed. Okay.
13 But what's actually going to -- and how are they
14 going to be used and -- and exactly under what
15 circumstances. We're mostly concerned about, you
16 know -- because of the work of Len Jacobs, you know -
17 - you know, following -- following the Sandy Hook
18 School shooting that -- you know the -- the use of
19 these kits is -- is most likely, if you will -- to
20 be, you know, to save the most lives in the setting
21 of an active shooter event. Clearly in the event of
22 a -- of a single event, you know, resulting in
23 bleeding, something along those lines, it's a much
24 simpler proposition. But these are things that all
25 need to be considered as you know -- as -- as we

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2 continue to roll this out. And I just want to
3 encourage the group and I'll be happy to participate,
4 you know -- want to encourage the group to continue
5 the -- you know, the -- the strong work that's --
6 going forward. I think a -- a -- a guidance document
7 of sorts would be extremely helpful. Thank you.

8 MR. WAKEMAN: I -- I appreciate Dr.
9 Cooper's comments. I -- I just wanted to reiterate
10 to everybody that, again, these kits are probably --
11 we -- our heads go to M.C.I. events and active
12 shooter events. They're more likely to be needed for
13 non-events like that, right? Just a child falls off
14 the monkey bars or just goes through glass and -- you
15 know, we certainly need to consider those
16 circumstances. But we also want them to be available
17 for, you know, these other preventable problems.

18 MR. CURRAN: In -- in the same way the
19 -- the concept is just as important, right? So it's
20 what do you have on you that can be used to apply
21 pressure versus is there a magic kit that you're
22 nearby because this can be used on the school bus, it
23 can be used in the playground, it can be used -- any
24 of the concepts can be used anywhere to enhance the
25 number of potential rescuers.

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2 DR. BANK: Okay. Just getting back to
3 the motion for the letter that Dr. Wallenstein
4 summarized, everybody who is in favor, please raise
5 your hands. Anybody who is not in favor? So that
6 motion will pass and I hope to -- the pediatric
7 subcommittee stays involved on -- on updating a best
8 practice document for content of the kids and where -
9 - how many there should be in schools.

10 MR. CLAYTON: Just a quick note, the
11 Court's reporter is asking that, could you please
12 announce your name when you speak? It would be
13 helpful. She's having a hard time keeping up. Thank
14 you. That was Dan Clayton, by the way.

15 DR. BANK: Okay. This is Dr. Bank.
16 Next is the A.T.S. -- New York chapter of the A.T.S.
17 report.

18 MR. CLAYTON: And Carrie Garcia is not
19 here this afternoon. She was not able to join us.
20 But Kate Maguire is going to give the report from New
21 York's City A.T.S.

22 MS. MAGUIRE: Thank you. So as we
23 look ahead, a few important initiatives around the
24 horizons. We have 2025 distinction awards.
25 Nominations will be open soon. Please consider

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2 submitting deserving candidates for recognition for
3 their outstanding contributions for this calendar
4 year. 2026 grant funding applications will be going
5 out as well shortly. And we have a total of twenty
6 thousand dollars in grants to be awarded this coming
7 year. 2026 elections, we will hold elections for
8 president-elect, secretary and treasurer in 2026.
9 There will be a leadership transition in 2026.
10 Carrie Garcia will be ending her term and I will
11 begin my term. Just want to thank everyone for
12 continued commitment and engagement as we plan for a
13 very productive year ahead.

14 DR. BANK: Any question for the A.T.S.
15 report? Okay. And then, Dr. Dailey for, SEMAC
16 report.

17 MR. DAILEY: Thanks, Dr. Bank. So
18 just briefly, a few topics that came up. One is we
19 have had a very successful implementation of the
20 basic life support ideal program through the folks
21 down on Hudson Valley. We await distribution of that
22 on a broader basis that will impact the trauma system
23 just because you may get patients who come in with i-
24 gels in place and basic life support providers caring
25 for those -- for those folks. We await the guidance

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2 from the department or from the bureau -- sorry, in
3 terms of exactly how that's going to work. Blood --
4 we await the blood regs. But we have a number of
5 different programs that are starting to put
6 significant amount of work into developing concepts
7 that will then be ready to take off when the regs are
8 completed. One topic that has been causing some
9 angst is pertinent to the trauma community, is some
10 concerns about how rapid sequence intubation
11 credentialing is going to be done on a region-by-
12 region basis. There are some regions that have been
13 doing it regionally, but potentially cannot be done
14 regionally. But best practices can be shared across
15 the region. So that clarification is being brought -
16 - brought to each of these programs and hopefully,
17 will stabilize out shortly. One piece of news that
18 came to the SEMAC that is also of note to the STAC is
19 we were looking to sundown the critical care
20 technician certification in the State of New York
21 effective 2027. That we were told will no longer
22 sundown. That is profoundly pertinent to this body
23 because that means that you will have a number of
24 patient -- of providers that are advanced life
25 support providers, will not be advancing to

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2 paramedic, will not be able to participate in things
3 like blood programs and are reducing a level of care
4 available to their communities from the standard
5 paramedic level. This is something that each
6 community needs to look to see how they want to
7 continue to -- to work with. And the SEMAC and the
8 collaborative protocols groups will continue to work
9 on this as it moves forward. Because we are not
10 training any of these people anymore and this is
11 training that was completed and last updated in 1999.
12 Things have changed since then. So we hope to
13 continue with advance care across the state from
14 that. And one thing that's very important that some
15 of us were talking about this morning is there is a
16 growing push in the E.M.S. community to minimize the
17 use of cervical collars. Many of you recognize that
18 cervical collars by themselves, provide very little
19 spinal motion restriction. There's a -- quite a body
20 of data that demonstrates the harm that they can
21 ultimately cause and we're going to look to update
22 the E.M.S. protocols that ultimately will become some
23 E.D. guidance around use of cervical collars. So
24 people that are interested in participating in a
25 small working group with folks from the SEMAC, please

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2 let Dr. Bank know and we will put a couple calls
3 together. Thank you.

4 DR. BANK: Any please -- Dr. Bank, any
5 questions for Dr. Dailey?

6 MR. GESTRING: Yeah. Right, I -- I
7 have two questions. First off, about the spinal
8 immobilization. I know that over the last probably
9 decade, this has been getting, you know, reevaluated
10 and reevaluated and reevaluated to the point where
11 patients are showing up now sitting up in their
12 stretchers. You know, the only thing that's even
13 close to mobilization is the collar. So starting --
14 even though I was a big proponent of some of those
15 earlier moves and starting to get a little skeptical
16 about making that go away. So just throwing that out
17 there for you guys to talk about because we're no
18 longer using spine boards, we're no longer laying
19 them flat. There's just a bunch of things, you know
20 and to me, the only downside to a collar is if you
21 leave it on too long, you're going to get a pressure
22 ulcer. Like you know, that's not a pre-hospital
23 concern, I think. But you guys will look at it
24 scientifically. But I would just caution you to --
25 to maybe go a little bit slow when you look at this.

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2 That's the first thing. And the second thing I just
3 wanted to note, you might not be the right person,
4 but maybe I'll go update on where we stand with pre-
5 hospital blood for the ground units. I know we were
6 talking about that all the time. But is that a
7 regional thing, or you know, is that a question for
8 Ryan? I'm sorry I don't -- hate -- hate to keep
9 bringing it up, but I think it's an important topic
10 for us.

11 MR. GREENBERG: Yeah. No, that --
12 that's a nice thing. So you know, we're excited to
13 see that the statute has changed. The statute
14 required regulations. The regulations -- and thank
15 you to everybody who helped in drafting those
16 regulations. There's a lot of teamwork with Gina and
17 her team and George sitting to my left and the SEMSCO
18 members who really, you know, helped on that front.
19 And I'm sorry -- and also Wadsworth. So in addition
20 to the blood regs, putting pre-hospital blood out in
21 the field, it also moved ambulance transfusion
22 services over from Wadsworth to us, which there were
23 a lot of challenges when it was over in Wadsworth.
24 No fault of Wadsworth, just, you know, the way the
25 processes are and different things and -- you know,

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2 what we have access to as the Division of State
3 E.M.S., with what they had access to from an
4 informational point of view, there was a lot of
5 duplication, things like that. So we think that's
6 really going to be seamless over with us. Those regs
7 were -- I would say would probably, you know, expect
8 to go out and hope just to go out in, you know, Q One
9 of 2026, but go out for public comment. We'll make
10 sure to share that with everybody on this council and
11 beyond to be able to make comments on the blood regs
12 and then to, you know, push it out from there. I
13 think the biggest struggle and I know Dr. Dailey and
14 I have had a couple conversations on this one that is
15 going to come up with pre-hospital blood, is that I
16 think we all probably can agree, you know, putting
17 blood on five thousand ambulances around the state
18 probably wouldn't be the best use of blood. And then
19 trying to determine how those regional approaches are
20 designed in order to have blood in the right places
21 at the right time. You know, some of our systems are
22 -- are very, you know, you can kind of look at and
23 it's realistic. You know, we look at, you know, and
24 they haven't moved forward that they're going to do
25 something. But we look at a system like, you know,

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2 Colonie E.M.S. who puts out ten or fifteen
3 ambulances, covers a large geographic area and has,
4 you know, one or two shift supervisors, you know,
5 maybe putting in just on the supervisor's vehicle,
6 who has the ability to get and back up and do things
7 like that. Those are the types of approaches that
8 we're going to need to do when we talk about blood in
9 the field. It is going to force, probably in some
10 cases with some picking -- some collaboration amongst
11 agencies that, you know, prior to now, didn't always
12 like working together and you know, turning and
13 saying, hey, you know, rather than, you know, us and
14 -- you know, I think of Long Island and I think of
15 the -- you know, the town, you know, Islip that has
16 five ambulance services. But they all have come
17 together and do a tack unit. So out of the five
18 ambulance services, one ambulance, you know, is
19 stacked every day as like an -- an extra unit, you
20 know, looking at it in a collaborative to say, hey
21 well, let's stack one of our units with blood rather
22 than all of them. So you know, it -- it's going to
23 be a little bit of a challenge, a struggle. We'll be
24 working with our regional councils on that one, you
25 know, to figure out what is the best model. And that

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2 model is going to look different around the field.
3 It will look different depending on the region it is
4 -- the -- the density and the availability of blood.
5 But that is probably one -- one of the biggest
6 conversations and challenges that will come up with
7 it. But like I said, beginning part of 2026 and you
8 know, hopefully that'll be out there.

9 MR. TEPERMAN: Just a follow-up on
10 that Director Greenberg, so Q One '26 functionally,
11 when would you expect -- expect to see, assuming the
12 comment period goes well, blood in the fields.

13 MR. GREENBERG: If you can coordinate
14 the comment period to go well, we with no substantive
15 changes. So realistically, if the comment period
16 goes well, you know, when we were to come out in 2021
17 -- 2026, there's the comment period, it's open for a
18 sixty-day period, the first comment period. It comes
19 back. We have to review everything, determine if
20 there's any substantive changes versus non
21 substantive changes. And then, you know, if all goes
22 well, I'd say by the end of 2026, that can be in
23 place, realistically. The other important part and I
24 think Dr. Dailey brought up briefly, is once those
25 regulations are out for public comment, the general -

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2 - you know, the E.M.S. agencies and things will be
3 able to see what the requirements are. They'll be
4 able to see what the expectations are. I don't --
5 even if there's a substantive change in those
6 regulations in the process, I don't see a significant
7 change. Substantive means, you know, something that
8 has to go back out for public comment again. But the
9 bulk of the regulations that are being designed, you
10 know, by subject matter experts, by people who've
11 done it in the past and things like that, I think
12 won't come with a lot of surprises. But now people
13 can start to say, let's have that conversation,
14 right? Let's start framing out what our system will
15 look like so that when the regs are enacted, that
16 they'll be able to, you know, go in place. I do
17 believe, you know, we will probably see those regs
18 also when they -- a lot of regs when they come in --
19 enacted, have a period of time before they have to be
20 followed. I think that one will probably be a
21 shorter period of time for those that are, you know,
22 in order to allow it to get into place faster.

23 MR. TEPERMAN: Matt, I just had one
24 more. Thank you, Director Ryan. That was very
25 helpful. One more question for Dr. Dailey. This may

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2 be my own ignorance. You mentioned paramedics and
3 R.S.I. So you know, my own thinking is that
4 paramedics get -- they go to school, they get their
5 degree, you guys give them a license, they're good to
6 go with R.S.I., something changing. Doctors actually
7 follow the same pathway. They go to red -- residency
8 in between. And we have graduated responsibility
9 through residency. When somebody comes out of
10 paramedic school, they may or may not be ready for
11 the graduated responsibility that allows them to push
12 paralytics depending on the system. Certainly in my
13 system, that's not something that I would grant to a
14 brand-new paramedic because the question is not
15 whether or not you can push a drug because everybody
16 can certainly push a drug, it's whether or not, you
17 know, when not to push that drug. So that's
18 basically the process of credentialing folks in -- in
19 these additional high -- high risk high reward
20 procedures.

21 DR. BANK: So it a -- it's a separate
22 --

23 MR. TEPERMAN: Sorry. It's a -- so
24 the, they've got the schooling, they've got their --
25 their license and then it's a separate D.O.H. --

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2 Department of Health process to allow them to perform
3 R.S.I.

4 MR. GREENBERG: It's not a -- it's not
5 a separate D.O.H. thing, it's actually up to the
6 agents and medical directors. So we're going to see
7 some agencies say, this is something we need. We're,
8 you know, far from the hospital. There's other --
9 you know, we know what the acuity of our patients
10 are, things of that nature that they may turn. We
11 may have some agencies that turn and say every one of
12 our transports is three minutes away, that in the
13 city, the -- the hospital's post. We have some of
14 our agencies that may turn and say, our supervisors
15 are going to be able to be the ones who, you know,
16 perform this skill, but not our entry level
17 paramedics. And so that's some of the discretion to
18 leave to them. It is in the protocol set for
19 paramedic to be able to do it. If trained and
20 equipped, is the famous line that we use in, you
21 know, our protocols that allow that, you know, kind
22 of optional option to be there. And -- and I would
23 say there -- there are many agencies that have R.S.I.
24 and there are many agencies that do not have R.S.I.
25 And so, you know, just perfect example in New York

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2 City, R.S.I. is really not used in New York City.
3 Whether or not it should be or not, it's another
4 story and maybe conversations for you to have at a
5 local level. I think we've heard conversations going
6 in both directions on it and for different things.
7 And you know, it's one of those system level
8 decisions and agency level decisions that have
9 happened. So this skill set is there. I think the
10 other thing to keep in mind in E.M.S. is, you know,
11 E.M.S. is growing, the skill set is growing. You
12 know, when I became a paramedic, we couldn't do
13 R.S.I. When I've been paramedic, we couldn't do
14 twelve leads. So you know, there's a certain amount
15 of things in medicine for all of us that, you know,
16 medicine grows, skills grow and then that additional
17 training and things like that is, you know, dependent
18 normally with a standard set by a region or the
19 state, but training that often happens at the local
20 level. Summarized that all right?

21 MR. DAILEY: I think you summarized
22 that beautifully. It's almost -- it's almost like,
23 you know the E.M.S. systems. No, I -- I think the
24 other thing that we have to remember, right, is there
25 are eighteen regions in New York. Each one of those

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2 regions has a very different footprint, very
3 different culture as well. And these things will all
4 -- both of them really will have to come out and be
5 developed over time. With blood, I think the most
6 important thing is going to be both whether or not
7 the agencies are robust enough to care for that
8 product and care for it well, but also whether or not
9 they're going to be willing to go and help their
10 neighbors when their neighbors have a problem.
11 Because I am -- certainly in our region itself, if
12 you don't agree to go to assist another nearby agency
13 when they need the resource that you have, you will
14 not be allowed to participate in that program and the
15 control on that to some extent is going to come
16 because we are going to want to make sure that we're
17 not wasting any blood products across the state. We
18 want to make sure that these blood products are
19 returned to the hospitals. The hospitals are able to
20 use those. That's going to require an awful lot of
21 work by some of the people sitting around this table
22 working with their hospitals in order to make sure
23 the hospitals are ready to consume that product in
24 order to keep the cost of the system down and in
25 order to preserve the resource, which is why it's

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2 really -- really important, yes -- and I agree with
3 Ryan. We don't want it everywhere, but we can't
4 sustain everywhere either. We have to be very
5 careful and judicious in -- in how this process works
6 to make sure that there is no risk.

7 DR. BANK: Any other questions for
8 Dailey?

9 MR. MANZO: Hi, Frank Manzo, Finger
10 Lakes, just. Dr. Dailey mentioned the i-gel project
11 and I think this community should pay attention to
12 that because the idea of a B.L.S. provider dropping
13 in an -- an i-gel is a pretty good idea -- good idea
14 for a trauma patient versus taking the time on scene
15 to do an intubation or an R.S.I. So it's something
16 the pilot program went very well. My agency in -- in
17 Rochester participated. It did go well across the
18 state. So this team should be paying attention to
19 that because the idea of pushing your agencies to
20 just drop an i-gel on your trauma patients, which is
21 a decent airway for getting them to the center in a
22 timely manner, could make a big difference, rather
23 than messing around on scene for twenty minutes and
24 trying to put that tube in the correct hole. So --

25 MS. GUZMAN: I do have one other

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2 question, if I may. Roseanna Guzman Central New
3 York, about the C-collars. What is the motivation
4 behind the change? Is it a harm question? Is it a
5 cost problem? And would there be any instances in
6 which a C-collar would still be recommended, for
7 example, if there are obvious neurodeficits or are we
8 saying get rid of them altogether?

9 MR. DAILEY: I'm not saying anything.
10 What I'm -- what I'm saying is let's get a group of
11 experts together to come up with what New York state
12 is going to guide both from the STAC and from -- from
13 the SEMAC. You know, from -- from my perspective,
14 right, it's not the collar, it's the spinal motion
15 restriction that the collar is encouraging to occur,
16 right? One of the things that bothers me and Dr.
17 Edwards and I have had long conversations about this,
18 is when we've got a patient who's been just fine for
19 hours, gets into our trauma bay and the first thing
20 that happens is the first resident in the door slaps
21 a collar on the patient, right? They're fine, stop.
22 Right? But it's the -- not moving the head is very
23 important. You've got different patients, right.
24 You've got an absolutely fine one with, you know, a
25 little scratch on their forehead and you've got the

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2 one that's obtunded and then you've got the one with
3 a significant pattern of injuries that I'm going to
4 go and paralyze and intubate. I would argue that --
5 that patient number three is the one that's the most
6 hazard because no matter what happens with the --
7 with the other ones, there is some type of muscular
8 spasm until I push paralytic medications, right? So
9 I think we need to look at all of them and then
10 ultimately develop guidelines so that the patients
11 that we can examine, at least will have one set of
12 guidelines and then it'll follow through for the ones
13 that we can't because of their mental status, things
14 they're on board or whatever else. So I think it's
15 going to be -- don't think it'll be a long set of
16 conversations, but I think they're very important
17 ones because I don't think this is a situation where
18 we really want to throw the baby out with the bath
19 water. No offense, talking to my pediatric doctors.

20 MR. EDWARDS: I -- we -- in our
21 institution, the harm has not been published yet. It
22 is something I'm looking at. In a geriatric patient,
23 the restriction of movement and breathing, that
24 they're usually inappropriately placed to because
25 they just drop their chin underneath. Cervical

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2 restriction or cervical collar restriction,
3 definitely different than cervical spine and
4 mobilization. Five million collars are placed every
5 year. I don't know that it's a cost issue, but I
6 think that we are in our geriatric population doing
7 it. I think the criteria for pre-hospital clearance
8 is pretty sound and us bringing patients with blood
9 mechanisms and using distracting injury to throw a
10 collar on patients, I think is probably
11 inappropriate. And so I think that there's
12 significant movement within the hospital. And as
13 we've been talking Dr. Dailey outside possibly to
14 reexamine what we're doing with cervical collar, not
15 necessarily cervical immobilization. Dr. Edwards,
16 Albany Medical Center.

17 MR. DAILEY: Sometimes, it's the other
18 Albany Medical Center.

19 MR. GESTRING: So just -- just
20 summarizing the SEMAC report. We -- we bounced
21 around a lot between blood and -- and spinal motion
22 restriction and intubation and airways. But -- but I
23 will say that the trauma community is, you know, is
24 very interested in pre-hospital blood availability.
25 I don't think we need -- we need to be in the weeds

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2 like -- like we just said about the -- the details
3 for each region. But I think as a STAC certainly and
4 as a trauma community, we should be regularly asking,
5 are we there yet, are we there yet, are we there yet.
6 And I think I would advocate that we even put it on
7 our agenda as a bullet point because this group
8 should be asking at every meeting, where is it, why
9 is it not done yet. And I -- I just think we should
10 really be doing that. And the how we do it is up to
11 the experts. I agree with -- with Ryan. I don't
12 think we should be telling different regions how to
13 do it. But -- but we should strongly be advocating
14 for this to move forward as a group.

15 DR. BANK: Any other questions for Dr.
16 Dailey? Okay, I'll move on. Dr. Cooper, E.M.S.C.

17 MR. COOPER: Thank you. Dr. Cooper,
18 E.M.S.C. We met last month. We are meeting again on
19 December 2nd. The -- the major issues being
20 discussed by E.M.S.C. at the present time are the
21 educational package for pediatric agitation with the
22 assistance of folks from Northwell, particularly
23 organized through Matt Harris. Several videos have
24 been -- have been completed. The scripts have
25 already been developed by folks from the -- from the

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2 Fire Department of New York. And it's our hope that
3 we'll be able to review those at our December
4 meeting. As you recall, they focus on three distinct
5 types of problems frequently encountered in pediatric
6 pre-hospital care for children. And we think you'll
7 be as thrilled as we all are with -- with this
8 educational program. The second issue has to do with
9 pediatric sedation. Now we're not so much focusing
10 on sedation from a pharmacologic point of view, as
11 from sedation from a comfort point of view. There
12 are many -- many procedures that are formed --
13 performed in E.D., you know, for example, taking
14 blood, starting I.V.s, applying splints that, you
15 know, that can be terrifying and -- you know, and --
16 and very -- very discomfoting both for patients and
17 for their parents. So there's a group that is
18 looking into this to -- with a goal -- the goal of
19 developing a -- a guidance document on pediatric pre-
20 hospital comfort care, if you want think of it that
21 way. Not just -- not just pre-hospital, but also in
22 hospital comfort care so that we can reduce the pain
23 and anxiety that often accompanies some of these
24 procedures both in the field and in the E.D. A -- a
25 questionnaire, a first draft of a questionnaire to

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2 send out to our constituents has been developed.
3 It's actually going to be discussed at a special
4 meeting at four o'clock this afternoon. And we hope
5 to have more for you at the January meeting about
6 this. But you know, if you think back to your own
7 pediatric E.D., you know, experiences, you'll of
8 course remember that there are many -- many children
9 who just basically get held down and you know, it can
10 be pretty -- pretty -- pretty torturing for some of
11 those poor -- those poor children when that happens.
12 So you know, we all understand that, you know, life
13 is not pain free. But at the same time for our kids,
14 we want to make it as pain free as we possibly can.
15 So that's the main work. We continue to focus, of
16 course, on Always Ready for Children and there are
17 numerous other projects that -- that are just being
18 considered among them working with the Kings County
19 Group to develop a -- a child abuse screening tool
20 that we can share with everyone statewide. Of
21 course, as you're all aware, new Heart Association
22 guidelines were published on the -- this two -- last
23 -- last week on the 22nd of October. And we'll be
24 discussing those at our upcoming meeting. And of
25 course, we'll be discussing some of the issues that

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2 have arisen at this meeting such as the Stop the
3 Bleed issue to assist, you know, the Pediatric Trauma
4 subcommittee in its work. So we have a pretty full
5 agenda ahead of us for the next -- for the next few
6 months. So thank you for your attention. I'll be
7 happy to answer any questions you might have.

8 DR. BANK: Any questions for Dr.
9 Cooper? No. Okay. Move along, old business. I
10 don't have any specific old business on the agenda.
11 Anyone, any comments? No old business that we should
12 review? No. Moving along. New business. Anyone
13 want to bring any new business that we have not
14 already discussed in front of the STAC? No. I want
15 to announce our next meeting will be January 28th,
16 2026 here. Is that correct, Dan? Okay. Next
17 meeting will be January 28th, 2026 at the Saratoga
18 Springs Holiday Inn. Any questions about that?
19 Okay. Do I hear a motion to adjourn? We got Dr.
20 Teperman says one motion. Do I hear a second?

21 MR. CONN: Matthew Conn second.

22 DR. BANK: Okay. We have a second.
23 Thank you very much. Looking forward to seeing
24 everyone here in 2028.

25 (The meeting concluded at 2:13 p.m.)

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STATE OF NEW YORK

I, ANNETTE LAINSON, 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 number 1 to 59, inclusive, is a true record prepared by Associated Reporters Int'l., Inc. from materials provided by me.

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ANNETTE LAINSON, Reporter

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