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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

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APPEARANCES:

ABENAMAR ARRILLEGA
AMY EISENHAUER
ARIEL GOLDMAN
ARTHUR COOPER
CRISTY MEYER
DANIEL CLAYTON
DEREK WAKEMAN
DR. EDWARDS
DR. VOSSWINKEL
ERIC KLEIN
FRANK MANZO
GEORGE AGRIANTONIS
GEORGE STATHIDIS
GUZMAN CURTIS
JERRY RUBANO
KATE MAGUIRE
KERRIE SNYDER
KIM WALLENSTEIN
LYNN FARRUGGIA
MARK GESTRING
MATTHEW CONN
MEGHAN MILLEN
MICHAEL DAILEY
ROBERT CURRAN
ROBERT VELLA
ROBERT WINCHELL
RYAN GREENBERG
SHELDEN TEPERMAN
SRIHIVAS REDDY
TOM BONFIGLIO
WENDY PATTERSON
WILLIAM FLYNN

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(The meeting commenced at 1:06 p.m.)

DR. BANK: Okay, if I could call the STAC to order. First business is to do the Pledge of Allegiance, which Dr. Winchell will lead us through.

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.

DR. BANK: Okay. Next order of business is going to be attendance and roll call. Mr. Clayton.

MR. CLAYTON: And for the Stenographer, we can go on the record. Dr. Bank?

DR. BANK: Here.

MR. CLAYTON: Dr. Gestring.

DR. GESTRING: Here.

MR. CLAYTON: Dr. Doynow. He's excused. Dr. Winchell?

DR. WINCHELL: Here.

MR. CLAYTON: Dr. Goldman?

DR. GOLDMAN: Here.

MR. CLAYTON: Dr. Cooper. Dr. Dailey?

DR. DAILEY: Here.

MR. CLAYTON: Dr. Guzman-Curtis?

DR. CURTIS: Here.

MS. CLAYTON: Melana King?

MS. KING: Here.

MR. CLAYTON: Meghan Mullen?

MS. MULLEN: Here.

MR. CLAYTON: Dr. Flynn?

DR. FLYNN: I'm here.

MR. CLAYTON: Francis Manzo?

MR. MANZO: Here.

MR. CLAYTON: Kerrie Snyder?

MS. SNYDER: Here.

MR. CLAYTON: Dr. Edwards?

DR. EDWARDS: Here.

MR. CLAYTON: Dr. Prabakaran is excused. Kate McGuire?

MS. MAGUIRE: Present.

MR. CLAYTON: Dr. -- Dr. Angus? I believe he's excused. Dr. Klein?

DR. KLEIN: Present.

MR. CLAYTON: Dr. Arrillaga?

DR. ARRILLAGA: Present -- present.

MR. CLAYTON: Dr. Vosswinkel?

DR. VOSSWINKEL: Here.

MR. CLAYTON: Matthew Conn?

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MR. CONN: Here.

MR. CLAYTON: Dr. Agriantonis?

DR. AGRIANTONIS: Present.

MR. CLAYTON: Dr. Reddy?

DR. REDDY: Present.

MR. CLAYTON: Dr. Teperman?

DR. TEPERMAN: Here.

MR. CLAYTON: We have twenty-one. We have more than a quorum.

DR. BANK: Okay, great. The next order of business is approval of the previous meeting minutes. The minutes are on the website if anyone wants to review them. Can I have a motion for the approval of the previous minutes from the May, 2025 STAC meeting?

MR. AGRIANTONIS: Motion.

DR. BANK: Dr. Agriantonis has a motion. Do we have a second?

MR. TEPERMAN: Second.

DR. BANK: Dr. Teperman or Dr. Vosswinkel both second it. Any discussion? Great. Minutes are approved. Next order of business is the Division of State E.M.S. report. Our Director, Ryan Greenberg, is here next to me.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

think it deserves its own recognition within those titles.

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

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

MR. CONN: Thank you.

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

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

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

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

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

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

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

DR. BANK: Any questions for Dr. Winchell?

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

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

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

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

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

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

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

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

In addition, we had discussion of the

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

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

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

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

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

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

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

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

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

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

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

DIRECTOR GREENBERG: That's great. Congrats.

MR. CONN: Thank you.

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

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

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

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

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

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

Dr. Sam Hawkins gave a nice

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

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

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

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

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

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

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

MR. TEPERMAN: That's great.

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

MR. TEPERMAN: Great.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. TEPERMAN: It's on the screen.

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

MR. TEPERMAN: We'll get the letter up

in a second.

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

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

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

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commissioner.

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

MS. WALLENSTEIN: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. BANK: Any other questions for Dailey?

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

MS. GUZMAN: I do have one other

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

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

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

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

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

MR. DAILEY: Sometimes, it’s the other Albany Medical Center.

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

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

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

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

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

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

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

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

MR. CONN: Matthew Conn second.

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

(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.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 13th day of October, 2025.

ANNETTE LAINSON, Reporter

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