

5-25-2021 - Emergency Medical Standards  
NEW YORK STATE  
DEPARTMENT OF HEALTH

MEDICAL STANDARDS MEETING

DATE: May 25, 2021 at 8:06 a.m.  
CHAIRS: LEWIS MARSHALL  
VENUE: WebEx

1 5-25-2021 - Emergency Medical Standards  
2 (The meeting commenced, 8:06 a.m.)  
3 DR. MARSHALL: Good morning, everyone.  
4 Welcome to the Medical Standards Subcommittee meeting  
5 of Tuesday, May 25th. We have an agenda with quite a  
6 bit of discussion planned for this morning. So we  
7 will try to make sure it's -- it's streamlined.  
8 Just a couple on housekeeping. If  
9 you're not speaking, please keep yourself on mute so  
10 that we don't get any background noise.  
11 So we'll start. We'll call the  
12 meeting to order and I'll ask Valerie to record the  
13 attendance. I guess since we're recording, the  
14 attendance is recorded.  
15 MR. MACMILLAN: Just give us a second,  
16 Dr. Marshall. We're logging her on.  
17 DR. MARSHALL: Okay. You're muted,  
18 Valerie.  
19 MS. OZGA: There we go. All right.  
20 We're early, so.  
21 Okay. I'm going to take roll call.  
22 Dr. Alexandrou?  
23 DR. ALEXANDROU: Present. Good  
24 morning.  
25 MS. OZGA: Okay. Just a reminder

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2 APPEARANCES:  
3 PETER RODIE, HOST  
4 PANELISTS  
5 ALEXANDER KACZOR  
6 DAN OLSSON  
7 JACOB DEMAY  
8 JOHN MACMILLAN  
9 LEWIS MARSHALL  
10 STEVEN DZIURA  
11 VALERIE OZGA  
12  
13 YEDIDYAH LANGSAM  
14 DONALD HUDSON  
15  
16 RYAN GREENBERG  
17 JOSEF SCHENKER  
18 BRIAN WALTERS  
19 MATTHEW MAYNARD  
20 TIFFANY BOMBARD  
21 ARTHUR COOPER  
22 MARK PHILIPPY  
23 TERESA HAMILTON  
24 DANIEL CLAYTON  
25 DAVID KUGLER  
DON DOYNOW  
JACK DAVIDOFF  
JEFFREY RABRICH  
JEREMY CUSHMAN  
JOE BART  
MICKEY FORNESS  
NIKOLAOS ALEXANDROU  
ATTENDEES  
BETH MCGOWAN  
CAROL BRANDT  
CHARLOTTE CRAWFORD  
DAVID GRASS  
DAVID VIOLANTE  
EDWARD MAGER  
JARED KUTZIN  
MARK DEAKERS  
MELISSA LOCKWOOD  
MICHAEL COX  
MIKE MCEVOY

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2 everybody, if you could just announce your names for  
3 the stenographer, that would be great.  
4 Joseph Bart?  
5 Jeremy Cushman?  
6 MR. CUSHMAN: Here.  
7 MS. OZGA: Michael Daily? Not here.  
8 Dr. Davidoff?  
9 DR. DAVIDOFF: I'm here.  
10 MS. OZGA: Don DeTraglia?  
11 Dr. Doynow?  
12 DR. DOYNOW: Here.  
13 MS. OZGA: Mickey Forness?  
14 MS. FORNESS: Mickey Forness here.  
15 MS. OZGA: Donald Hudson?  
16 MR. HUDSON: Donald Hudson, present.  
17 MS. OZGA: Dr. David Kugler?  
18 DR. KUGLER: Dr. David Kugler,  
19 present.  
20 MS. OZGA: Jared Kutzin?  
21 MR. KUTZIN: Jared Kutzin, present.  
22 MS. OZGA: Dr. Langsom?  
23 DR. LANGSOM: Yedidiah Langsom,  
24 present.  
25 MS. OZGA: Dr. Marshall?

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 2 DR. MARSHALL: Lewis Marshall present.  
 3 MS. OZGA: Dr. Pam Murphy?  
 4 Dr. Olsson?  
 5 DR. OLSSON: Dan Olsson here.  
 6 MS. OZGA: Dr. Rabrich?  
 7 DR. RABRICH: Jeff Rabrich here.  
 8 MS. OZGA: Dr. Walters?  
 9 DR. WALTERS: Walters here.  
 10 MS. OZGA: Dr. Young?  
 11 Okay. Roll call is complete.  
 12 DR. MARSHALL: Thank you, Valerie.  
 13 So the first item of business on the  
 14 agenda is the New York State Unified Protocols, which  
 15 were sent out to everyone to review. I would like to  
 16 go over some of the changes because I do not believe  
 17 you received a -- a redline version. So I will just  
 18 go through the protocols and tell you what specific  
 19 things were changed.  
 20 So for the most part, most of the  
 21 changes were formatting to bring us more in line with  
 22 the collaborative protocols. And there are some  
 23 other things that were added, which I will get to.  
 24 So for example, on the nontraumatic cardiac arrest  
 25 protocol, this was combined, and it removed some of

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 2 a new protocol, which reflects the uniformity of the  
 3 adult protocols. And some of it was previously  
 4 included under septic shock and this should bring us  
 5 more in line with the collaborative protocols in that  
 6 -- in that area.  
 7 Obstetric emergencies included  
 8 paramedics that can treat eclampsia with magnesium  
 9 sulfate under standing orders. This is also  
 10 available in the collaborative and in New York under  
 11 the seizure protocol where they can administer  
 12 magnesium sulfate under standing orders.  
 13 Under the adult C.O.P.D., wheezing,  
 14 both for adult and pediatric patients, we added  
 15 ipratropium bromide as -- at the E.M.T. level  
 16 consistent with changes in the national E.M.S. scope  
 17 of practice, which does allow medical directors to  
 18 determine which of these medications can be used.  
 19 We added dexamethasone to -- under the  
 20 steroids and dexamethasone is one of the medications  
 21 that was approved as an alternative medication under  
 22 our medication protocol or policy from years ago.  
 23 Undifferentiated shock protocol, it's  
 24 a newly added protocol for the general management of  
 25 patients and shock despite treatment under other

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 2 the subprotocols that we had like for V-fib pulse  
 3 with V-tach and P.D.A., and combine them into the one  
 4 nontraumatic cardiac arrest protocol.  
 5 Similar for pediatrics with the change  
 6 of assisted ventilation rate to reflect the current  
 7 PALS recommendation based on the AHA update. In  
 8 addition to that one, all other protocols were  
 9 brought in line with the most recent American Heart  
 10 Association update.  
 11 In the respiratory distress protocol,  
 12 nitroglycerin I.V. bolus dosing was added. This was  
 13 based on a -- an article in 2020 in prehospital  
 14 emergency care on using bolus dosing nitroglycerin.  
 15 Systolic -- minimal systolic blood pressure for  
 16 dosing of nitro was changed from one -- changed to  
 17 one twenty verses from one hundred, which it was  
 18 previously.  
 19 Excited delirium protocol.  
 20 Medications standing orders and medical control  
 21 option medications were changed to weight-based  
 22 dosing to increase patient safety profile.  
 23 V-fib, V-tach with a pulse, we added  
 24 lidocaine as an option.  
 25 Under pediatric dysrhythmias, this is

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 2 specific protocols. And vasopressin was included  
 3 here. Vasopressors are norepinephrine, dopamine,  
 4 push-dose epi, and vasopressin.  
 5 Under the stroke protocol, criteria  
 6 for New York City's LAMS score, exclusion criteria to  
 7 greater than twenty-four hours from last known well,  
 8 with a score of greater than or equal to four.  
 9 Consistent with the current guidelines for  
 10 thrombectomy for large vessel occlusion.  
 11 General pain management, a newly added  
 12 protocol which organized all analgesic medication  
 13 options in one protocol to eliminate pain medications  
 14 and specific protocols.  
 15 Under procedural sedation, we removed  
 16 -- it's a new protocol. We removed a lot of what was  
 17 under the G.O.P., where a lot of these treatments  
 18 were -- were available. It's now a separate protocol  
 19 under procedural sedation.  
 20 Pediatric patients requiring sedation  
 21 will still require online medical control contact.  
 22 Under general trauma care, it's a new  
 23 added protocol. It just brings all the trauma  
 24 related protocols into one place and removes some  
 25 redundancy of previous protocols such as chest

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 2 injuries and abdominal injuries. It also includes  
 3 treatment for open chest wounds and impaled objects.  
 4 And those are all the significant  
 5 changes, as I mentioned. Other changes were  
 6 formatting changes and some wording changes to bring  
 7 the unified protocols more in line with the  
 8 collaborative protocols. Certainly, if -- if Nick  
 9 has any comments, or if anybody has any questions on  
 10 any specific protocols or the -- the things that I've  
 11 mentioned, please feel free to bring it up now.  
 12 DR. DAVIDOFF: Jack Davidoff. Just  
 13 two questions, actually. As I read through them,  
 14 there were several protocols where it talks about  
 15 I.V., but doesn't mention I.O. And I think that's  
 16 probably just something that was left out and you  
 17 might want to add on as you go through it.  
 18 And secondly, you folks added the  
 19 nitroglycerin I.V. bolus protocol, which we've all  
 20 been sitting on because of the packaging of the  
 21 nitroglycerin. Have you gotten around that, or are  
 22 you just ignoring that?  
 23 DR. MARSHALL: We have not gotten  
 24 around the packaging at this point. I think that  
 25 that's still something to be worked out. But once

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 2 that's worked out, then that would be available.  
 3 DR. DAVIDOFF: So are you carrying an  
 4 I.V. nitroglycerin? Or maybe I shouldn't ask you at  
 5 this point. Maybe that's an offline question.  
 6 MR. GREENBERG: Hi everyone. Good  
 7 morning.  
 8 DR. MARSHALL: Good morning. Yes,  
 9 good morning.  
 10 MR. GREENBERG: This is Ryan.  
 11 DR. MARSHALL: Yes, I hear you, but I  
 12 don't see you.  
 13 MR. GREENBERG: You don't see me yet.  
 14 I'm not on camera yet. Nobody really wants to see  
 15 me.  
 16 To -- to answer, Jack, both of your  
 17 questions, actually, we are working on an exemption or  
 18 essentially a waiver to our executive order to allow  
 19 for that I.V. nitro to be permitted on an ambulance.  
 20 However, I will warn everybody, the waiver will only  
 21 last as long as the executive order is in place  
 22 because we do not have a waiver process beyond that.  
 23 So just want to give that update. I know Dr. Dailey  
 24 has submitted a list of agencies that are looking for  
 25 that waiver to occur. If there are other agencies

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 2 that are looking for that similar waiver in the near  
 3 future, if they contact us, we'd be happy to help  
 4 facilitate that.  
 5 And if it is a more global thing and  
 6 this does seem like something that wants to happen  
 7 more statewide, we can ask legal if it can be done  
 8 more statewide. It might have to be per agency just  
 9 based on some of the verbiage and the way that we're  
 10 doing it. However, we're happy to look into that  
 11 because we want to take it as more of a statewide  
 12 approach.  
 13 DR. MARSHALL: Thank you, Ryan. And  
 14 we can't wait to see you.  
 15 DR. OLSSON: I just have a quick  
 16 question.  
 17 DR. MARSHALL: Yes.  
 18 DR. OLSSON: I have forgotten. Is  
 19 I.V. nitroglycerin in the formulary?  
 20 DR. MARSHALL: I do not recall. I  
 21 would have to go back and look.  
 22 DR. OLSSON: I -- that's why I'm  
 23 asking. I don't remember, either.  
 24 DR. MARSHALL: Yeah.  
 25 DR. OLSSON: I think we need to head

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 2 in that direction that -- I think we can all agree  
 3 that I.V. nitroglycerin is -- is going to happen.  
 4 And we've had discussions on it, so I want to at  
 5 least make sure it's in the formulary.  
 6 DR. DAVIDOFF: It's currently only  
 7 sublingual. It is not listed. I take that back.  
 8 Under S.T. elevation, it is listed as I.V. or I.O.  
 9 bolus in the current protocols listed on the new app.  
 10 DR. OLSSON: Okay.  
 11 DR. SCHENKER: Do I -- can I comment  
 12 on other things? It's Jo Schenker.  
 13 DR. MARSHALL: Yes, please go ahead.  
 14 DR. SCHENKER: There's one comment  
 15 about I.O. versus I.V. In our standing order, in our  
 16 G.O.P., we do have language that says that I.V. and  
 17 I.O. are interchangeable. So that -- that answers  
 18 that point. And I believe Tridol is in the state  
 19 formulary list of medications.  
 20 DR. GREENBERG: And I will add one  
 21 other thing for those agencies that have first  
 22 response. A.L.S. first response agencies are not an  
 23 actual ambulance. There is a waiver process even  
 24 after the E.O. expires to allow them to carry.  
 25 DR. DAVIDOFF: Ryan, can you say that

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 2 again? So A.L.S. first responders can carry it, but  
 3 ambulances can't?  
 4 MR. GREENBERG: No. So there's a wait  
 5 -- there's a process right now, which we are working  
 6 on, and realistically within the next couple of  
 7 weeks, we'll get out, to allow anybody to have a  
 8 waiver to carry the glass vials. So ambulances ...  
 9 service vehicle. There is -- there is a process ...  
 10 in the current regs to allow that ... happen. The  
 11 ambulance cannot.  
 12 Now, again, we are working on trying  
 13 to change regs to have that ability to have a waiver  
 14 process in place that would allow us to do it, but it  
 15 doesn't exist yet.  
 16 DR. DAVIDOFF: Ryan, I hate to get  
 17 down to nitty gritty semantics here, but actually  
 18 E.S.V. vehicles can apply for a waiver and they can  
 19 carry it. If they bring it to the ambulance, the  
 20 ambulance is not stocking it. Will the ambulance be  
 21 able to transport it?  
 22 MR. GREENBERG: I would say that's  
 23 getting into nitty gritty. And I would think that as  
 24 soon as they ... anyway, it would become acceptable  
 25 because it's two hundred and fifty milliliters or

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 2 above, I would assume you drop below the two fifty  
 3 mark once you start the process. But I think you're  
 4 getting into the finer details. And I'm happy to  
 5 have that discussion with you further offline if  
 6 you'd like.  
 7 DR. MARSHALL: Just one thing to be  
 8 clear, guys. ...  
 9 THE REPORTER: I'm having a very  
 10 difficult time hearing.  
 11 DR. MARSHALL: Excuse me, yeah. Put  
 12 yourself on mute, please. If you're not on mute, put  
 13 yourself on mute unless you're speaking. Also, when  
 14 you begin speaking, please state your name so that we  
 15 can make sure that we attribute comments to the right  
 16 individuals. Thanks.  
 17 DR. DOYNOW. ... If we do the  
 18 collaborative protocol over the app, under the  
 19 formulary, nitro is not listed. ... somebody else.  
 20 DR. MARSHALL: All right. Don, you're  
 21 breaking up a lot. Your -- your audio is breaking up  
 22 a lot. So did you say that nitroglycerin is not in  
 23 the collaborative protocol formulary?  
 24 DR. DOYNOW: It's not in the  
 25 formulary, specifically. It is in the actual -- you

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 2 know, under the protocols.  
 3 DR. MARSHALL: Okay.  
 4 DR. DAVIDOFF: This Davidoff. Don, if  
 5 you look under the medication listing, nitroglycerin  
 6 is listed for STEMI as an I.V. dosing. Under the  
 7 list of medications or formulary, per se.  
 8 DR. DOYNOW: I mean it says five point  
 9 eight medication formulary. I don't see it there,  
 10 but maybe some reason I don't have an updated list.  
 11 I tried updating it, didn't see there was anything  
 12 missing. But okay, as long as you see it, I don't see  
 13 it. But okay.  
 14 DR. MARSHALL: Any other -- any other  
 15 comments either about nitroglycerin, the waiver, or  
 16 any of the other changes in the New York City Unified  
 17 Protocols?  
 18 DR. KUGLER: Hi. It's David Kugler.  
 19 DR. MARSHALL: Yes.  
 20 DR. KUGLER: May I? Thanks. So two  
 21 things. Just a point of correction, the minutes say  
 22 New York State, not New York City Unified Protocols.  
 23 I believe that just needs to be corrected because  
 24 we're not addressing the collaboratives. We're  
 25 addressing New York City's version.

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 2 The second thing is something that  
 3 goes back to prior to Director Greenberg, when the  
 4 SEMAC tried to ask New York City to switch over to a  
 5 particular protocol, which escapes me at the moment.  
 6 And the decision at that time was to not require New  
 7 York City to switch to that protocol because the  
 8 expense of training the uniformed providers in the  
 9 region would have been in the millions of dollars.  
 10 And so we allowed them a pass on that protocol.  
 11 What I don't understand is now here's  
 12 an opportunity for New York City to come in alignment  
 13 with the New York State protocols at the same expense  
 14 it would be to train their staff to this new set of  
 15 protocols. But the -- I mean and -- and you have  
 16 clearly said that there -- there was an effort to  
 17 bring many of the protocols to reflect the New York  
 18 State pre-hospital care protocols, just not all of  
 19 them. I don't understand why the New York City REMAC  
 20 can't switch to the New York State protocols and then  
 21 add in their specialty protocols which is allowable  
 22 under State regulations. That's my question.  
 23 DR. MARSHALL: Thank you, Dr. Kugler.  
 24 That's a very good question. I think we've asked  
 25 that question over the years, as we've --

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 2 UNIDENTIFIED SPEAKER: Every time.  
 3 DR. MARSHALL: Every time. As we've  
 4 gone from individual regional sets of protocols to a  
 5 more global collaborative protocol, which encompasses  
 6 the majority of regions, and I believe there's two  
 7 regions that are not on the collaborative are Suffolk  
 8 and New York City, although New York City's Unified  
 9 Protocols -- it's not a -- it's not a new set of  
 10 protocols and these are the same protocols that we've  
 11 had before. And I'll let Jo speak to this in a  
 12 second, but it was just bringing them into one  
 13 document.  
 14 And I think, Dr. Schenker, you have  
 15 some other comments on that?  
 16 DR. SCHENKER: Well, I -- I -- I --  
 17 the protocols haven't changed. So as Dr. Kugler  
 18 suggested that, you know, retraining everybody to the  
 19 collaborative protocols, if we're going to retrain to  
 20 this, we're going to retrain to that. It's -- this  
 21 is the actual same protocols that we submitted last  
 22 year. It's just the A.L.S. have been added and  
 23 clarified to match the most current literature.  
 24 So from the standpoint of retraining,  
 25 we did do the retraining on this last year. We were

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 2 required by the State to have everybody onboarded  
 3 with the Unified Protocols on January 1, and we met  
 4 that deadline, I think, ninety-five percent. So we --  
 5 --we are currently using these protocols, just  
 6 clarifications, a lot of the stuff that we went over  
 7 -- that is matching the most current literature and  
 8 bringing things a little more streamlined.  
 9 I think that, you know, we've had this  
 10 discussion multiple times about the State's  
 11 Collaborative Protocol versus the New York City  
 12 Unified Protocols. And, you know, we keep having  
 13 this discussion, even on a regional level, to see  
 14 what the feeling is. And I think that it really  
 15 boils down to the medicine is not that different. It  
 16 is a overarching difference of opinion of how to use  
 17 protocols. The State has more of a guideline, and  
 18 the New York City has more of a protocol because of  
 19 the operational requirements of a system the size  
 20 that we have.  
 21 We have been trying to mirror and --  
 22 and close the gap on the medicine, which is really  
 23 the key to what we're talking about on a Medical  
 24 Standards Committee. But I think a lot of the  
 25 stepwise approach that we follow versus the bulleted

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 2 and more of a guideline that the State follows is the  
 3 --- the overarching difference between the two.  
 4 But again, we all agree that the  
 5 medicine is the medicine. The literature shows what  
 6 the most current medicine is, and we're trying to  
 7 bring our protocols to that point. I think that's  
 8 the major difference.  
 9 DR. MARSHALL: Thank you, Dr.  
 10 Schenker.  
 11 Any other comments on the -- on the  
 12 protocols that are presented? Seeing none --.  
 13 DR. WALTERS: Lew, this is Brian  
 14 Walters.  
 15 DR. MARSHALL: Yes, Dr. Walters?  
 16 DR. WALTERS: I have one question.  
 17 Maybe you or Jo can answer. And -- and aside from  
 18 the -- the difference in stepwise versus guideline  
 19 that you just mentioned, Jo, and the difference in  
 20 the protocols, how many other areas are there  
 21 actually different in the medicine in the protocols,  
 22 or what's on the standing order versus not in that?  
 23 Is there any -- do you have any idea or sense of that  
 24 or kind of a comparison of those two?  
 25 DR. SCHENKER: I mean, when I reviewed

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 2 it originally, you know when we had a discussion, a  
 3 year and a half ago, or maybe it's more now I don't  
 4 remember, there is very minimal differences. And I  
 5 mentioned that the other time -- the -- the last time  
 6 is that the medicine is the medicine. And we all  
 7 agree that that pre-hospital medicine has, you know,  
 8 certain evidence-based stuff that we're all  
 9 following.  
 10 I think that a large part of it is  
 11 just using the protocols is more of an operational  
 12 tool, because of the size of our system. But the  
 13 medicine is very close. I don't think there's any  
 14 major differences in the medicine.  
 15 DR. MARSHALL: Yeah, I would agree  
 16 with Jo, looking at both.  
 17 Okay. Any other comments, questions?  
 18 DR. HUDSON: Dr. Marshall, Don  
 19 Hudson.  
 20 DR. MARSHALL: Yes, Dr. Hudson?  
 21 DR. HUDSON: Good morning, everyone.  
 22 Happy to see you all. I'm -- just procedurally I  
 23 want to make sure we're -- we got our ducks in a row.  
 24 I'm looking at the collaborative protocols versus the  
 25 Muru app. And I don't see in the collaboratives

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 2 where I.V. nitroglycerin is listed for that S.T.  
 3 elevation.  
 4 I agree it's something we should move  
 5 towards, as Dr. Olsson said, and wrap our hands  
 6 around, you know, being able to implement this once  
 7 the packaging issue is tackled. But I just want to  
 8 make sure we have our references correct.  
 9 DR. MARSHALL: Is anybody taking a  
 10 look at that? No?  
 11 DR. DAVIDOFF: Lew, it's Davidoff. It  
 12 would appear that on the collaborative, I can't find  
 13 a copy or list of the formulary, per se. And in the  
 14 protocol, it only calls for sublingual nitroglycerin.  
 15 I don't know what happened to the formulary, which is  
 16 supposed to be part of these.  
 17 DR. RABRICH: The formulary's in  
 18 there, and it's not listed. I'm sorry, it's Rabrich.  
 19 It's not listed as I.V. in the formulary, either,  
 20 that I know.  
 21 DR. DOYNOW: It's Don Doynow. Yeah, I  
 22 couldn't find it either under the formulary, so it's  
 23 something we need to add.  
 24 DR. MARSHALL: Okay. So that will  
 25 need to be added to the collaborative?

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 2 DR. DOYNOW: Correct. I think it,  
 3 initially, was a pilot program. And that may be why  
 4 it never made it in there. I think that's the way  
 5 Dailey originally started it.  
 6 DR. MARSHALL: Okay. So I guess, if -  
 7 - if you wanted to do that, at -- at this meeting, we  
 8 could probably -- could probably bring that forward  
 9 as an addition to the collaborative protocols. And  
 10 maybe for SEMAC, give you a chance to talk about it.  
 11 Make sense?  
 12 DR. DOYNOW: Dr. Doynow. That makes  
 13 sense, when we add it and then bring it to SEMAC.  
 14 DR. MARSHALL: Okay. All right. Any  
 15 other questions or comments on the New York City  
 16 Unified Protocols? No.  
 17 DR. BART: Can we call them the New  
 18 York City Collaborative Protocols, instead?  
 19 DR. MARSHALL: New York City  
 20 Collaborative Protocols? The New York City Unified  
 21 Collaborative Protocols.  
 22 DR. BART: Oh, yeah. All right. I  
 23 think I said that last time, too.  
 24 UNIDENTIFIED SPEAKER: But yeah, we're  
 25 okay with that. You want to call it Unified

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 2 Collaborative, Unified, that's it ...  
 3 DR. BART: Jo, I'm just teasing. No,  
 4 I rate -- let me spin things from the top of -- ...  
 5 even from the format they are the same, like I see us  
 6 getting closer and closer every time we bring this  
 7 thing up. So I appreciate the efforts being put in  
 8 on everybody's part.  
 9 DR. MARSHALL: Thank you, Dr. Bart.  
 10 DR. SCHENKER: ... when I came to you  
 11 last year, presenting this, the goal is to get them  
 12 closer. There are obviously operational ... city,  
 13 but the medicine is the medicine and the goal is to  
 14 get them as close as possible.  
 15 DR. BART: Yeah, and I think, as you  
 16 pointed out, already -- already, Joe, I mean, our job  
 17 here as a subcommittee, is to listen to you and to  
 18 safeguard these protocols consistent with the medical  
 19 standards for E.M.S. providers. And that's the  
 20 question and answer.  
 21 DR. MARSHALL: All right. If there's  
 22 no other comments, then we will vote.  
 23 Valerie, are you still with us?  
 24 MS. OZGA: Yes, I'm still here.  
 25 DR. MARSHALL: Can you do a roll call

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 2 vote, please?  
 3 MS. OZGA: I can.  
 4 DR. OLSSON: I have a procedural  
 5 question first, please. Do we need a motion?  
 6 DR. MARSHALL: Yeah, I guess we do  
 7 need a motion to approve the New York City Unified  
 8 Collaborative Protocols as presented.  
 9 DR. OLSSON: And I would like to make  
 10 that motion with whatever verbiage you decide.  
 11 DR. MARSHALL: Thank you, Dr. Olsson.  
 12 Is there a second?  
 13 DR. ALEXANDROU: Nick Alexandrou,  
 14 second.  
 15 DR. MARSHALL: Thank you, Dr.  
 16 Alexandrou.  
 17 Any further discussion? Seeing none,  
 18 we'll proceed to a roll call vote.  
 19 Valerie?  
 20 MS. OZGA: I just found a couple  
 21 members I missed through roll calls. So additional  
 22 members of Medical Standards that are on this call is  
 23 Dr. Matthew Maynard, Dr. Bombard, and Dr. Cooper, I  
 24 believe is on also. So just to make a note of that.  
 25 Okay. Dr. Alexandrou?

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 2 DR. ALEXANDROU: Dr. Alexandrou, yes.  
 3 MS. OZGA: Dr. Bart?  
 4 DR. BART: Bart, yes.  
 5 MS. OZGA: Dr. Cushman?  
 6 DR. CUSHMAN: Cushman, yes.  
 7 MS. OZGA: Dr. Davidoff?  
 8 DR. DAVIDOFF: Davidoff, yes.  
 9 MS. OZGA: Dr. Detraglia?  
 10 Dr. Doynow?  
 11 DR. DOYNOW: Doynow, yes.  
 12 MS. OZGA: Mickey Forness?  
 13 DR. FORNESS: Forness, yes.  
 14 MS. OZGA: Donald Hudson.  
 15 DR. HUDSON: Donald Hudson, yes.  
 16 MS. OZGA: Dr. Kugler?  
 17 DR. KUGLER: Dr. Kugler, yes.  
 18 MS. OZGA: Jared Kutzin?  
 19 DR. KUTZIN: Jared Kutzin, yes.  
 20 MS. OZGA: Dr. Langsom?  
 21 DR. LANGSOM: Langsom, yes.  
 22 MS. OZGA: Dr. Marshall?  
 23 DR. MARSHALL: Marshall, yes.  
 24 MS. OZGA: Did Pam Murphy join? I  
 25 don't think she's on.

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 2 Dr. Olsson?  
 3 DR. OLSSON: Olsson, yes.  
 4 MS. OZGA: Dr. Rabrich?  
 5 DR. RABRICH: Rabrich, yes.  
 6 MS. OZGA: Dr. Walters?  
 7 DR. WALTERS: Walters, yes.  
 8 MS. OZGA: Okay. Matthew Maynard?  
 9 Dr. Maynard?  
 10 DR. MAYNARD: Dr. Maynard, yes.  
 11 MS. OZGA: Dr. Bombard, are you on?  
 12 Okay. I know she's attempting to get on.  
 13 Dr. Cooper?  
 14 DR. BOMBARD: Bombard, yes.  
 15 MS. OZGA: Okay. Thanks, Tiffany.  
 16 Dr. Cooper, you might need to unmute  
 17 yourself. Oh, I don't think he's on. Okay. Dr.  
 18 Cooper, are you there?  
 19 Okay. Motion does pass. And that's  
 20 the end of the -- of the roll call.  
 21 DR. MARSHALL: Oh, thank you. Okay.  
 22 So moving on. The next item on the agenda is the  
 23 viral pandemic protocol. And I'll ask Ryan to talk  
 24 about this in a second. But we did have a telephone  
 25 conference and we talked about this, actually, at the

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 2 last meeting in terms of what do we do with this  
 3 current viral pandemic triage protocol, which is  
 4 still active, but would be activated within a region  
 5 based upon regional needs and conditions at the time.  
 6 So we had some discussion about  
 7 revising this, to make it more general, to cover more  
 8 types of disasters with the thought of keeping it in  
 9 place and active, and again, being able to activate  
 10 it at the regional level based upon local conditions,  
 11 with some, you know, notification to the Department  
 12 that you've activated it at your regional level.  
 13 So the thought was that we would have  
 14 a workgroup that would take this document and modify  
 15 it and bring it back to the next meeting, with the  
 16 hopes that it would be a more generalized disaster  
 17 response type of protocol, again, always in the  
 18 background, and only activated by the region when --  
 19 when the region conditions require it.  
 20 So I'll ask Ryan, would you like to  
 21 make some additional comments?  
 22 DR. COOPER: Dr. Marshall?  
 23 DR. MARSHALL: Hold on, Ryan, first.  
 24 Hold on.  
 25 DR. COOPER: Dr. Marshall, this is Dr.

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 2 Cooper.  
 3 DR. MARSHALL: Yeah, Dr. Cooper?  
 4 DR. COOPER: Yes. Just as a point of  
 5 ... I'm so sorry. I -- for some reason, my audio was  
 6 not working when you called the roll call. I do vote  
 7 yes for the New York City Protocol. Thank you.  
 8 DR. MARSHALL: Thank you.  
 9 All right, Ryan?  
 10 MR. GREENBERG: Hello, everyone,  
 11 again. So speaking under Steve ... name this time,  
 12 as you can tell I've moved around the building here.  
 13 Dr. Marshall, I think you were spot  
 14 on, on what we're thinking about here, like the  
 15 triage protocol, and essentially, you know, to think  
 16 of it as creating a set of disaster protocols for the  
 17 State, and those disaster protocols would be turned  
 18 on or turned off by a region, based on situations or  
 19 things that are going on.  
 20 So you know, let's say, you know, as  
 21 we're going into, in theory, hurricane season. And  
 22 if this past year, we'll probably get hit with one  
 23 straight on. But as we go into, you know hurricane  
 24 season, Long Island, Nassau, and Suffolk County may  
 25 be hit with something and need to use, you know, a

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 2 disaster protocol that doesn't need to be used in  
 3 Buffalo. Or fast forward to an ice storm in the  
 4 North Country.  
 5 So I think the thought process here  
 6 would be to create not just a pandemic triage  
 7 protocol, but a series of maybe, you know, a limited  
 8 number of, you know, four or five, maybe -- you know,  
 9 maybe ten disaster protocols that would be turned on  
 10 or turned off based on what's going on in a  
 11 geographic region.  
 12 Now, what this would also allow is for  
 13 our paramedics and our providers to be able to still  
 14 learn one set of protocols or a limited number of  
 15 protocols, to know that this disaster protocol is in  
 16 place, but not turned on, but is the same from region  
 17 to region. It's not unique, it's not different, it's  
 18 not each region creating their own, so there's less  
 19 confusion. There'll be one set, and then the region  
 20 will make the determination of whether to turn it on  
 21 or turn it off.  
 22 This would also mean that it would be  
 23 preapproved, we wouldn't be dealing with last-minute,  
 24 you know, trying to create a protocol, or on short  
 25 notice, or other things that -- that we've learned

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 2 through this past pandemic can be challenging, and  
 3 would allow us to have those in place and kind of  
 4 just off to the side in a filing cabinet.  
 5 DR. MARSHALL: Any questions for Ryan?  
 6 Or any questions about this plan? If not, I would  
 7 ask that if anybody would like to volunteer, please  
 8 do so. You can either email me directly or put it in  
 9 the chat to -- to the group, and then we will set up  
 10 a first meeting to start the process.  
 11 DR. MARSHALL: Okay. If there are no  
 12 further questions on that, the next item on the  
 13 agenda is community paramedicine. And I know that  
 14 there was some discussion on the phone call. And  
 15 here I'll ask Ryan, as well, to jump in. But we did  
 16 have some question about what is going to be the  
 17 status of community paramedicine once the pandemic is  
 18 over and -- and -- and once in place is no longer a  
 19 place, and what will we do with community  
 20 paramedicine?  
 21 Ryan, you want to comment on that,  
 22 wherever you are?  
 23 MR. GREENBERG: Absolutely. Still in  
 24 Steve's office again, so it's Ryan, not Steve  
 25 talking. So ... actually really excited about the

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 2 community paramedicine front. As many of you know,  
 3 through an executive order, we are permitted to have  
 4 community paramedicine with a couple of limitations.  
 5 But been pretty widely accepted.  
 6 We opened up the application process  
 7 and have just under fifty community paramedic  
 8 programs, covering forty counties throughout New York  
 9 State. They've been partnered with local health  
 10 departments and different agencies throughout the  
 11 state, which has been really exciting. And the one  
 12 that I -- I guess I just wasn't expecting, but it  
 13 seems to be the most current, or the most recent  
 14 partnership that's going on is partnering the  
 15 community paramedic programs with the school  
 16 districts to vaccinate the -- the -- the children in  
 17 the school districts because their ability and  
 18 versatility and the ability to get out there. So  
 19 it's been a really positive thing.  
 20 All this is great, right now during  
 21 while executive order is in place. However, as soon  
 22 as that executive order expires, all the community  
 23 paramedicine would go away. We are in, you know,  
 24 discussions. We've made that very clear, you know,  
 25 all the things that would no longer be possible. I

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 2 don't perceive the executive orders going away too  
 3 quickly. In particular, just because I think it will  
 4 number the things that are happening around the state  
 5 right now related to COVID and vaccinations and  
 6 things like that are all under those executive  
 7 orders. As well as there's the big unknown of if we  
 8 will have to do a booster shot come the fall. And  
 9 so, you know, I do think this will last through then.  
 10 That being said, I really think it's  
 11 something that we need to address at a more global  
 12 level in whatever way that is to, you know, put  
 13 together a plan for long-term ability to have  
 14 community paramedicine. It just continues to show  
 15 the value of it, the strengths. And just again,  
 16 fifty agencies around the state, doing community  
 17 paramedicine is phenomenal when, three months ago, we  
 18 had, you know, maybe three or four that were skirting  
 19 whether or not they were doing community  
 20 paramedicine.  
 21 So it's definitely shown the value of  
 22 it. And also, a lot of really positive feedback from  
 23 our community paramedics on how much they enjoy doing  
 24 it. And I think, in part, that's, you know, getting  
 25 to get out in the community and do something



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 2 different. You know, people are excited to see you  
 3 in most cases. So it's a very different experience.  
 4 So but I -- you know, I think that, you know, will  
 5 yield more to our ability to keep paramedics longer  
 6 and make it more of a career and, you know, give more  
 7 options and pathways and roadmaps for people who are  
 8 looking to stay, you know, as a paramedic, but, you  
 9 know, have more options in what they want to do  
 10 besides maybe just ...  
 11 End of report.  
 12 DR. MARSHALL: And thank you. Any  
 13 questions for Ryan? Any comments, thoughts about how  
 14 we should move forward? I hear crickets -- or  
 15 cicadas, I guess, would be the term. No? Okay. All  
 16 right. So we'll figure out how to move forward on  
 17 that.  
 18 So the next item on the agenda is the  
 19 i-gel supraglottic airway pilot project. This is out  
 20 of Hudson Valley, if you recall. It was for use by  
 21 E.M.T.s during cardiac arrest only. It was initially  
 22 one specific agency. This came forward as a pilot  
 23 project, was approved by Medical Standards. And it  
 24 was approved by SEMAC, with some questions from --  
 25 some input from Training and Ed also commented on it.

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 2 There was one question in terms of -- in end tidal  
 3 CO2 and the requirement to use end tidal CO ...  
 4  
 5 2  
 6 airway.  
 7 And I have to admit I don't recall the  
 8 outcome of that discussion. Hopefully, somebody else  
 9 does. But at this point, I think that it's had all  
 10 the approvals. I have to go back and check the  
 11 SEMSCO minutes, but I do believe it was passed there,  
 12 as well. It would have to go to the commissioner for  
 13 approval as a pilot project.  
 14 The other part of this was that it was  
 15 opened up during discussion at SEMAC and SEMSCO that  
 16 it would be open to other agencies, and they would  
 17 have to contact Hudson Valley to be included in the -  
 18 - in the pilot project through them.  
 19 Comments? Recollections? Ryan?  
 20 Steve? Is anybody there? Hello?  
 21 DR. BART: Is it in the vote of  
 22 approval?  
 23 DR. MARSHALL: Say that again, Bart?  
 24 DR. BART: I'm having trouble finding  
 25 that protocol for the pilot. The documents in the  
 ... I just want to review it.  
 MR. GREENBERG: So Dr. Marshall, I

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 2 believe where we left it off at the last meeting was  
 3 there was a group of people who you were coming back  
 4 -- or they were coming back with additional edits.  
 5 And it was working on determining whether or not you  
 6 were going to make it a statewide pilot or just that  
 7 region. And so I think that's where it was left  
 8 outstanding.  
 9 There were certain questions, if I  
 10 remember correctly. There wasn't specific quality  
 11 benchmarks that you were looking for. And those were  
 12 going to be updated. I don't recall seeing any  
 13 updates or who was working on that part.  
 14 DR. MARSHALL: All right. I'll have  
 15 to go back and look at my notes and see who was  
 16 working on that.  
 17 Dr. Bart, I just forwarded, to your  
 18 email, the document.  
 19 DR. PHILLIPY: Dr. Marshall, it's Mark  
 20 Philippy. I think one of the questions that had come  
 21 up earlier also was what would be the process for  
 22 other agencies, slash, regions. We had mentioned  
 23 contacting Dr. Murphy and the folks in the Hudson  
 24 Valley that were piloting the project to inclusion,  
 25 but we didn't really establish a way of doing that or

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 2 -- or publicizing that. So I think that also should  
 3 be part of the project.  
 4 DR. BOMBARD: Hey, it's Tiff Bombard.  
 5 My understanding was that we actually did open this  
 6 to everybody and that you were to, as Mark said, just  
 7 contact Dr. Murphy to gain entry to the program. And  
 8 Dr. Murphy had some literature for whoever wanted to  
 9 sign up and become part of the pilot with them. And  
 10 I did have contact information from Dr. Murphy. I  
 11 can send that to you guys when it's helpful.  
 12 DR. MARSHALL: Yeah, and that should  
 13 be in the minutes. So --.  
 14 DR. OLSSON: Dan Olsson. Page twenty-  
 15 four of the minutes is ... was when it starts the  
 16 discussion about the i-gel. There's a couple  
 17 paragraphs. It basically just mentions it and refer  
 18 to Training and Ed. I thought there was more of a  
 19 discussion on it than there -- than what I'm seeing.  
 20 I think I'm looking at the SEMAC minutes. There  
 21 might have been more in the Medical Standards.  
 22 DR. BART: In particular, what I  
 23 wanted to review fresh here was -- was the procedure  
 24 for other regions. This is ... specifically and, you  
 25 know, the protocol ... I mean, I don't want to ...

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 2 on this thing. But the protocol might be shared in  
 3 the inclusion for a ... agencies as far as the  
 4 reporting side of it. I don't -- I don't anticipate  
 5 that other people will take this. But if you -- if  
 6 you make this wide and widely available, it becomes  
 7 the new norm. And regardless of being part of a ...  
 8 or not in the reporting structure that might exist  
 9 through that study, it becomes new like, oh, we can  
 10 do this, you should do this, too. And it will lose  
 11 the opportunity that this is a pilot. That's my  
 12 first comment.

13 And the second, which I don't think  
 14 there's anything within the protocol itself talks  
 15 about a ... in the anticipation of how many  
 16 participants we're looking for, so that we can prove  
 17 this demonstration project is actually effective or  
 18 ineffective.

19 I know we've had that problem with a  
 20 couple of studies in the past in which it was, like,  
 21 well, how many times did we get this done? I don't  
 22 know, it seemed to work. I think for administration  
 23 like this, we're going to see -- we're going to have  
 24 to see a little bit more than it seems to work  
 25 subjectively. And perhaps some statistical analysis

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 2 ... in these situations, we had X amount of providers  
 3 statistically that were successful with it or on, you  
 4 know, so many regions. I think the data that would  
 5 go along with that would be valuable for all of us do  
 6 to -- to look at this, because this would be a  
 7 significant change of scope for B.L.S. providers.  
 8 And if we were even going to propose this, and we all  
 9 know that adding thirty more seconds to the  
 10 curriculum of a B.L.S. course right now, would be  
 11 contentious.

12 I'm not disagreeing. I actually love  
 13 this. I just want to make sure the idea of sharing  
 14 it along with some folks and the intended outcome are  
 15 universal.

16 DR. WALTERS: Dr. Marshall, it's  
 17 Walters. I -- so Dr. Bart, I -- I understand your  
 18 concerns. I guess there's two ways to look at this.  
 19 Are we -- because I do understand, and I don't  
 20 disagree. Do we want to keep this smaller, more  
 21 controlled to really do a pilot demonstration  
 22 project? Or is there value in opening it up to try  
 23 to get a larger number of uses to really look at the  
 24 data? And if you're trying to do that in a timely  
 25 fashion, is it better to open it up to -- to

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 2 different agencies?  
 3 And I don't know the answer. I'm just  
 4 raising this as a point of discussion. And I -- I  
 5 think we had a discussion last time and I don't think  
 6 it made it into a motion or actually made it to the  
 7 SEMAC. I don't remember if it was at Med Standards  
 8 or the SEMSCO -- or Med Standards or the SEMAC. I  
 9 don't think it made it to the SEMSCO. Do we -- do we  
 10 limit this? If you do or you are looking for a  
 11 certain number of uses in a certain amount of time,  
 12 or you want to get a higher number of -- of data, do  
 13 you -- do we limit this to just i-gel, or do you open  
 14 it up to other supraglottic devices?

15 Because my -- my thought is you may  
 16 get more agencies who already -- that their B.L.S.  
 17 providers and an A.L.S. agency are already using one  
 18 device, whether that's a ... a gel, whatever happens  
 19 to be, do we want to include those and not make it  
 20 specifically just for the i-gel?

21 Because my thought would be if this is  
 22 successful, and I think it will be, if this does get  
 23 moved to the B.L.S. scope of practice, I don't know  
 24 that we're going to say only i-gel. I think, you  
 25 know, we've never really taken the stance that you

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 2 can only use this one product or this one device or  
 3 this one brand.

4 And if we aren't going to open it up  
 5 down the road, is there value in opening it up now to  
 6 look at those different -- even comparing, you know,  
 7 successes, failures between the different devices, is  
 8 that of use?

9 DR. BART: I -- I think that the --  
 10 ... I guess that's how its proposed here. If the  
 11 demonstration is using i-gel and the trainings go  
 12 along specifically with that, there is a lot of  
 13 language in this protocol that talks about the  
 14 insertion of supraglottic airway. However, the  
 15 direct insertion that comes ... bullet points,  
 16 specifically is related to the i-gel inclusive of the  
 17 sizes of the i-gel, which is not universal for all  
 18 supraglottic airways.

19 So I guess where I'm looking at this  
 20 to say that it -- it will be controlled by Hudson  
 21 Valley on this -- on this pilot and it's a  
 22 demonstration project for -- for their providers. It  
 23 looks like the test or -- I'm sorry -- the protocol  
 24 is just designed for the i-gel. But I totally  
 25 appreciate your point, Brian, that supraglottic

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 2 airways as a blind insertion is really the skill that  
 3 we're looking to introduce for B.L.S. providers and  
 4 ...  
 5 And I can see it going that way. As  
 6 such, it seems like if you're not using i-gel in your  
 7 in your system right now, you'd be excluded from this  
 8 particular pilot project, because it talks  
 9 specifically about i-gel. And if we didn't limit it  
 10 to there, I'd see other people saying, well, I use a  
 11 supraglottic airway that's kind of like the i-gel,  
 12 I'm going to include us in this as well.  
 13 So I guess I'm suggesting that a  
 14 little tighter control on the who's going to be  
 15 involved in this. It seems like you're going to have  
 16 widespread interest in it. And you're going to, you  
 17 know, see the potential losing control of that  
 18 protocol and not knowing who's involved with it under  
 19 ... particularly because this is using i-gel  
 20 insertions. That was -- that was my comment to you.  
 21 DR. MARSHALL: Thank you, Dr. Bart.  
 22 Just -- just to read up on the  
 23 minutes, so from the last SEMAC meeting minutes, this  
 24 did come forward as a motion to approve the Hudson  
 25 Valley i-gel project the way it was presented. And

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 2 there was a vote, and it was opened statewide. So if  
 3 any agency did want to participate, they would need  
 4 to contact Hudson Valley in order to do that.  
 5 And several -- at least one region has  
 6 done so and was waiting on Commissioner's approval.  
 7 That did go to a vote. And that vote was almost  
 8 unanimous. There was one abstention. But other than  
 9 that, that's how far this got. It got up through  
 10 SEMAC. And I guess the next step would be to go to  
 11 SEMSCO and request Commissioner's approval.  
 12 If there's some desire to change what  
 13 was presented in the protocol, then I think that  
 14 that's a -- a discussion we should also have, as  
 15 well.  
 16 Are there any questions on -- on that?  
 17 That's on page thirty-four to thirty-six, by the way,  
 18 in the SEMAC minutes of January, if anybody's  
 19 interested other than me.  
 20 MR. GREENBERG: Dr. Marshall, it's  
 21 Ryan Greenberg.  
 22 DR. MARSHALL: Yes, Ryan.  
 23 MR. GREENBERG: So I did have one -- I  
 24 guess I'll put in my two cents on devices. I would  
 25 suggest that you stick with one. And I -- and I

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 2 would also suggest that we go more than Hudson Valley  
 3 only from the point of view of the ability to get --  
 4 to have numbers to look at. I think if we just go in  
 5 that Hudson Valley, particularly in that one area,  
 6 that the number of cardiac arrests and the number of  
 7 cardiac arrests without A.L.S. on scene, I think  
 8 you'll start to really limit it.  
 9 The one question I would ask this  
 10 group is what happens if it's a ... Medic unit that  
 11 shows up? So it's an E.M.T. and a paramedic on a  
 12 cardiac arrest? And what would the SEMAC be looking  
 13 for or what do you think that, I guess, Med Standards  
 14 would be looking for in this pilot? Do you have the  
 15 E.M.T. perform the -- the function? Or is that  
 16 something that nope, there's a medic on scene, they  
 17 should be intubating or --?  
 18 And I think that would also affect  
 19 your numbers and the research and how many you would  
 20 get. Because if we leave the New York City area, it  
 21 is a large amount of people -- large number of  
 22 systems that run with an E.M.T. and a paramedic or an  
 23 E.M.T. and a C.C. on a truck. And I think that that  
 24 should probably be determined prior to.  
 25 DR. MARSHALL: I don't recall that

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 2 specific question being addressed in the proposal and  
 3 the pilot project that came forward, but -- just  
 4 trying to take a look, but I don't really see. I  
 5 don't see anything, quickly. I'll have to take a  
 6 closer look.  
 7 DR. ALEXANDROU: Lew, it's Nic  
 8 Alexandrou. Can I comment on that?  
 9 DR. MARSHALL: Yes, Dr. Alexandrou.  
 10 DR. ALEXANDROU: I have something in  
 11 my notes that specifically had said that E.M.T.s to  
 12 be trained to place the supraglottic airway in  
 13 cardiac arrest, and then A.L.S. would also have to be  
 14 dispatched to respond at the same time. So there  
 15 would have to be a backup for the airway.  
 16 I'm assuming if there's a ... medic,  
 17 that then at that point, the medic would take over  
 18 and probably place a -- a -- an E.T. tube and the  
 19 tracheal intubation. But that's what I have in my  
 20 notes. So that was not, I think, a discussion  
 21 specifically last time around.  
 22 DR. SCHENKER: Lew?  
 23 DR. MARSHALL: Yes.  
 24 DR. SCHENKER: It's Schenker. So I  
 25 think that a lot of this is going to be based on the

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 2 data collection tool if you're doing a pilot project,  
 3 whether it's the medic or the E.M.T. that intubated -  
 4 - or placed an airway, I should say. There's plenty  
 5 of literature that we all know about that says that  
 6 in cardiac arrest, intubating might not be the best  
 7 option. An alternative airway is probably a better  
 8 option, in most cases, in order to not disrupt  
 9 cardiac arrest, C.P.R., and everything.  
 10 So I don't know that, you know, even  
 11 in New York City, we allow the medical director to  
 12 determine if an alternative airway should be first or  
 13 intubation should be first. I'm not sure how that is  
 14 in the rest of the state or what other medical  
 15 directors are doing, but I don't think that just  
 16 because there's a medic and an E.M.T., that should  
 17 preclude possible entry into a pilot project. And an  
 18 E.M.T., if they perform the skill, and it's  
 19 documented as such on a data collection tool, should  
 20 be included in the data -- in the -- in the data set  
 21 for the purpose of identifying if this is safe and  
 22 appropriate to use going forward.  
 23 As far as one, I think the skill has  
 24 to be similar, whether it's an i-gel or another type  
 25 of L.M.A. versus a King L.T. I think the skill has

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 2 to be similar. The King has a little bit more, I  
 3 guess, user comfort level that has to happen with it,  
 4 versus a -- just a simple supraglottic L.M.A. type  
 5 airway. Maybe that has to be considered in the pilot  
 6 if the pilot was specific or not.  
 7 DR. ALEXANDROU: Lew, can I make  
 8 another comment on Joe's comment, please? Nic  
 9 Alexandrou.  
 10 DR. MARSHALL: Yes.  
 11 DR. ALEXANDROU: Yeah, there --  
 12 there's another comment I have here in my notes that  
 13 I think we discussed, specifically, the King device.  
 14 And we said that this would not include the King  
 15 device. Just -- just to bring everybody up to date.  
 16 DR. MARSHALL: Yes, I recall that  
 17 discussion, as well. Thank you, Dr. Alexandrou.  
 18 DR. OLSSON: I would like to make an  
 19 observation. We seem to be discussing nuances of a  
 20 pilot project, but I, for one, certainly don't  
 21 remember all of the little intricacies involved in  
 22 it. And I would suggest that we have access to the  
 23 written text of that project, so that we can better  
 24 define and refine our comments. Thank you.  
 25 DR. MARSHALL: Thank you, Dr. Olsson.

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 2 You know we can work -- we can certainly send it out  
 3 again to all people to take a fresh look at it  
 4 because it's been a while. And then we can have  
 5 further discussion tomorrow at SEMAC. That might be  
 6 a possibility.  
 7 Don, how does that sound for SEMAC?  
 8 DR. DOYNOW: Dr. Doynow. That sounds  
 9 fine. I think it'd be a good idea. I'm trying to  
 10 look through SEMSCO notes to see if we had brought it  
 11 up, but I can't find anything there, from last time.  
 12 DR. MARSHALL: Okay. I will forward  
 13 the document to Valerie now and she can send it out  
 14 to the group.  
 15 If you would, please, Valerie?  
 16 If there's no further discussion on  
 17 that, we'd like to -- the item is the SEMAC advisory  
 18 for transfer of Ebola patients. So I'd like to ask  
 19 Ryan or someone from the Department to make comments  
 20 on that because --  
 21 DR. GREENBERG: Yeah, so first I'll  
 22 say, as far as the information that you'll send over  
 23 to Valerie, we will get that up onto the portal so  
 24 that everybody will have access to those documents.  
 25 No problem at all.

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 2 And as far as the Ebola policy  
 3 statement, I am going to switch the mic over to Steve  
 4 Dziura so he can make an update on that.  
 5 DR. DZIURA: Morning, everyone. So  
 6 the Office of Health Emergency Preparedness has asked  
 7 if the SEMAC would consider the Ebola transfer policy  
 8 statement that's been provided to you. The language  
 9 is -- is open. That's -- that's the gist of what  
 10 they're trying to get at. Essentially, they're  
 11 looking for protocol that deviates from -- or  
 12 advisory that would deviate from closest appropriate  
 13 facility in the transfer of Ebola patients.  
 14 These are known Ebola patients that  
 15 have gone -- have already been seen in a primary  
 16 facility and are being -- I'm sorry -- have already  
 17 been seen, are being transferred to a primary Ebola  
 18 facility.  
 19 Obviously, this came up because of the  
 20 recent outbreak in Africa. In the -- in the sudden  
 21 beginning of screening procedures at J.F.K. brought  
 22 this to light again. It is something that's been  
 23 kind of stewing for -- for at least a couple years  
 24 and they're -- they're looking for some clarification  
 25 on the ability to bypass closest facility for ...

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 2 Ebola patients.  
 3 DR. MARSHALL: ... I just have a  
 4 couple of questions. One is these known Ebola  
 5 patients, are they coming from the airport and then  
 6 going to an Ebola facility? Or are these patients  
 7 who have been seen at another hospital and identified  
 8 as a -- a positive Ebola patient and then inter-  
 9 facility transport to the tertiary center?  
 10 DR. DZIURA: That's correct. The  
 11 latter is the correct version of -- of what's trying  
 12 to be accomplished. This is not for the initial  
 13 presentation of an Ebola patient. It's for the  
 14 transfer of an Ebola patient in the event that they  
 15 were to decompensate en route to the transfer  
 16 facility. This is to clarify that it's still more  
 17 appropriate to continue to the transfer facility, as  
 18 opposed to expose another hospital to this patient.  
 19 MR. GREENBERG: The other component  
 20 and what's come up several times before is that  
 21 often, if we are transporting a patient, an Ebola  
 22 patient from -- not often but we're transporting a  
 23 patient -- an Ebola patient from one hospital to  
 24 another and the patient starts to decompensate, which  
 25 is a high possibility based on, you know, the risk

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 2 and -- and severity of the -- the patient, that if we  
 3 were to divert to a closer hospital in between the  
 4 two, that the amount of time it would take for that  
 5 hospital to prepare to accept the Ebola patient,  
 6 versus the amount of time it would take to complete  
 7 the transport to the specialized center would be  
 8 almost equal in most cases. And that the specialized  
 9 center is prepared and more versed to dealing with  
 10 that type of patient.  
 11 DR. MARSHALL: Thanks. This is Dr.  
 12 Marshall, I think it's perfectly reasonable during  
 13 the inter-facility transport, an Ebola patient begins  
 14 to decompensate to continue transferring to the -- to  
 15 the facility that's capable of taking care of them  
 16 without exposing additional, you know, pre-hospital  
 17 or hospital providers. I think that that's perfectly  
 18 reasonable. And then, you know, we have the means  
 19 within the ambulance during the inter-facility  
 20 transport to respond to that decompensation, whether  
 21 it's fluids, intubation, or other mechanisms of  
 22 treatment.  
 23 So anyone else?  
 24 DR. FORNESS: Dr. Marshall, it's  
 25 Mickey Forness asking. There doesn't seem to be any

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 2 facilities in the mid-state region. Would some  
 3 facility have to be declared in that area?  
 4 DR. DZIURA: So Office of Health  
 5 Emergency Preparedness is in the process of re-  
 6 verifying the facilities capable of accepting Ebola  
 7 patients for long-term treatment. Right now, to my  
 8 knowledge, New York City, there are a few and Buffalo  
 9 -- or Buffalo and Rochester.  
 10 MR. GREENBERG: Buffalo. Long Island  
 11 has one. ... list. But we can get the list -- well,  
 12 you're looking at a list, but if you circulate, I do  
 13 know that they are looking further into that one.  
 14 And they are also looking into, you know, based on  
 15 particular hospitals with a, you know, one possible  
 16 fly the patient versus go by ground.  
 17 DR. MARSHALL: Thank you. Any other  
 18 questions for Ryan or Steve?  
 19 DR. WALTERS: Dr. Marshall, it's  
 20 Walters. I don't -- I mean I don't disagree with the  
 21 intent of what we're saying, but Steve maybe you can  
 22 clarify. Are we looking -- are you looking at  
 23 changing the policy statement 2102 or is there  
 24 another document you're looking at? I'm not sure  
 25 what we're referring to right now.

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 2 DR. DZIURA: This is a new SEMAC  
 3 advisory that would come out just clarifying that in  
 4 the case of inter-facility transfer of Ebola  
 5 patients, the closest appropriate facility is as  
 6 outlined in the protocols today, on a decompensating  
 7 patient would be disregarded in lieu of sending the  
 8 patient to an appropriate Ebola facility and not  
 9 exposing others. That's the gist of it, boiled down.  
 10 DR. WALTERS: Okay. So I understand.  
 11 I mean, I guess -- I guess I would argue the closest  
 12 appropriate facility is the one that's prepared to  
 13 take Ebola patients but -- but I understand you want  
 14 to clarify that a little bit.  
 15 Would it make more sense to update  
 16 that policy statement on Ebola 2102 to add that  
 17 specific language, as opposed to having a policy  
 18 statement, then a SEMAC advisory, having two things  
 19 that someone would have to refer to, to get all the  
 20 information, put it into one combined document, if  
 21 we're going to add this?  
 22 DR. DZIURA: So yes. However, that  
 23 policy statement had to come out prior to this  
 24 meeting and clarification of that particular item.  
 25 So once the SEMAC advisory came out -- comes out, we

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 2 can update that policy statement to reflect that  
 3 change, as well, in reference, the SEMAC advisory.  
 4 This -- it came down to being a SEMAC advisory  
 5 because, while I agree with you, that closest  
 6 appropriate should be considered the Ebola treatment  
 7 facility, it can be argued that it's not clear in the  
 8 protocol on a decompensating patient, and that they  
 9 should go to the closest appropriate facility capable  
 10 of treating an airway or cardiac arrest issue or some  
 11 other issue from the decompensation.  
 12 So this just makes that very clear for  
 13 everyone.  
 14 DR. MARSHALL: Thanks, Steve.  
 15 Do we have ... yet or is -- or not  
 16 yet?  
 17 DR. DZIURA: I'm sorry; Dr. Walters  
 18 and Lew, you covered each other up.  
 19 DR. MARSHALL: So I was asking if we  
 20 have this draft advisory in writing yet.  
 21 DR. DZIURA: I believe -- didn't I  
 22 provide that to the group?  
 23 DR. HUDSON: It is -- this is Don  
 24 Hudson. It's it is up on ... It's in the SEMSCO May  
 25 2021 folder.

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 2 Just while everyone's looking and I  
 3 have your attention, I agree with Dr. Walters. It'd  
 4 be nice if we had one stop shopping, rather than  
 5 providers hunting around trying to compare documents  
 6 if this, do that, go here, go there. It just seems  
 7 simple to me, you know, in the case of inter-facility  
 8 transport of Ebola patients under those situations  
 9 that you divert from the established hospitals.  
 10 DR. DZIURA: Correct. As I said, if -  
 11 - if this group decides to push forward the advisory  
 12 to the SEMAC for approval, then the policy -- state  
 13 policy statement ...  
 14 DR. MARSHALL: I'd have to look for  
 15 the document. I don't see it right now, but.  
 16 DR. BART: Dr. Marshall, do we all  
 17 have access to the items in the SEMSCO folder if  
 18 we're not on SEMSCO? I don't think I can find that  
 19 on ...  
 20 DR. MARSHALL: If you give me just a  
 21 minute to find it on my computer, I can share the  
 22 screen with you and put the language up.  
 23 MS. OZGA: I can also upload it to ...  
 24 right now. What document are you looking at?  
 25 DR. BART: Okay. I found it.

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 2 MS. OZGA: I thought we had all the --  
 3 all of them uploaded.  
 4 MR. GREENBERG: Val, I think the  
 5 document might only be in the SEMAC file, not in  
 6 Standards file. So if we just make sure that both of  
 7 those are referencing in both.  
 8 MS. OZGA: Yes, I can. Which file do  
 9 you need in Medical Standards again?  
 10 MR. GREENBERG: The draft SEMAC  
 11 advisory ...  
 12 DR. DZIURA: Peter, can you ... share  
 13 my screen? Okay. Can everyone see that?  
 14 MS. OZGA: Okay, everyone. I just put  
 15 the SEMAC advisory in ... under the Medical Standards  
 16 committee. So it should be there.  
 17 MR. GREENBERG: And as everyone is  
 18 reading this, this is also a proposed SEMAC advisory.  
 19 We can edit, we can shorten, we can --.  
 20 DR. LANGSOM: Lew, it's Yedidiah. I  
 21 don't want to speak out of turn.  
 22 DR. MARSHALL: Yes.  
 23 DR. LANGSOM: Are we -- I'm confused.  
 24 It almost reads as if we're dictating to hospitals,  
 25 how they become a receiving facility for this. I

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 2 guess I'm confused. I mean, I know that you know,  
 3 F.D.N.Y. has a very specific policy, and I guess Nick  
 4 could speak more to this, of who are the receiving  
 5 hospitals. It's done in conjunction with Health and  
 6 Hospitals and, and the regional E.M.S. committee to  
 7 decide in terms of who are the appropriate Ebola  
 8 receiving facilities.  
 9 I don't, I guess -- is the purpose of  
 10 this document is to the hospitals or to the E.M.S.  
 11 providers or the E.M.S agencies?  
 12 DR. MARSHALL: Yes. Yes. If I  
 13 recall, I think that, you know, it's really the  
 14 Department of Health itself, with the Commissioner's  
 15 order, as mentioned here, hospitals that wanted to  
 16 take on this specific role signed up to do so. It  
 17 wasn't something that -- that E.M.S. necessarily put  
 18 in place and it's requiring hospitals to do.  
 19 You know that in New York City, we at  
 20 least, Bellevue has always been the local facility  
 21 that would accept Ebola patients. And there's more  
 22 now I'm aware of, but I think this would be the same  
 23 for other regions. But I would suggest that people  
 24 take a look at this, read it.  
 25

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 2 This would be SEMAC advisory, Don, if  
 3 we could have ... SEMAC? Does that sound reasonable?  
 4 DR. DOYNOW: That's fine. I think we  
 5 need to look at it a little bit better. Some  
 6 questions that are coming through on my phone about  
 7 whether folks would need to continue C.P.R. if  
 8 somebody were to arrest ... long distance until they  
 9 got to a receiving center, or if the person arrested,  
 10 would they need to go back to the initial sending.  
 11 That's something we'll probably need to look at  
 12 tomorrow.  
 13 DR. MARSHALL: All right. Thanks.  
 14 All right, folks. So that was the last thing on the  
 15 agenda, a specific item. So please take a look at  
 16 that proposed advisory for more discussion tomorrow.  
 17 And at this time, I'll ask if there's any old  
 18 business. Seeing none, any new business?  
 19 DR. DAVIDOFF: Lew, this is Davidoff.  
 20 DR. MARSHALL: Yes.  
 21 DR. DAVIDOFF: I guess maybe Ryan or  
 22 Steve, I'm not sure who's going to be able to help  
 23 answer this. We have this new app called Muru, which  
 24 lists the protocols, the collaborative protocols.  
 25 We've had the collaborative protocol app, and there's

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 2 been this P.P.P. app out there. There's three apps  
 3 now that paramedics have access to, to look at these  
 4 protocols.  
 5 It seems like the old telephone game  
 6 for those of you who can remember back that far.  
 7 Each time we get a new app, the wording changes a  
 8 little bit. ... difference with the I.V.  
 9 nitroglycerin ... the other. And more importantly,  
 10 there's been some changes in the wording of excited  
 11 delirium, the agitated patient and ketamine dosing.  
 12 And I'm seeing more and more medics, thinking that  
 13 the appropriate dose for an agitated patient, not  
 14 excited delirium patient, but the agitated patient is  
 15 two hundred and fifty milligrams I.M.  
 16 In the current political atmosphere, I  
 17 don't want to see my agitated patients becoming ...  
 18 and maybe having bad outcomes. And I wonder if there  
 19 isn't some way we can kind of control what's going on  
 20 with their, for lack of better word, social media  
 21 apps. It doesn't seem like SEMAC, or SEMSCO, Medical  
 22 Standards has any control over those.  
 23 DR. DZIURA: Thanks, Dr. Davidoff.  
 24 This is Steve. That is exactly why we contracted for  
 25 this particular app. We did a solicitation to the

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 2 providers. This app came in at the rate -- contract  
 3 rate and was approved.  
 4 This takes the P.D.F. app -- P.D.F.  
 5 protocol directly from our website we provided to  
 6 them that was approved by the commissioner, so  
 7 approved by your group. It was submitted up.  
 8 Whereas the other apps are -- we don't know exactly  
 9 where they're pulling from or if they're all up to  
 10 date.  
 11 And in some cases, they were doing --  
 12 they were created by the regional collaborative  
 13 groups. And again, we assume that the language in  
 14 there is right, but we're not always sure that the  
 15 final copy that was approved by this group, the  
 16 SEMSCO, and the commissioner, is what makes it onto  
 17 the app. So this does give us exactly that control  
 18 to be able to do that, going forward.  
 19 DR. DAVIDOFF: The original -- the  
 20 original collaborative protocol, I thought, included  
 21 I.V. nitroglycerin did not, yet Muru does. And if  
 22 you look at the wordings on some of the -- I've not  
 23 had a chance to look at all of them, but certainly if  
 24 you look at the excited delirium, agitated patient,  
 25

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 2 there's again some changes. So I don't know where  
 3 Muru is getting their information from.  
 4 DR. DZIURA: So that's -- that's  
 5 probably part of this issue is the collaboratives  
 6 present their document to the SEMAC, and then SEMSCO,  
 7 and during that process, there tends to be changes  
 8 and discussion and movement that happens. We don't  
 9 take that document before it goes to the commissioner  
 10 for final approval and is signed off.  
 11 What -- what may be happening is that  
 12 the other folks, be it the regional collaboratives or  
 13 just the protocol providers or the protocol end  
 14 providers, are just posting whatever was presented  
 15 without the changes that were discussed in and made  
 16 during meetings.  
 17 DR. MARSHALL: It's Dr. Marshall.  
 18 Thanks, Steve.  
 19 I think, to echo Jack's concern, if I  
 20 if I get this right, Jack, is really to reduce some  
 21 confusion, we really need one source of truth, right.  
 22 And whether it's in the collaborative app or the Muru  
 23 app, or -- or the P.P.E. protocol app, but we just  
 24 need -- funnel -- maybe funnel it all through one  
 25

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 2 funnel so that we have one source of truth so we  
 3 don't create confusion amongst our providers.  
 4 DR. DZIURA: So as far as the  
 5 collaborative app goes, that was paid for in -- in  
 6 collaboration with multiple regional councils. And  
 7 this will replace that. Their -- their contracts are  
 8 probably expiring, but this was an agreement between  
 9 all the program agencies who had been maintaining  
 10 this in the state to take this responsibility over.  
 11 Since really we were paying for it out of the ...  
 12 locality funding anyway, through reimbursement to the  
 13 councils. It just makes it cleaner.  
 14 As far as the P.P.P., those are  
 15 independent app creators that are getting their  
 16 source from somewhere and posting it that is not at  
 17 the approval of the Department, nor does that require  
 18 it. So that's why we've tried to push this as the  
 19 state approved app, the source of truth.  
 20 DR. MARSHALL: Okay. So just so I  
 21 understand, sorry, Jack, the collaborative protocol  
 22 app will, at some point in the near future, go away  
 23 and Muru will be the only New York State protocol  
 24 app. Is that correct?  
 25

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 2 DR. DZIURA: Correct. The -- the  
 3 Department will no longer be reimbursing the regions  
 4 for their app that they have. So it's anticipated  
 5 it'll go away. They've all said it will.  
 6 DR. DAVIDOFF: And I think that's a  
 7 great concept. I'm all in support of having one  
 8 source of information out there. But right now, out  
 9 of the three, I think the Muru has least accurate  
 10 information for our providers. I think someone at  
 11 the state at a subcommittee, someone's got to be  
 12 reviewing this and going through it and making sure  
 13 it's worded properly and has the right information.  
 14 DR. MARSHALL: So yeah, thanks, Jack.  
 15 Yeah, I think we need to make sure that it's  
 16 accurate. We're not going to do that at this meeting  
 17 right now. But perhaps we can set up a process with  
 18 Steve and Ryan to figure out how it's being viewed  
 19 and making sure that it's accurate when it goes out.  
 20 DR. ALEXANDROU: This is Nic  
 21 Alexander. Can I just make one comment on that, as  
 22 well?  
 23 DR. MARSHALL: Yeah, go ahead.  
 24 DR. ALEXANDROU: We looked at the Muru  
 25 a little bit here at the fire department. And I have

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 2 to say that some of the hospital designations and  
 3 what their sub-specialties are, are not as accurately  
 4 reflected as we have them here on our -- on our  
 5 system for hospitals.  
 6 So that needs to be looked at, as  
 7 well, because members may be using those hospital  
 8 designations to go to those -- to those hospitals and  
 9 don't have the correct services. But they still work  
 10 under our operations guide. So that will help, but  
 11 outside where that may not exist, paramedics or  
 12 E.M.T.s may be transporting to hospitals that don't  
 13 have the proper services.  
 14 DR. DAVIDOFF: This is Davidoff, one  
 15 more time.  
 16 DR. MARSHALL: One more question --  
 17 one more comment, Jack?  
 18 DR. DAVIDOFF: Another comment, yeah.  
 19 The collaborative protocols had a very good feature  
 20 built in for medical control members, which we don't  
 21 have built into Muru. I don't know if that's  
 22 something that can be done or not. But I know a lot  
 23 of providers rely on that collaborative protocol app  
 24 to make their call to medical control and they've  
 25 lost that with the Muru.

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 2 DR. DZIURA: Dr. Marshall?  
 3 DR. MARSHALL: Yeah, go ahead, Steve.  
 4 Question for you. Yeah.  
 5 DR. DZIURA: That is available and  
 6 will be updated as we continue on with the app.  
 7 DR. MARSHALL: Okay. Thank you,  
 8 MR. GREENBERG: Dr. Marshall, it's  
 9 Ryan. I would just also add in there, so you know,  
 10 the bulk of the information from ... comes from the  
 11 state website. And that includes the hospital  
 12 destinations and, you know, specialty centers and  
 13 things like that. ... to work with anyone who feels  
 14 that information is not the most up to date, because  
 15 that could mean that also that it's not the most up  
 16 to date on our website, as well. And so we'd want to  
 17 fix that immediately.  
 18 But as far as the hospital  
 19 destinations and information on that one, again, that  
 20 comes off of the D.O.H. website is where they're  
 21 pulling information. So if the city is having  
 22 slightly different information for nine one one  
 23 destinations or something of that nature, then we  
 24 should be taking a look at that, as well.  
 25



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 2 DR. PHILIPPY: Dr. Marshall, this is  
 3 Mark Philippy.  
 4 DR. MARSHALL: Yes, Mark.  
 5 DR. PHILIPPY: So, I'm going to cut to  
 6 the chase, just a little bit. I have had some  
 7 conversations with Steven Blacker is one of the  
 8 primary programmers and folks from the Muru app.  
 9 He's been very responsive. He's agreed to work with  
 10 our program agency and to reach in our REMAC, to try  
 11 and address some of those local issues.  
 12 So as Director Greenberg suggests, I  
 13 would ask anyone who's finding those issues, perhaps  
 14 contact Mr. Blacker at that Muru through their --  
 15 there's a very robust help feature in the app that  
 16 will allow you to do that. I know that the director  
 17 and distributor and I will probably be talking about  
 18 this a little bit more.  
 19 But it does have a lot of great  
 20 features. It does have -- I do see this as kind of a  
 21 beta version, because there are some things that will  
 22 need to be cleaned up. But again, they've been very,  
 23 very responsive.  
 24 DR. MARSHALL: Thank you, everyone.  
 25 Thanks everybody. It's at -- we're at the end of our

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 2 STATE OF NEW YORK  
 3 I, HANNAH ALLEN, do hereby certify that the foregoing was  
 4 reported by me, in the cause, at the time and place, as  
 5 stated in the caption hereto, at Page 1 hereof; that the  
 6 foregoing typewritten transcription consisting of pages 1  
 7 through 66, is a true record of all proceedings had at the  
 8 hearing.  
 9 IN WITNESS WHEREOF, I have hereunto  
 10 subscribed my name, this the 13th day of June, 2021.  
 11  
 12  
 13 HANNAH ALLEN, Reporter  
 14  
 15  
 16  
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 23  
 24  
 25

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 2 meeting. So I think in terms of the -- the app, I  
 3 think that we have some good direction on how to send  
 4 in ... notices, errors, or what needs to be fixed.  
 5 So is there any other new business?  
 6 If not, I'll entertain a motion to adjourn. Anybody  
 7 want to make that motion?  
 8 DR. KUGLER: David Kugler. Motion to  
 9 adjourn ....  
 10 DR. DOYNOW: Don Doynow, second.  
 11 DR. MARSHALL: Thank you. All in  
 12 favor?  
 13 ALL: Aye.  
 14 DR. MARSHALL: All right. I'll see  
 15 you all at the next meeting. Enjoy the rest of your  
 16 day.  
 17 (The meeting adjourned at 9:37 a.m.)  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25

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