5-26-2021 - SEMAC
NEW YORK STATE
DEPARTMENT OF HEALTH

WebEx
SEMAC COMMITTEE MEETING

DATE: May 26, 2020 at 9:10 a.m.
CHAIR: Peter Brodie

1 5-26-2021 - SEMAC
2 (On the record 9:10 a.m.)
3 CHAIRMAN DOYNOW: I'd like to welcome
4 everyone back. I'm hoping that maybe in the fall we
5 can have an in person meeting but that is yet to be
6 seen. So I would like to also welcome Joshua Lynch
7 and Tiffany Bombard who are new members of SEMAC.
8 Welcome. If we can pledge allegiance to the flag and
9 then we'll have the roll call.
10 I pledge allegiance to the flag of the
11 United States of America. And to the republic, for
12 which it stands, one nation, under God, indivisible,
13 with liberty and justice for all.
14 Okay. Thank you all. Val, if we can
15 have the -- the roll call. And if I could also
16 mention if you are going to speak could you please
17 just state your name prior to speaking so our -- our
18 squad actually write down who's speaking? Val?
19 SECRETARY OZGA: Good morning
20 everyone. Dr. Alexandrou?
21 DR. ALEXANDROU: Alexandrou present.
22 SECRETARY OZGA: Dr. Bart?
23 DR. BART: Good morning. Present.
24 SECRETARY OZGA: Dr. Berkowitz?
25 DR. BERKOWITZ: Present.

1 5-26-2021 - SEMAC
2 SECRETARY OZGA: Dr. Berry?
3 DR. BERRY: Present.
4 SECRETARY OZGA: Dr. Bombard?
5 DR. BOMBARD: Present, Tiffany.
6 SECRETARY OZGA: Okay. Good. Dr.
7 Cooper has informed me he'll be a little bit late.
8 Dr. Cushman?
9 DR. CUSHMAN: Cushman present.
10 SECRETARY OZGA: Dr. Dailey?
11 DR. DAILEY: Dailey present.
12 SECRETARY OZGA: Dr. Davidoff? Dr.
13 Davidoff? I know -- I'll put him at -- in attendance
14 because I know he's there.
15 UNIDENTIFIED SPEAKER: He went for
16 Bourbon.
17 SECRETARY OZGA: Dr. Detraglia?
18 Attendees, make sure you take yourself off mute when
19 you need to speak. Dr. Detraglia, are you there?
20 Dr. Doynow?
21 CHAIRMAN DOYNOW: Doynow here.
22 SECRETARY OZGA: Dr. Gomez? All
23 right. Dr. Gomez -- we know Dr. Gomez is here under
24 the attendees -- over to Dr. Kugler?
25 DR. KUGLER: Dr. Kugler present. Dr.

1 5-26-2021 - SEMAC
2 Kugler is present.
3 SECRETARY OZGA: Dr. Lynch?
4 DR. KUGLER: Josh Lynch is here.
5 SECRETARY OZGA: No problem. Dr.
6 Markowitz?
7 DR. MARKOWITZ: Dr. Markowitz present.
8 SECRETARY OZGA: Dr. Maynard?
9 DR. MAYNARD: Dr. Maynard is present.
10 SECRETARY OZGA: Dr. Marshall?
11 DR. MARSHALL: Dr. Marshall present
12 SECRETARY OZGA: Dr. Murphy? Dr.
13 Olsson?
14 DR. OLSSON: Olsson here.
15 SECRETARY OZGA: Dr. Pickett? Dr.
16 Walters?
17 DR. WALTERS: Dr. Walters is here.
18 I'm working on a little video technical issue but I'm
19 here.
20 SECRETARY OZGA: Okay. Dr.
21 Wicelinski?
22 DR. WICELINSKI: Wicelinski present.
23 SECRETARY OZGA: Okay. We meet
24 quorum.
25 CHAIRMAN DOYNOW: Okay. Thank you,

1 5-26-2021 - SEMAC
2 Val. Appreciate that. Can we have approval of the
3 minutes from January 13th?
4 DR. MARSHALL: So moved.
5 CHAIRMAN DOYNOW: Is that Dr.
6 Marshall? Have a second?
7 DR. KUGLER: Second.
8 CHAIRMAN DOYNOW: Excellent. Thank
9 you. Minutes have been approved. Ryan, you're up
10 for the bureau staff report. Very quick.
11 DIRECTOR GREENBERG: Morning. So
12 bureau staff report. A whole lot going on. Probably
13 the biggest thing I can say here and I think this
14 group would understand a little bit is COVID is over
15 so shouldn't we have plenty of time left? COVID has
16 not ended for the Department of Health or for any of
17 us really. We still have about seventy percent of
18 our staff out on COVID related assignments,
19 everything from -- sorry Peter is giving me hand
20 signals to ... here ...
21 We still have about seventy percent of
22 our staff that are assigned to COVID related
23 activities so vaccination sites, testing sites, other
24 things that are going on in the Department of Health.
25 So please be patient with us. Lots going on.

1 5-26-2021 - SEMAC
2 Obviously they are different activities than they
3 were before but they are still things that are taking
4 up a lot of our staff hours most of the day.
5 In addition to that one, from the
6 administration side and on -- on that there's -- they
7 are processing a lot of invoices including our
8 program agencies, our REMACs, our REMSCOs. And
9 processing those too however keeping in mind they are
10 also there with about four times the amount of
11 contracts and invoices related to COVID functions.
12 So please be patient with that one. But if you have
13 any questions on anything you haven't heard from us,
14 you're concerned about that, payments that haven't
15 been processed, please feel free to reach out to
16 myself or Lynn [phonetic spelling] so that we can
17 look into it.
18 So on the excited front and, you know,
19 and especially in the world, the middle of a pandemic
20 is we are excited about the world of community
21 paramedicine. I bring this up because it's Policy
22 Statement Twenty o one that is up on our -- our
23 website. And community -- policy statement twenty
24 one relates to community paramedicine and programing.
25 So community paramedicine is permitted through an

1 5-26-2021 - SEMAC
2 executive order that is in place, and it really
3 became a push over the last five months, since our
4 last meeting, because of the vaccination efforts.
5 So our community paramedicine where
6 before we in the state we kind of had three or four
7 E.M.S. agencies that -- that didn't have a physical
8 community paramedicine program but it kind of
9 borderline did. All now that have very official
10 community paramedicine programs. More importantly,
11 we have just under fifty community paramedicine
12 programs statewide. So fifty community paramedicine
13 agencies covering forty counties. The ultimate goal
14 is to get to at least one community paramedicine
15 agency per county to help with the effort.
16 So those community paramedicine
17 agencies have been doing a lot. Things from testing
18 to vaccination and -- and other functions. There was
19 a question yesterday that came up during the
20 committees and saying can community paramedicine
21 programs only do vaccinations and testing? They can.
22 They are restricted to COVID related functions.
23 That's a pretty broad one and we do have many of our
24 agencies that are -- do many different things
25 although I will say the bulk of our community

1 5-26-2021 - SEMAC
2 paramedicine agencies right now are doing or became
3 community paramedicine agencies to vaccinate their
4 community.
5 And the other interesting part about
6 the community paramedicine is we did geographically
7 you become a community paramedicine agency by county
8 not by specific region, and we did that very
9 intentionally so that you can partner with your local
10 health departments or with your county administration
11 and be able ... So excited on that one but though
12 please keep in mind the community paramedicine will
13 only be in place as long as the executive order is in
14 place that permits it. Thank you.
15 On the operations front, Operation
16 Policy Statement Twenty o -- twenty-one of two is out
17 which is related to Ebola. And this is one of the
18 situations to where just a couple weeks ago we were
19 in a situation in other parts of the world where they
20 did not know the pathway of where the Ebola outbreak
21 was going, and so out of caution we did put back up
22 policy statement twenty o two. Or not back up but
23 additional guidance on Ebola. So please take a
24 chance to take a look at that one. If you do have
25 any additional questions on it please let us know. I

1 5-26-2021 - SEMAC
2 do believe later in this meeting there will be some
3 discussion on SEMAC advisory related to both that
4 guidance and just Ebola in general.
5 On the education front there is a lot
6 going on. They are staying very busy. When we talk
7 about that thirty percent that is actually in the
8 office that is primarily from our education section,
9 and that is part because if they go anywhere we won't
10 have any providers left. So we make sure that they
11 help with this front. So the C.M.E. program
12 continues to expand. Our testing program with P.S.I.
13 continues to ... quite nicely with much fewer
14 problems than before.
15 It is, you know, some people will try
16 and say well the P.S.I. isn't working, the computer
17 base isn't working here and there. And they say we
18 never had these problems with, you know, with paper.
19 If you were in our office on a Thursday night of ...
20 it's about similar to what we faced with those
21 problems. You know, people not having a SIM card or
22 something similar. We're seeing about the same
23 problems ... We expect that a certain amount on your
24 testing upwards of twenty to thirty thousand
25 providers a year that, you know, you're going to have

1 5-26-2021 - SEMAC
2 some pick-ups along the way. So bear with us with
3 that one although it does seem to be going really
4 well.
5 Policy Statement Twenty-one o three
6 which is related to education standards is up on our
7 website as well. This goes into a number of
8 different things. Goes into core sponsor extension.
9 It goes into some different things on provider cards
10 and certifications. But the most important or
11 significant thing in there is it does start to show
12 our transition to national registry for the paramedic
13 exam. So all of in 2022 and transition during 2021,
14 all initial paramedic -- initial paramedic
15 certifications will require you to take the national
16 registry exam and the national registry P.S.C. ...
17 So we have put in place over the last
18 two years national registry proctors to P.S.C. I was
19 actually out last week or two weeks ago for a P.S.C.
20 exam. There's about six internal and probably
21 another ten external to the bureau who can proctor
22 exams. So thank you to all of our proctors who has
23 helped us with this transition. And we go out and
24 proctor the paramedic exams.
25 Now the two questions that I have

1 5-26-2021 - SEMAC
2 gotten is what happens with the bridge program and
3 what happens if this program is not accredited. So
4 we also in that policy statement talk about paramedic
5 programs having to be accredited or in the
6 accreditation process as of 2022. So keep that one
7 in mind. And once you're in the accreditation
8 process, whether or not you're accredited or not, you
9 do become eligible for ...
10 So with that understanding we are
11 moving toward that direction for our paramedic exams.
12 We are -- give the option for D.O.S. exams to either
13 do that or not. Either take national or take the
14 state exam but it's an optional choice on which they
15 want to do.
16 We have education day coming up in
17 June. The exact date now of our education day is
18 June 11th. It is eight hours of educator education
19 so if you have any of your core sponsors or
20 instructors or C.L.I.s or C.S.E.s still looking for
21 education this is eight -- eight hour virtual day
22 that's happening on June 11th.
23 SECRETARY OZGA: The 18th is the
24 leadership ...
25 DIRECTOR GREENBERG: Yes. But

1 5-26-2021 - SEMAC
2 education is June 11th. And so that's going on
3 there. In the data world, Policy Statement Twenty
4 one o four, yes we've been busy on policy statements.
5 In the data world, policy statement twenty-one o four
6 talks about our transition of how we're going to
7 accept paper P.C.R.s. They no longer will be
8 accepted by mail into our program agencies. They
9 will only be accepted via the electronic portal or
10 transitioning to an E.P.C.R. platform so that's
11 what's going on in the data world.
12 And we are continuing to increase (and
13 looking over a ... We are considering the increase
14 in number of agencies that we have going electronic
15 pretty significantly in a pretty productive pace so
16 thank you to all those that are moving in that
17 direction whether it be through the free platform on
18 the state or a paid platform in they choose.
19 E.M.S.C. is progressing along. Amy
20 Eisenhauer is doing a phenomenal job as well as Donna
21 and Alesha from our southern tier who helps us with
22 our ... program. Really just again continuing to
23 expand ... still more opportunities. And most
24 recently we started being back out in the community
25 in our road tour. Amy was able to get out to one of

1 5-26-2021 - SEMAC
2 the local conferences here and bring that -- all the
3 pediatric transport devices. And so it's one of the
4 programs that we have. We actually have a box for
5 each region where you can go and try all the
6 different pediatric transport devices and -- and as a
7 provider know how to use them. So that is one of the
8 programs that we're doing.
9 I will also say that the -- it's
10 E.M.S. week this week. I went out and one of the
11 things I do on E.M.S. week is I go out on an
12 overnight. I went out on an overnight and it was
13 about one o'clock in the morning. I'm at one of the
14 hospital E.R.s and talking to a bunch of crews and
15 another ambulance comes in and they bring in a
16 probably two-month-old baby. And I watch them go in.
17 When they come back out I -- hey, can I talk to you
18 for a few minutes? Said sure, absolutely.
19 I said I saw that you carried out a
20 little baby. And they said yeah. Baby needed to
21 come to the hospital. ... How did the baby get to
22 the hospital and they said on the stretcher. Okay.
23 On the stretcher holding someone, on the stretcher
24 device? No, they put him in the device. It straps
25 to the stretcher, we put the baby in the device. And

1 5-26-2021 - SEMAC
2 I will tell you it absolutely -- it absolutely just -
3 - it was great. It was a great feeling. It was good
4 to know that not only did they have the device but
5 they used the device.
6 So a shout out to ... for that one.
7 Who's the one who brought them in and I think it was
8 W thirty-eight who was the -- the crew member. But I
9 will tell you I thought for sure based on them
10 walking out with the baby that we were going to get
11 the -- the parent held them. And it wasn't. So
12 we're starting to transition to that. So as medical
13 directors, please, please, please, ask your agency
14 how they would transport that baby. If they were in
15 a similar situation and it's a stable baby that
16 needed to go to the E.R., you know, and how would
17 they handle that. So thank you for that one. And it
18 shows, you know, these initiatives are making a
19 difference.
20 Trauma world is going well. We're
21 doing a lot of virtual visits right now and Steve ...
22 is working on that one and is participating in those.
23 And most importantly in the trauma world was there --
24 their needs assessment committee which created a
25 joint chair committee of all of our councils from the

1 5-26-2021 - SEMAC
2 bureau. So E.M.S.C., SEMAC, SEMSCO and trauma, and
3 they met and had a -- a really positive meeting
4 recently.
5 In part the -- one of the biggest
6 things that came out of that meeting was working on
7 helping to define some of the capabilities around our
8 state in the areas that need more capability. So,
9 you know, access to trauma services. Access to
10 E.M.S. services. Access to different things from
11 each of our chair perspectives. And so there's
12 definitely going to be on the ... we look into that
13 and move that forward. But we're excited to, you
14 know, have that collaboration ... come together.
15 Vital signs, a lot going on in vital
16 signs. We're doing about three C.M.E.s a week. The
17 hotels are open for all those who are joining us at
18 the vital signs conference and we are excited that it
19 is in person this year. We'll actually be a hybrid
20 ... it will be a hybrid in part because we only have
21 about four hundred spots that we'll be able to ... as
22 of today ... you know, regulations only about four
23 hundred spots keeping in mind we normally have about
24 fifteen hundred people at the conference. So if
25 you're planning on attending, plan on sign up early

1 5-26-2021 - SEMAC
2 and hopefully as time goes on we'll be able to open
3 up more -- more space at the conference.
4 We spoke about the education day.
5 There's also a leadership day. So if your agency ...
6 And we'll be working on that one for our leadership
7 day. It is a number of different topics geared
8 towards the new supervisor. Our E.M.S. weekly calls
9 continue to go on. Bi -- they go on biweekly now.
10 Anybody can join so if you have any of your agency
11 leadership that would like to join please attend
12 that. ... Or please let them know on that side.
13 And a couple of other smaller stuff.
14 In your SEMAC councils you will see instructions on
15 how to sign up for A.T.S. accounts. That will be
16 going out -- will become a web page on our website
17 and it is in part because we have new -- I don't know
18 if you can see or not E.M.C. certifications. So new
19 E.M.C. certifications are going out or will be going
20 out in June. There are cards that look like this. A
21 whole bunch of information on the back.
22 There's a ... on the front that is for
23 validating the actual certification directly through
24 our database. These are the instructions that will
25 be going out on our website. So a combination of

1 5-26-2021 - SEMAC
2 everything together. In the near future probably
3 over the summer at some point, these cards will also
4 be available as a digital version on the health
5 commerce account so an individual will be able to go,
6 download their digital version of their new E.M.T.
7 card. And be able to progress from there.
8 And then the other important part was
9 ... and we have a card that can even get through the
10 wash at least once, and so we achieved that one.
11 We're going to let that one sit for a while. This
12 sounds like a crazy thing but this was like a top
13 priority on the one listening with a card that can go
14 through the wash at least once and we've managed to
15 achieve that.
16 Two last things that I have is another
17 page that will be going up on our website to share it
18 with everybody on Boardable is the balance of mental
19 health and wellbeing for E.M.S. providers. This is a
20 really important topic for us in mental health and
21 ... as medical directors we hope for you as well.
22 But there is a new web page that we are putting on to
23 our website related to mental health. It has a
24 number of resources and contacts on it specifically
25 targeted for E.M.S. providers to be able to get help.

1 5-26-2021 - SEMAC
2 It also has programs on there that
3 agencies can start to make sure that the health and
4 wellbeing and that there's balance that their members
5 recognizes is a major thing for our providers. And
6 we want to make sure that they're safe and balanced
7 and, you know, if they do need help they have
8 reasonable access to or a good place to find where
9 they can find care. So that's all on that.
10 The last thing that I have on this one
11 is particularly for our -- our medical directors ...
12 we are excited to announce a new protocol act. And
13 so our new protocol act is in partnership with Muru
14 and has been launched I think during E.M.S. week. It
15 launched last week, the beginning of last week and we
16 are very excited about this one. And I think, Don,
17 are we doing that presentation now or we doing it
18 later as new business?
19 CHAIRMAN DOYNOW: We can do it now.
20 That's fine.
21 DIRECTOR GREENBERG: Okay. Is Steve
22 on?
23 MR. BLOCKER: Yes, I'm right here.
24 DIRECTOR GREENBERG: There we go. All
25 right. Excellent. So, Steve, we are going to turn

1 5-26-2021 - SEMAC
2 presenter over to you. Steve Blocker is the C.E.O.
3 of Muru who is our partner on this project and he is
4 going to give a brief less than ten minute
5 presentation. Actually I think it's only four
6 slides. So keep in mind this is very high level
7 presentation just to give situational awareness. And
8 then Muru will be ... the REMSCOs and the REMACs and
9 can do a longer presentation there. This is really
10 more just a high level situation awareness so you
11 understand a little bit about ...
12 We have gotten some good feedback
13 about it including can we make this app available for
14 medical directors or medical control physicians. It
15 is something that we are -- if it hasn't happened
16 already ... for assessments too. If people have
17 comments, suggestions, input, please make sure to
18 send that to both Steve Blocker or myself so that we
19 can hear them and work towards it -- with that.
20 Steve, you should be presenter now and you should be
21 able to bring it up on your screen.
22 MR. BLOCKER: Okay. Great. Can you
23 guys see me? And can you see the present --
24 presentation okay?
25 MR. BLOCKER: Okay. Great. Hi, my

1 5-26-2021 - SEMAC
2 name is Steven Blocker. I'm the -- as Ryan, Dr.
3 Greenberg -- Director Greenberg said I'm the C.E.O.
4 of Muru. So to get started, what we deal with is
5 taking protocols and making them far more digital
6 than they have been in the past, right. As a
7 paramedic myself, protocols up till now have been
8 taken from paper and made into digital paper. And
9 while digital paper is great, digital paper is just
10 not really coding it into a system to allow software
11 to fully utilize it and give as much power as we can
12 to something.
13 So what do we do and why is this
14 problem important? For one, digital -- by digitizing
15 something we avoid three major problems we have and
16 we'll just take P.D.F.s. But when you say paper make
17 them P.D.F.s. One, is right now as P.D.F.s alone the
18 information is scattered, right. Getting things from
19 the county or from the state, a medical manufacturer
20 information, hospitals, all that information is filed
21 in different places.
22 Two, is that when you use protocols,
23 we have to make it patient -- patient agnostic,
24 right, meaning that when we actually get to that
25 patient we have to do things like this in

1 5-26-2021 - SEMAC
2 calculations. And the same thing goes from the
3 provider's side where you have to take a document, a
4 protocol set or anything else and write it for every
5 single level of provider that may read it. But with
6 us we don't. We are able to solve that.
7 What Muru does is really two sides of
8 the coin. On the first side we make an app that
9 combines everything into one location. And then on
10 the opposite side now that it's all in one location
11 where the providers can find anything that they need,
12 we then make it really easy and fast for them to
13 access that information.
14 For example, we take ... hospital have
15 their own hospital page as well as a way to find the
16 correct hospital that you may be looking for. Same
17 thing with protocols coming from both the regions and
18 the state level. Combine them properly based on the
19 organization that they're in. Each organization can
20 enter the equipment they have and the manufacturer's
21 manuals and any of the manufacturer's recommendations
22 are downloaded into the app as well.
23 And same thing with medications where
24 they can look at meds and see everywhere the med is
25 used in pediatric and adult protocols. They can see

1 5-26-2021 - SEMAC
2 all the doses of it everywhere and if and when the
3 state ever decides to implement a formulary again,
4 that information will be there as well.
5 On the other side for rapid access,
6 anything that they ask for and anything that they
7 look up is customized to bear certification level.
8 So trying to attempt to do a paramedic dose and
9 you're an E.M.T. simply will not work. And same
10 thing for finding equipment or medications or
11 anything else in the system that you want, right.
12 You don't have to browse through every county to see
13 their specific things but only the county that you
14 applied to and only the state items that are
15 applicable to you as well.
16 So from there a few other pieces of
17 technology that we have integrated in. One is that
18 the app works -- works entirely offline no matter
19 when you're using it or how you're using it, the
20 phone can work completely independently. That gives
21 us both the reliability and speed that you want no
22 matter what your Internet connection is or what your
23 Wi-Fi is. It does not matter. The phone does
24 everything independently. As we talked about, it's
25 already individually personalized.

1 5-26-2021 - SEMAC
2 The app only pulls together sources
3 from officially trusted documents meaning that there
4 is nothing being pulled into this from the web in
5 general. Everything is vetted and brought in from
6 official sources only and those sources are always
7 viewable inside the app on any page that you're on.
8 You can always see a direct copy of the original
9 P.D.F. where we pulled that information from.
10 If there is a change and the phone is
11 connected to the Internet that phone, that provider
12 will then get the direct push notification of that
13 change meaning that anything that happens, state,
14 county, hospital wide that applies to that provider
15 they'll immediately know about that change. And then
16 last but not least ... and other pieces like that, we
17 make it very easy with minimal training T.C.I. ...
18 meaning that they can just get right into the
19 application, ask any question they want. It doesn't
20 matter how they ask it. All the information we
21 understand medic and understood the jargon and lingo
22 and it will immediately answer the question for them.
23 Specifically looking at it from the
24 D.O.H. side this provides some really key benefits.
25 Right. One is now if there's a protocol change that

1 5-26-2021 - SEMAC
2 needs to happen whether quickly or not, the reach is
3 unlimited, right, as many providers as the state has
4 or the region has immediately can -- the app can
5 handle all of it. And anything that changes that
6 will instantaneously up -- be updated. A new
7 protocol comes out, a new advisory, anything. If it
8 is urgent they will get a notification directly on
9 their phone saying hey you need to read this right
10 away.
11 We keyed everyone included so whether
12 it from the hospital to the regions, to the state,
13 everyone is allowed to customize and maintain their
14 content on our platform. We are actively doing it
15 ourselves but, again, any issues or anything that you
16 would like tweaked we're happy to do. With all of
17 this said, there's really minimal work on the county
18 or state side, right. Our full time team of
19 paramedics and engineers are working twenty-four
20 seven on making sure that everything is in there and
21 available to you.
22 So we will be attending meetings.
23 We're checking everyone's websites. We're going and
24 pulling manufacturer's recommendations. That's all
25 being done without any additional burden on the

1 5-26-2021 - SEMAC
2 state. And with our design there's really no on
3 loading. So the general provider can pick up the
4 app. We've been seeing this across the thousands of
5 providers that signed up last week alone and are
6 immediately starting to use it and immediately
7 starting to understand how to use it.
8 Any training that we want we can
9 integrate into the app but there is no need to have
10 every provider go to a training or class and to be
11 able to understand how to use Muru. ... So that was
12 the notifications and this is what a hospital ...
13 looks like.
14 With that we do have three versions of
15 the app out there. The state partnership allows
16 everything to be in one location as well as allow it
17 to be all offline and make notifications of any
18 changes in the system. There are certain other key
19 features that we have available like an automatic
20 dosing calculator and natural language search which
21 the individual or the agency can get at a price that
22 would be on our website.
23 And with that for the purpose of
24 COVID, we've made all these things free and have for
25 a very long time now even before the state

1 5-26-2021 - SEMAC
2 partnership. Towards the end of COVID when it starts
3 winding down at the end of the year, agencies and
4 individuals will then be able to purchase the
5 additional features of Muru if they choose. If not
6 the state partnership is included there. And then
7 there's additional advantages for the agency as well
8 like notification compliance and insights on where
9 training should be focused.
10 And that's it. You can really get
11 Muru now anywhere in the state completely available.
12 Just go to Murumed.com. Sign up free. It walks you
13 through several questions about identifying which
14 agency you are, your level of credential, things like
15 that. And once that done -- once that's done you can
16 download the app and get right up and running. So
17 I'm happy to answer any questions anyone has.
18 CHAIRMAN DOYNOW: Does anybody have
19 any questions for Steve?
20 DR. DAVIDOFF: Hi. Davidoff. I'd
21 asked a question yesterday but since we've got you
22 here now is there any way of incorporating the med
23 control phone numbers for each of the hospitals along
24 with a dial capability from the app to make it easier
25 on our providers?

1 5-26-2021 - SEMAC
2 MR. BLOCKER: Sure, yes. So we
3 actually have a button for every single hospital when
4 you look up that hospital name. That is the primary
5 phone number that that hospital or that region would
6 like them to call. In addition -- so right away when
7 you can look up any hospital by nickname even it will
8 show right there as a big button, call immediately.
9 On top of that we have a directory of
10 state numbers and county numbers that each region
11 puts in that is available to all providers in that
12 region as well. So that could be anything from any
13 additional hospital, medical control numbers you'd
14 like all the way through things like child protective
15 services.
16 DR. DAVIDOFF: What's the number
17 that's listed were main numbers to the hospitals not
18 med control numbers? How is it --
19 MR. BLOCKER: Yeah, so --.
20 DR. DAVIDOFF: -- best to contact and
21 make those changes?
22 MR. BLOCKER: Yes. So we're directly
23 reaching out to each county through the bureau but
24 we're going to be going to each county and the
25 regions to allow them to work with that and hopefully

1 5-26-2021 - SEMAC
2 each region will put us directly in touch with the
3 E.D. director. Can give us any additional phone
4 numbers from there.
5 According -- with our agreement with
6 the bureau we didn't want to put out any information
7 without the direct authority of the hospital or the
8 region's approval or the bureau's approval, so we
9 need just approval to input those numbers and we're
10 happy to put in anything that they need.
11 MR. PHILLIPPY: Steven, Mark
12 Phillippy. Thank you very much. Just for the number
13 of the SEMAC here, Steven's been very responsive.
14 We've had some great interactions both by e-mail and
15 Steven did a presentation on this material for me and
16 I really appreciate that. We found out very early on
17 that there were a couple of small issues with agency
18 identification which I think we've rectified at least
19 in -- in one -- one instance. So if any of your
20 agency staff or employees are having difficulty
21 finding your agency that might be because they're
22 using the -- the state licensing name for that. So I
23 know that's part of what Steven was looking at.
24 I did notice that there was a hospital
25 in my region missing. Completely not in the

1 5-26-2021 - SEMAC
2 directory. And one of my providers brought up the
3 idea that having a hundred and ninety-nine hospitals
4 on the list is very nice but we really need to know
5 what's in our region and what our regional
6 capabilities are at a glance. Not -- not to
7 disparage any particular category but knowing which
8 hospital is an ... hospital in my region is probably
9 not as important as knowing which level one trauma
10 center is nearby.
11 Is there a way to sort that
12 information so that the stuff that we need that is
13 part of our immediate care ... such as stroke
14 centers, P.C.I. capable facilities so when stuff of
15 that sort is top list and we can sort that for our
16 providers in a real time way?
17 MR. BLOCKER: Yes, sure. So I'll just
18 to touch on both points. So one is when every agency
19 in the system was put in with their -- with the list
20 that we had from the state's website which was
21 certificate of need names, so we've been actively
22 working through any agencies that have switched
23 names, have been combined together or anything like
24 that to help people find issues. We have a live help
25 chat in the app and so thirty percent of all requests

1 5-26-2021 - SEMAC
2 for help have been about finding that so far. So if
3 anyone has any issues with that, we are actively
4 working through them. We're down to zero issues
5 right now but I'm sure as it grows we'll go from
6 there.
7 For the hospital information, if there
8 is a hospital missing just let me know right away.
9 We will absolutely rectify that. The way you look
10 through hospitals in the system is twofold. Either
11 you can simply search for any hospital, naming any
12 capability you want. So you could say adult trauma
13 or pediatric trauma one and it will immediately pull
14 up the closest ones to you. But then in browse it is
15 not just the nearest hospitals button. When you go
16 to hospitals in browse it pulls up a list of all
17 capabilities as per the state. And in New York City
18 as per New York City. And you can immediately pick
19 the capability type you want and it will only show
20 you those hospitals sorted by G.P.S. distance from
21 the phone. But we will -- as soon as we get off this
22 call I will take care of that one other hospital ...
23 right away.
24 CHAIRMAN DOYNOW: Anybody else with
25 any other questions?

1 5-26-2021 - SEMAC
2 DR. BART: Yeah, I have one. Steven,
3 Joe Bart from western New York.
4 MR. BLOCKER: Hi. How are you?
5 DR. BART: Hi. Good thanks.
6 Appreciate you coming on and telling us more about
7 the application. You mentioned a few times about
8 feedback and obviously when you have a new app in its
9 development it's going to -- you know, and you work
10 out your bugs through feedback of course. But as
11 providers give you feedback on behalf of the
12 application or even the protocols that are there, I
13 just want to make sure that there's some sort of stop
14 gap plan in between.
15 We often have protocols and protocol
16 changes that are suggested from the provider level
17 that are -- that are very good. But ultimately they
18 have to go through the right channels to make sure
19 that they are vetted and approved and ultimately
20 actually this body would go through that approval
21 process to ensure that any protocol suggestions or
22 change in medical management is approved through us
23 before you make those functional changes. And I'm
24 just wondering how you're handling that for your --
25 your feedback part.

1 5-26-2021 - SEMAC
2 MR. BLOCKER: Yeah, sure. Sure. I'll
3 -- that will be very clear. There is nothing that
4 changes in this -- in this system as far as a
5 protocol goes without direct approval from the
6 bureau. It is not even -- there is not an option for
7 that in any way, shape or form. We spent an
8 inordinate amount of time making sure that
9 permissions on changes are very, very clear. And
10 although an agency individually can change out the
11 inventory that they use, right, I'm just saying this
12 concentration of Fentanyl instead of that or this
13 piece of equipment instead of that, there is no such
14 thing as changing out a protocol without direct
15 approval from the bureau.
16 We are tracking things from REMAC and
17 REMSCO meetings as they make their way up to the
18 state so that we are ready to immediately publish
19 them as soon as they get approval from the state.
20 But nothing ever gets updated as a protocol piece
21 without your body directly approving it. It will
22 never ...
23 DR. BART: Yeah, no, I -- I appreciate
24 that. I appreciate you saying it out loud and I
25 decided I wanted to make sure that that was

1 5-26-2021 - SEMAC
2 addressed.
3 MR. BLOCKER: I want to be a hundred
4 percent clear. That is not even a possibility.
5 DR. BART: Appreciate that. One of
6 the things you mentioned as far as, you know,
7 understanding the different platforms that are
8 available. And you said in COVID-19 everything's
9 kind of opened up wide for the time being. I'm
10 assuming at some point this will hide behind the pay
11 wall and in particular with some of the dosing
12 calculations and the calculators that are out there.
13 Pediatric patients comes to mind right
14 away with -- with the suggestion that having that as
15 part of the free or sponsor type from the state makes
16 most sense medically because that's where we have
17 their biggest potential for medical errors. Some of
18 the other add on features when it comes to patient
19 care delivery, yeah, okay, I mean, this is a business
20 perspective from where -- where things will hide
21 behind the pay wall ... -- or not hide behind the pay
22 wall ... but, you know, that's where they're
23 available for upgraded features.
24 But certainly suggestive of what is
25 the best medical management in tight situations like

1 5-26-2021 - SEMAC
2 that. Pediatric dose calculations make sense to me
3 but that probably should be included as a free item.
4 MR. BLOCKER: Yes. So although our
5 arrangement with the state is -- we are trying to
6 provide as much as we can to every provider in the
7 state with minimal financing going into that. We
8 have kept me what I believe the price to be
9 incredibly low and we're happy to work with each
10 region of the state and any sort of subsidy they
11 would like to do on that pricing.
12 We've actually been talking to several
13 regions about it as well as the state, so the dosing
14 calculator is an incredibly complex piece. It is not
15 just a standard calculator. It looks at your
16 protocol set, your certification, identifies the
17 right dose then looks at the inventory from your
18 organization to figure out the concentration of
19 medication your carrying. Applies the weight based
20 calculation to that and delivers your final answer
21 all completely offline.
22 It is an incredibly expensive part of
23 the app to build. It is many, many -- I cannot even
24 tell you how long it actually took. So we do need to
25 -- it is a very specific part but we're happy to work

1 5-26-2021 - SEMAC
2 with you guys at reducing the price as much as we can
3 to the provider level. So however that would work.
4 DR. BART: In a -- in a region or, I
5 mean, that's certainly a program agency. But a
6 region or a system or an agency make that purchase on
7 behalf of their providers?
8 MR. BLOCKER: Yes. So our goal is not
9 to ever -- our -- although the provider can't
10 individually purchase this our goal is to have
11 agencies providing it for their providers. As a
12 matter of fact when an agency purchases it for all
13 their providers they get significantly more features
14 and insight on training, Q.A., compliance than they
15 would if the individual purchased it. So our goal is
16 to hope that agencies or regions purchase the product
17 for their individuals.
18 We really -- it is a only if no other
19 available option is available do we expect the
20 provider to pay for it themselves, but we do not want
21 the provider to set out for it because their agency
22 did not provide it to them.
23 DR. BART: Yeah, I -- no, I understand
24 it. But, again, I don't think this won't be as much
25 for you as I might lean back a little bit on what

1 5-26-2021 - SEMAC
2 Ryan and Steve had said yesterday. The transition
3 away from the idea of the sponsorship of the current
4 collaborative protocol app with the transition on
5 this one, we -- we all agree there should be a single
6 stop. But when the single stop involves, you know,
7 additional payment on behalf of that, we always had a
8 bit of trepidation here when it comes to budgets.
9 Maybe an idea of adding that on.
10 So if -- if the example provided is
11 that we want to move on to this because it's better
12 technology and I think we all agree, having steps in
13 there where certain features might not be available
14 if somebody doesn't feel they have the funds to do
15 that. But it's the state's preferred method and
16 there is no other option, I'm going to challenge the
17 state back to maybe find a way to help those agencies
18 to pay for some of the additional. So this is not as
19 much for you, Steven. I appreciate ...
20 MR. BLOCKER: Yes, my pleasure.
21 DR. BOMBARD: Agreed, Joe. That's --
22 that dosing calculations are paramount and, Ryan, we
23 need to talk about them. Steven doesn't need to be
24 involved in that conversation. But, Ryan, you do.
25 We can't really have an app that is going out to

1 5-26-2021 - SEMAC
2 people without a search option. And more importantly
3 without a dosage calculator that then the price falls
4 to the individual provider or an E.M.S. agency
5 because you know they're not going to all pay for it.
6 And you know we're going to have errors and that's on
7 our heads. So that's not okay. We got to figure out
8 how to pay for this.
9 DIRECTOR GREENBERG: Sure. I'm happy
10 to have some more conversations about that and look
11 at other options. I would think that the -- I'm
12 happy to have more conversations about that and I
13 would think that maybe we bring that to one of the
14 committees to further discuss or take it offline and
15 happy to talk to people on that one as well.
16 DR. BART: Steven, thank you for
17 answering questions. Appreciate you.
18 MR. BLOCKER: No problem. Just to let
19 you know we're -- we're, you know, we're actively
20 working. The -- the bureau has been more than open
21 to -- to working with us on making sure that the top
22 quality ... gets to all the providers, so. I'm sure
23 we'll have to ... conversations ...
24 MR. PHILLIPPY: ... Are there any
25 other questions anybody has for Steve at this point?

1 5-26-2021 - SEMAC
2 DIRECTOR GREENBERG: So I know there
3 are -- I know there are a number of chat questions
4 that have come in. And so John is taking a look to
5 those right now. Some of them we're going to be able
6 to answer in the chat just in the essence of time.
7 And then maybe what we'll do is circle back to him at
8 the end if anyone if that there's time ... That
9 work?
10 CHAIRMAN DOYNOW: That -- that sounds
11 fine.
12 MS. GOMEZ: Okay.
13 CHAIRMAN DOYNOW: Just to avoid
14 confusion, Ryan or -- or Dr. Dailey since you're the
15 keeper of the collaborative app, what's our time
16 frame to be switching over from the current
17 collaborative app to this app?
18 DR. DAILEY: Well, there's no such
19 thing as switching over here, Don. I think it's a
20 question of when Steve's app is up and running, which
21 it is. Providers will start to use that and you'll
22 see folks gradually employ that within their --
23 within their practice. Steve and I have had a couple
24 long discussions and he's been extremely responsive
25 to -- to things that I've brought to him.

1 5-26-2021 - SEMAC
2 One thing in particular that I'm
3 looking forward to being engaged within the Muru app
4 is the -- the hyperlinks within the protocols because
5 that is something that we have had in our app two --
6 two generations ago. That would be the app that was
7 paid for by REMO and some donations and things. And
8 when it was last updated because we had some delays
9 in terms of approval, some of those hyperlinks did
10 not get -- get placed in appropriately.
11 And that's something that providers
12 have looked to and -- and been upset that they're not
13 there. So I'm looking forward to -- to Muru being
14 something that will be more responsive being able to
15 make these changes and hopefully will provide great
16 value added for the -- for our providers.
17 Along with that though, Don, I think
18 the other thing that I think is going to be important
19 or in particular med standards and education to look
20 at. That I certainly hope will not hide behind a pay
21 wall as we've spoken about it's just general
22 statistics. I think that this group, med standards
23 and the education committees all need to know how
24 many times each one of these apps is accessed so we
25 can look both at complex care situations that don't

1 5-26-2021 - SEMAC
2 get a lot of attention from providers, and which --
3 and which protocols appear to get the most reviews so
4 that we can tailor education to suit that.
5 MR. BLOCKER: So, Dr. Dailey, to
6 answer your question on that one, first I've been
7 loving our conversations as well and I'm glad you
8 like the pace working -- working with you. But too
9 we are absolutely working on a portal that will be
10 available to the bureau and to whatever the bureau
11 adds on to that to allow for greater insight. And as
12 we continue to grow the product we'll continue to
13 take feedback on what you want to see and actively
14 work on making sure that those who are writing
15 protocols understand how they're being digested. And
16 as far as switching over from one to the other, I
17 would say we're getting between average of seven
18 hundred -- at the low end one hundred, at the max
19 seven hundred per day of new providers adding on to
20 the ...
21 DIRECTOR GREENBERG: And I would just
22 add and then I really ... and welcome more questions.
23 But just don't want to take up too much time of the
24 SEMAC. Mike, when -- when you talk about a hyperlink
25 can you just explain to everybody an example of what

1 5-26-2021 - SEMAC
2 a hyperlink was for?
3 DR. DAILEY: Absolutely. You're in a
4 -- a protocol discussing sepsis, for example. And
5 you come to the norepinephrine dosing in the sepsis
6 protocol. You click on a link there and it takes you
7 to the dosing calculator and -- and information about
8 norepinephrine. Not formulary. It's actually in the
9 protocols now and it was something that we had built
10 in to the -- to the app.
11 DIRECTOR GREENBERG: Great. Thank
12 you.
13 CHAIRMAN DOYNOW: Thanks, Mike. Do we
14 have a particular sunset time when the requirement of
15 a protocol app will no longer be updated or should be
16 used basically? Another -- I know folks are picking
17 up Muru but we'll probably need a date when we
18 basically say ... protocol app is no longer something
19 that a provider should be accepting I would think.
20 DR. DAILEY: We'll discuss that
21 through the collaborative and then get that
22 information out to the regions so they're using the
23 app.
24 CHAIRMAN DOYNOW: Okay. Thanks, Mike.
25 Appreciate it. All right. Unless there's anything -

1 5-26-2021 - SEMAC
2 -.
3 DR. DAVIDOFF: It's Davidoff, can I
4 ask a question?
5 CHAIRMAN DOYNOW: Sure.
6 DR. DAVIDOFF: Davidoff for a
7 question. Steve, I notice you have a -- a ... on the
8 app or equipment and there's certain pieces of
9 equipment listed and the company's manufacturer.
10 Obviously it's not a complete listing of equipment
11 that we use. Maybe this needs to be discussed
12 offline and discuss the ethics of listing the
13 equipment and not -- not listing equipment. Have any
14 of those equipment manufacturers contributed to the
15 cost of this? If not could we go to them and ask
16 them to do something to pick up the cost that we're
17 ... additional costs to region or providers?
18 MR. BLOCKER: So I can answer the
19 first part of the question far better than the
20 second. So the first part of the question is we
21 don't -- we initially tried to do every piece of
22 equipment in the app when we were initially building
23 this out and testing it with fire departments locally
24 in the region I volunteer in. And what we found was
25 too much equipment was overwhelming and a lot of it

1 5-26-2021 - SEMAC
2 didn't provide much value, right. Putting in, you
3 know, an N.R.B. there wasn't really a manual or many
4 -- much manufacturer's recommendations on how to use
5 it. So we really stuck with equipment that we felt
6 was complex enough and sophisticated enough to meet
7 it. But we continually add more.
8 For example, viral filters at the
9 beginning of COVID we added for the several thousand
10 providers that were on our app towards the beginning
11 of COVID. And so we directly then looked for the
12 websites where those manufacturers post those
13 recommendations and then input that. So anything
14 public that is meant to be ... individual who
15 purchases the product we attempt to put in. And then
16 try and monitor those facilities to make sure that we
17 ... any updates.
18 We have yet to actually speak with
19 these manufacturers, but as our reach within New York
20 State grows, I believe those conversations will be
21 able to have more impact as we have a larger reach
22 and a better ability to help those manufacturers
23 reach the actual users of their product. So it's
24 definitely something on our agenda and on our list.
25 But to answer your first ask, you know, having

1 5-26-2021 - SEMAC
2 listening to every splint and every everything in the
3 system wasn't really useful but especially, you know,
4 pediatric pieces of equipment or anything else that
5 we would like we continued -- we will continue to add
6 more categories on and get those met, so.
7 DIRECTOR GREENBERG: All right. And I
8 want -- yeah, I just want to make sure that we move
9 on. If there's nothing ... Steve, thanks for
10 joining us. Steve Blocker I've been told I have to
11 make sure I say last names now because there's too
12 many Steve's. Steve Blocker, thank you so much for
13 joining us and, again, we will -- we're going to
14 share his contact information in the chat box so
15 anybody who does have additional questions can e-mail
16 him or ask those and then -- there's stuff that's now
17 there. And --.
18 MR. BLOCKER: I will also say that
19 anyone can also reach us through the live chat which
20 is both on the website and in the app where anyone in
21 the team will get to you right away.
22 CHAIRMAN DOYNOW: Okay. Appreciate
23 it. All right, guys, we really do need to move on.
24 We'll be running out of time here. We have to go
25 ahead to subcommittees. Dr. Marshall, if you would

1 5-26-2021 - SEMAC
2 Med Standards ...
3 DR. MARSHALL: Thanks, Dr. Doynow.
4 Good morning everyone. Medical standards met
5 yesterday morning and we bring forward just one item
6 of business that will require a vote. That one item
7 is the New York City unified protocols and these
8 protocols were sent out electronically and I would
9 like to take a minute to cover some of the -- the
10 changes. It didn't change all of the protocols but
11 some of the changes that were -- were sent forward.
12 A lot of the changes were formatting
13 protocols to better reflect or bring us in line with
14 the collaborative protocols. As was mentioned at a
15 previous meeting, the -- the names of the protocols
16 are the same, the medicine is the same. We also to
17 something that was brought up yesterday at our
18 meeting was in some of the other protocols it
19 mentions I.V. and does not say I.O. But in our
20 general operating procedure those two methods of
21 providing fluid are interchangeable.
22 In addition to that, several of the
23 protocols were changed to have weight based dosing to
24 -- for better patient safety. And with that there
25 are a few protocols that I would just like to mention

1 5-26-2021 - SEMAC
2 specifically. The V-fib, the tach protocol.
3 Lidocaine was added as an option. What's old is new
4 again. Under the dysrhythmia pediatric protocol,
5 which is actually new. It was previously under
6 septic shock so it was just moved to a separate
7 protocol. But the actual protocol did not change.
8 In terms of the respiratory distress
9 protocol, we did add nitroglycerin, I.V. bolus dosing
10 and there was some discussion yesterday about I.V.
11 nitroglycerin and the nitroglycerin glass vials or
12 bottles on and on services. And Ryan can correct me
13 if I'm mistaken but A.L.S. first response agencies
14 are allowed to carry the glass vials under the waiver
15 based upon the governor's executive order. Once the
16 waiver -- once that executive order expires, however,
17 so does the waiver. So I know the department is
18 working on that. Also I.V. nitroglycerin is not
19 specifically in the formulary although nitroglycerin
20 is.
21 The next one was the obstetric
22 protocol which was changed to allow the paramedic to
23 give magnesium sulfate under standing orders, and
24 this is similar to the seizure protocol where
25 magnesium sulfate can be administered. And then the

1 5-26-2021 - SEMAC
2 asthma protocol, this is new. We added ipratropium
3 bromide as an E.M.T. skill. And this is based upon
4 the national scope of practice which does allow
5 agency medical directors to allow use of this
6 medication so we've added that to the protocol.
7 Dexamethasone was also added to that
8 protocol, and dexamethasone is one of the
9 medications, alternative medications in the state
10 formulary. Overdose protocol was previously the
11 altered mental status protocol so that was changed.
12 Undifferentiated ... shock is new and it was under
13 general management before. Our stroke protocol was
14 brought current with the current guidelines for
15 L.D.L. General pain management was just an improved
16 organization of the actual protocol.
17 And procedural sedation was moved from
18 the G.O.P. Just want to point out that procedural
19 sedation for pediatrics still requires ... medical
20 control. And the general trauma care protocol was
21 consolidated to remove some redundancies. Did not
22 change the protocol. And those are the changes.
23 This comes forward as a seconded motion from Medical
24 Standards to SEMAC for your consideration.
25 CHAIRMAN DOYNOW: Okay. Do we have

1 5-26-2021 - SEMAC
2 any discussion on what Lou just mentioned? If not
3 could we have a motion to approve? Does anybody want
4 to second?
5 DR. ALEXANDROU: Dr. Alexandrou,
6 motion to approve.
7 CHAIRMAN DOYNOW: ... Who -- who's
8 seconding it
9 MR. WICELINSKI: Rob Wicelinski.
10 CHAIRMAN DOYNOW: I couldn't hear that
11 name. Could anybody make that out?
12 SECRETARY OZGA: I think it was Rob
13 Wicelinski
14 CHAIRMAN DOYNOW: Rob Wicelinski?
15 Okay.
16 MR. WICELINSKI: yes.
17 CHAIRMAN DOYNOW: All right. So, Val,
18 we'll need the roll call vote.
19 SECRETARY OZGA: All right. Dr.
20 Alexandrou?
21 DR. ALEXANDROU: Dr. Alexandrou, yes.
22 SECRETARY OZGA: Dr. Bart?
23 DR. BART: Yes.
24 SECRETARY OZGA: Dr. Berkowitz?
25 DR. BERKOWITZ: Berkowitz, yes.

1 5-26-2021 - SEMAC
2 SECRETARY OZGA: Dr. Berry?
3 DR. BERRY: Yes.
4 SECRETARY OZGA: Dr. Bombard?
5 DR. BOMBARD: Bombard, yes.
6 SECRETARY OZGA: Dr. Cooper?
7 DR. COOPER: Cooper, yes.
8 SECRETARY OZGA: Dr. Cushman?
9 DR. CUSHMAN: Cushman, yes.
10 SECRETARY OZGA: Dr. Dailey?
11 DR. DAILEY: Dailey, yes.
12 SECRETARY OZGA: Dr. Davidoff?
13 DR. DAVIDOFF: Davidoff, yes.
14 SECRETARY OZGA: Dr. Detraglia? Dr.
15 Doynow?
16 CHAIRMAN DOYNOW: Doynow, yes.
17 SECRETARY OZGA: Dr. Gomez? Dr.
18 Gomez. Dr. Gomez, we just unmuted you.
19 DR. GOMEZ: Gomez, yes.
20 SECRETARY OZGA: Thank you. Dr.
21 Kugler?
22 DR. KUGLER: Dr. Kugler, yes.
23 SECRETARY OZGA: Dr. Lynch? Dr.
24 Lynch? Dr. Markowitz?
25 DR. MARKOWITZ: Dr. Markowitz, yes.

1 5-26-2021 - SEMAC
2 SECRETARY OZGA: Dr. Maynard?
3 DR. MAYNARD: Dr. Maynard, yes.
4 SECRETARY OZGA: Dr. Marshall?
5 DR. MARSHALL: Dr. Marshall, yes.
6 SECRETARY OZGA: Dr. Olsson?
7 DR. OLSSON: Olsson, yes.
8 SECRETARY OZGA: Dr. Walters?
9 DR. WALTERS: Walters, yes.
10 SECRETARY OZGA: Dr. Wicelinski?
11 DR. WICELINSKI: Wicelinski, yes.
12 SECRETARY OZGA: ...
13 DR. LYNCH: Lynch, yes, also.
14 SECRETARY OZGA: Dr. Lynch?
15 DR. LYNCH: Yes.
16 SECRETARY OZGA: Yes, okay. Thank
17 you. Motion passes.
18 CHAIRMAN DOYNOW: Okay. Thank you,
19 Val. Lou, did we want to talk a little bit on med
20 standards about any I.V. nitro to the formulary?
21 That was a discussion yesterday.
22 DR. MARSHALL: Yes, we can. I mean,
23 nitroglycerin is on the formulary it's just not in
24 I.V. form. However, other medications that are on
25 the formulary we've allowed different -- different

1 5-26-2021 - SEMAC
2 ways of administering it. So we could certainly do
3 that. And then I have just a couple of items for
4 discussion.
5 CHAIRMAN DOYNOW: Okay. Perfect.
6 DR. MARSHALL: So we recommend -- I
7 recommend adding I.V. nitroglycerin to the state
8 formulary.
9 CHAIRMAN DOYNOW: Okay. I guess we'll
10 need a motion for that too.
11 DR. KUGLER: Dr. Kugler seconds.
12 DR. WICELINSKI: I'll make that
13 motion.
14 CHAIRMAN DOYNOW: Who second?
15 SECRETARY OZGA: I think it was Dr.
16 Wicelinski.
17 CHAIRMAN DOYNOW: Wicelinski, okay.
18 Ryan I'd go in for a whole roll call vote on this.
19 Is anybody opposed adding ... I.V. nitro to the
20 formulary? Save some time. Okay. Nothing heard. I
21 assume that passes. Okay. Back to you, Dr.
22 Marshall.
23 DR. MARSHALL: Okay. Thank you. We
24 did have some discussion from the last meeting. We
25 had talked about the viral pandemic triage protocol

1 5-26-2021 - SEMAC
2 that we put in place during the first wave of the
3 pandemic. And since then we've had some more
4 discussion regarding the triage protocol and how can
5 we make it more applicable to -- to more types of
6 disasters, not just limit it to a pandemic.
7 So we've had some discussion at a
8 conference call regarding this and, you know,
9 revising it to make it more compatible with use in
10 other disasters. And even to the point of
11 considering developing statewide disaster protocols.
12 Limited -- a limited number of statewide disaster
13 protocols that would allow -- that would be in place
14 and would allow regions to activate them based upon
15 regional needs and regional conditions.
16 So what we talked about yesterday was
17 setting up a work group to take this document and
18 start working considering which parts of disaster
19 protocols we may wish to have for the state at a
20 statewide level. And then we get to develop them.
21 So we asked for volunteers and we have -- I have two
22 volunteers so far. Just ask if Ryan would like to
23 make some comments as well?
24 CHAIRMAN DOYNOW: Ryan, do you have
25 any comments the pandemic protocol and --?

1 5-26-2021 - SEMAC
2 DIRECTOR GREENBERG: Yeah, so with the
3 pandemic protocol and essentially what we're moving
4 from on that one is or looking at in regards to it is
5 possibly creating some disaster protocols that would
6 be created now. That would be a -- a little bit more
7 generic and then a region would turn them on or turn
8 them off. So they'd still be part of statewide
9 protocols. All the providers would know what they
10 are, and they would be consistent statewide.
11 The only difference would be is
12 depending on the emergency or something going on in a
13 region on whether or not they would be permitted to
14 be used. And we really believe that, you know, now
15 is the time to do it so that, you know, in the middle
16 of a disaster we're not trying to do that. But
17 rather, you know, look at some of the things similar
18 to a pandemic triage protocol or others that would be
19 important to have in place.
20 And we have started to do some
21 research of what some other states have put together.
22 And in some cases we can even look within our state
23 and look at New York City and some of the specialized
24 protocols that they have. Again, you know, this
25 would be something that would essentially be created,

1 5-26-2021 - SEMAC
2 would be put into the protocol manual but be put in a
3 separate section. And then the region would
4 determine, you know, when to turn it on or turn it
5 off, dependent on the situation that's going on.
6 CHAIRMAN DOYNOW: All right. Thank
7 you, Ryan. Lew, do you have anything else to add?
8 DR. MARSHALL: No, not to that. So if
9 anyone is -- would like to volunteer please let ...
10 myself and Valerie so that we can set up a -- a
11 meeting to start planning how we're going to do this.
12 The next item we discussed was the i-
13 gel supraglottic airway pilot project from Hudson
14 Valley. Just to remind everybody, this pilot project
15 was approved by SEMAC at the last meeting. And it
16 was open to other agencies around the state who may
17 wish to participate in this pilot project. This
18 would, just to remind you, this would be allowing a
19 E.M.T. to use the supraglottic airway during cardiac
20 arrest.
21 I believe that this needs to go to
22 SEMSCO and then to the commissioner for approval
23 before it can begin. But they have had some agencies
24 already contact Hudson Valley who wish to
25 participate. So that -- that was a discussion item.

1 5-26-2021 - SEMAC
2 The other two, one was covered community
3 paramedicine. And then the SEMAC advisory will come
4 from Dr. Doynow, joint transfer of the Ebola
5 patients. That's my report.
6 CHAIRMAN DOYNOW: Okay. Thank you,
7 Lou. I don't know, Ryan if you wanted to mention a
8 little bit more about the Ebola transfer protocol.
9 DIRECTOR GREENBERG: Yes, so I will
10 actually -- I'm going to defer that one to Steve
11 Dziura, making sure I use last names here, as he's
12 going to talk about that one.
13 CHAIRMAN DOYNOW: Steve?
14 MR. DZIURA: Good morning. So this is
15 Steve Dziura. So the request by Office of Health
16 Emergency Preparedness here at the Department of
17 Health was to prepare a -- a SEMAC advisory to remove
18 any confusion on the transport of known Ebola
19 patients from a hospital to a Ebola treatment
20 facility hospital. So this is not the initial
21 presentation of a potential Ebola patient but only
22 relates to the transfer --.
23 DR. MARSHALL: Hello?
24 MR. DZIURA: Can you hear me?
25 DR. MARSHALL: Yes.

1 5-26-2021 - SEMAC
2 MR. DZIURA: The only -- only relates
3 to the transfer of known Ebola patients. The -- the
4 issues that in protocol it talks about decompensating
5 patients being transported to the closest appropriate
6 facility to -- to handle the -- the decompensation of
7 that patient. And -- and unfortunately just not
8 clear in the case of an Ebola patient the -- that
9 that most appropriate facility would be the Ebola
10 treatment facility and not just another hospital
11 somewhere along the way.
12 And this is done in an effort to try
13 and reduce potential exposure or -- or hospital
14 exposure rather to -- by bringing a decompensating
15 Ebola patient to them. So the language that -- that
16 was provided is -- was drafted by Office of Health
17 Emergency Preparedness based on conversations both
18 with the bureau and with New York City Emergency
19 Management and F.D.N.Y. to alleviate all those
20 concerns. So I'll leave it there and we can move
21 from that.
22 DR. KUGLER: Steve, it's David Kugler.
23 I have a quick question.
24 ...
25 DR. KUGLER: Okay. Thank you. So

1 5-26-2021 - SEMAC
2 briefly I -- I apologize if you had just unmuted --
3 remuted yourself. The question is -- that was asked
4 of me what if -- should this policy address if the
5 patient has a -- a cardiac arrest, does the -- should
6 we allow the ambulance crew to continue to the Ebola
7 facility that can better manage the patient? You
8 know, continue with the long -- and there may be a
9 very lengthy transport with someone who has expired.
10 And also the second question is should
11 the -- should there be language regarding
12 cardiopulmonary resuscitation in a known Ebola
13 patient that's ...
14 DIRECTOR GREENBERG: So I -- I can
15 talk just briefly about the transport to a -- to the
16 Ebola treatment center. Is that, yes, part of this
17 guidance is that essentially when we think about the
18 closest most appropriate with the closest most
19 appropriate being the actual Ebola center. The --
20 you know, and this does mean that it possibly would
21 bypass other hospitals. And -- and part of that is
22 is that if we were to go to a local hospital with
23 that wet patient in cardiac arrest, the amount of
24 time it would take them to prepare to treat the
25 patient versus the amount of time that it would take

1 5-26-2021 - SEMAC
2 to go to the -- to the -- to get to the actual center
3 that can treat them appropriately and is prepared to
4 treat them would probably be fairly equivalent.
5 Keeping in mind that also, you know,
6 on some of these transports we are looking at air
7 medical and other components that, again, limit the
8 amount of time and get them to the appropriate place
9 at the appropriate time.
10 In regards to how to treat that
11 patient in cardiac arrest, I would defer to this
12 group on if they, you know, what they feel on that.
13 And I would also want to just make sure that -- that
14 the advisory that we're -- that we're proposing or
15 the, you know, ... that has brought ... has brought
16 up, you know, is something that can be edited. So if
17 there is things that -- that this group feels should
18 be added, taken away, fill in the blank, you know,
19 that is -- this is the proposed and kind of first
20 draft. So please feel free to comment.
21 DR. KUGLER: Thank you, Ryan. I just
22 wanted to further clarify my question with regards to
23 the patients becoming deceased in the -- during the
24 transport was sometimes the providers might be so
25 inclined to bring the patient back to the sending

1 5-26-2021 - SEMAC
2 facility which may be closer already contaminated and
3 lessen their exposure risks versus continuing on to a
4 further -- for further transport with a decedent.
5 And it, you know, continuing their exposure risks. I
6 just -- so what would be the -- I mean, this is a --
7 that's -- that's a question for somebody smarter than
8 me.
9 DR. CUSHMAN: Dave Cushman if I could
10 on this.
11 CHAIRMAN DOYNOW: Sure go ahead.
12 DR. CUSHMAN: You know, Dave, what I -
13 - what I think you're actually getting to is the fact
14 that this is an extraordinarily complex interfacility
15 transport. I certainly don't know how everybody else
16 does their extraordinarily complex interfacility
17 transports, but at least in our system they're all
18 attended to by an E.M.S. physician that is directly
19 engaged in the plan surrounding that patient
20 transfer.
21 And we often make decisions in some
22 cases to not transfer that patient because their risk
23 of death during transport far exceeds their -- their
24 potential for survival. And we work out all of those
25 details of if this then that based upon that

1 5-26-2021 - SEMAC
2 individual's clinical decision. I don't know how one
3 can possibly create a policy that can account for
4 every clinical circumstance, distance, facility,
5 facility capabilities for a transfer that is this --
6 it was hard enough to transfer some COVID patients as
7 we all know, right.
8 Now we're talking about an Ebola
9 patient that, you know, I would encourage some
10 language that really requires the engagement of an
11 E.M.S. physician or a, you know, a physician team to
12 provide that crew with the necessary guidance and
13 continue to provide that guidance should clinical
14 status change during that transfer so that that poor
15 paramedic isn't stuck making a really, really
16 challenging decision all by themselves in the middle
17 of nowhere.
18 DR. ALEXANDROU: Don, this is Nick
19 Alexandrou from the fire department if I can comment
20 on that?
21 CHAIRMAN DOYNOW: Yeah, go ahead.
22 DR. ALEXANDROU: We've done a lot of
23 work here in New York City with a lot of
24 interfacility transports especially because of our
25 airports, our neighboring state New Jersey wanting to

1 5-26-2021 - SEMAC
2 bring patients in as well. And we worked very
3 closely with the office of emergency management and
4 the New York City D.O.H. in trying to prepare many
5 protocols to address many of these concerns.
6 In general, just to answer some of
7 these concerns especially David's about the patient
8 dying in transport. What we put in our protocol was
9 that if they died in transport they would continue on
10 to the Ebola facility that had the expertise and was
11 already set up to receive that patient. The
12 difference that we have here is that if the patient
13 is unstable and becomes unstable during the
14 transport, we would divert to the closest hospital
15 because as per C.D.C. guidelines, every hospital is
16 supposed to be prepared and able to receive an Ebola
17 patient.
18 That could be a patient that just
19 walks into the hospital so they would have to be
20 ready at all times in order to isolate and receive
21 that patient and treat that patient. So an unstable
22 patient would be diverted to a closer hospital
23 whereas a deceased patient we would continue on to a
24 facility that is already was a state designated Ebola
25 treatment center. And therefore we would continue on

1 5-26-2021 - SEMAC
2 to there.
3 As far as any invasive procedures, we
4 talked about that at great detail and it was our --
5 it was our idea that the best -- we would not get
6 invasive with these patients. There would be no
7 intubations. There would be no I.V.s. If anything
8 at the very least would be probably an I.O. if we
9 needed to connect in order to start an I.V. But that
10 would be it. There would not be any invasive
11 procedures in order to protect our members from
12 contamination.
13 So those were some of the -- the
14 policies that we put into place for our interfacility
15 transports that we were handling here at the time of
16 Ebola. I just wanted to comment on that.
17 CHAIRMAN DOYNOW: Thanks, Nick.
18 Appreciate it. So I guess the -- the question is
19 does the group feel comfortable voting on this? Do -
20 - I know we just showed it to you all. Do we want to
21 send this out to a committee to look at it a little
22 bit closer or bring back in to the next meeting?
23 Anybody have any comments on that?
24 DR. DAVIDOFF: Don, this is Davidoff.
25 I'd just like to say that this is a very, very

1 5-26-2021 - SEMAC
2 complex situation that we're talking about. It
3 involves a lot of ethical questions, decisions. I
4 really think it should be discussed at a committee
5 where we can have much more time to go through all of
6 the factors involved and the ramifications and bring
7 it back.
8 CHAIRMAN DOYNOW: Okay. I think
9 that's reasonable.
10 DR. COOPER: Don Doynow ...
11 CHAIRMAN DOYNOW: Hold on a second
12 here. Dr. Cooper, I think you were first and then
13 Jack, go ahead.
14 DR. COOPER: No, I just said I agreed
15 with Jack Davidoff.
16 CHAIRMAN DOYNOW: Oh, okay. Okay.
17 Anybody want to volunteer for being the chair?
18 Hearing crickets. Nick, since you've had a lot of --
19 .
20 DR. ALEXANDROU: I heard -- I heard
21 Davidoff was, you know, passionate about reviewing
22 it, so.
23 DR. DAVIDOFF: I'm very happy to be
24 part of this group. I don't think we necessarily
25 need to assign a chair. And I don't want to

1 5-26-2021 - SEMAC
2 volunteer people but certainly Art Cooper's done a
3 lot of ethics discussions in the past. I'd love to
4 work with Art if he's willing and a few other people.
5 But this is a very, very lengthy discussion and needs
6 to be so.
7 CHAIRMAN DOYNOW: So why don't we do
8 this, Jack? Why don't we have you -- it's not
9 necessary for you to be the chair but see if you
10 could organize a committee? Maybe Art will join in
11 and hopefully Nick. I'm happy to join as well and
12 anybody else if you just want to send Jack a -- an e-
13 mail. And then we can get together before the next
14 meeting and review this and -- and amend this to help
15 you all feel comfortable with it. Is everybody in
16 agreement with that?
17 DR. DAVIDOFF: I mean, let's do that.
18 If you guys can e-mail me let's get a group of five
19 or six and we'll set up some Zoom meetings and let's
20 get -- let's get this done.
21 CHAIRMAN DOYNOW: Okay. Thanks, Jack.
22 DR. COOPER: Don, this is Art Cooper.
23 I'm happy to work with -- with anyone on this. Thank
24 you.
25 DIRECTOR GREENBERG: And, Jack, if you

1 5-26-2021 - SEMAC
2 need anything from us we're happy to coordinate
3 putting together the Webex or coordinating schedules
4 or any of that administrative side of it. Val will
5 be happy to assist in coordination.
6 MR. DZIURA: Ryan, Director Greenberg,
7 does the state have a -- a set ... available?
8 DIRECTOR GREENBERG: I'm not sure.
9 MR. DZIURA: It's been discussed but I
10 think I may have the contact of the correct person
11 ... by the way. I might also recommend that we
12 extend a offer for one of the folks from Office of
13 Health Emergency Preparedness to participate.
14 CHAIRMAN DOYNOW: That would be great.
15 If you can do that, that would be fantastic.
16 DIRECTOR GREENBERG: And, Don, I know,
17 you know, not necessarily for this one in particular
18 but this might be something that we want to look at
19 on a more long term as well --
20 CHAIRMAN DOYNOW: Sure.
21 DIRECTOR GREENBERG: -- which is what
22 is the process for SEMAC advisory being that we only
23 meet three to four times a year. If something needs
24 to happen in between for a SEMAC advisor to come out
25 that -- you know in this particular case I think the

1 5-26-2021 - SEMAC
2 time is -- you know, I -- I don't think it's as
3 urgent. But let's say -- let's say something changes
4 and Ebola does have a larger outbreak and we don't
5 want to wait till September for the advisory to come
6 out.
7 Something that this committee may want
8 to look at is what is the pathway for releasing
9 advisories? And, you know, should it need to happen
10 in between a meeting or something of that nature, so.
11 CHAIRMAN DOYNOW: I think what we can
12 always -- we can always do is try to get the group
13 together on an emergent basis now that everything is
14 -- is video. It's much easier than driving and
15 getting everybody together.
16 DIRECTOR GREENBERG: Sure.
17 CHAIRMAN DOYNOW: And I think we've
18 done that in the past for some issues that were more
19 emergent. But that would be a -- would be a thought
20 just to arrange a time that we get a quorum together
21 video wise and ...
22 DIRECTOR GREENBERG: Sure. Like --
23 like I said just more -- more global things,
24 something to think about before we need it in a
25 crisis.

1 5-26-2021 - SEMAC
2 CHAIRMAN DOYNOW: I'll try to come up
3 with something for that. All right. Let's try and
4 move along because we are quickly running out of time
5 here. Dr. Marshall, anything else that you had at
6 this point before we move on?
7 DR. MARSHALL: No, nothing else.
8 Thank you.
9 CHAIRMAN DOYNOW: Okay. Next Mike
10 McEvoy for education.
11 MR. MCEVOY: Training and ed met
12 yesterday. We had a staff report. They went over a
13 few items pertaining to sponsor renewals which have
14 been extended a little bit. There are new B.L.S.
15 testing sheets that are coming out. Those are in the
16 approval process presently. There's a C.M.E. portal
17 on the web that is going into a trial phase and
18 depending on the results of that it -- it will come
19 out at some point later this year.
20 And then we had a discussion about
21 instructor certifications and spent some time on
22 Policy Nineteen zero one which is the instructor
23 policy. Talked a little bit about changing the
24 certificates that C.I.C. instructor coordinators get
25 to reflect those who are at the C.C. level which even

1 5-26-2021 - SEMAC
2 though there are no more C.C. original classes there
3 are still C.I.C.s who are overseeing the continuing
4 ed programs for those individuals. So the bureau is
5 going to make some tweaks to that form so that that's
6 more clear.
7 We talked a little bit about advance
8 standing. How a person who changes their level of
9 certification can then get instructor upgrade to that
10 level and what the requirements are for that. Then
11 we spent some time talking about retention of the
12 certified instructor coordinators and some ways that
13 we might be able to tweak the Nineteen zero one
14 policy. And so that's --we're going to play around
15 with some draft wording on that and bring that back
16 to the bureau.
17 We also had a discussion about the
18 ability of the bureau to set a deadline for people
19 who have completed their E.M.S. course to take the
20 computer based exam. Since the switch from written
21 exams to computer exams there's been a considerable
22 delay in people just procrastinating, signing up for
23 the test. And the data seems to pretty clear that
24 the longer you wait to take the exam, the more likely
25 you are to fail it.

1 5-26-2021 - SEMAC
2 And while the regulations give the
3 person a year from the time they complete the course
4 till when they have to test, it would appear as
5 though it might be wise to figure out a way to entice
6 people gently to take the test a little bit sooner
7 than that. So the bureau is going to talk to
8 division ... affairs and what authority they might
9 have to put some rules out that are -- are a little
10 bit tighter than what the regs say currently.
11 We had a brief discussion about
12 A.E.M.T.s and there was a question raised about
13 whether A.E.M.T.s are A.L.S. providers. And it
14 turned out to be basically a Suffolk County issue
15 that has to do with transfer of care from a higher
16 level down to an A.E.M.T. So the folks who raised
17 those issues are going to go back to Suffolk County,
18 talk to them about it a little bit.
19 We did briefly talk about the i-gel
20 pilot. And it was clarified that they had gone back
21 to their folks in the Hudson Valley and required
22 capnography with it and do some revision of the
23 training. In order to open it up statewide, they're
24 also allowing people to use the supraglottics other
25 than the i-gel, so that's all stuff that got put into

1 5-26-2021 - SEMAC
2 the -- the final package that we'll see at some
3 point.
4 And then the last item that we talked
5 about was a little bit of geographic restrictions in
6 the territory the core sponsor who runs E.M.T. and or
7 paramedic classes can actually cover. And for years
8 they have been assigned a geography. A recent
9 question from one of the core sponsors about the
10 authority to do that resulted in on somewhat
11 surprising interpretation from Division of Legal
12 Affairs that there really is no authority to set
13 geographic areas. And so that has the bureau going
14 back to take a look at the policy statement and
15 probably do some revisions of that. So stay tuned
16 for more information along those lines.
17 We do have one seconded motion to
18 bring forward which I blasted out on Boardable a
19 little while ago. And that has to do with a notice
20 of change that came out from the National Highway
21 Traffic Safe Administration. And it's a pretty long
22 document but ... down and ... what NHTSA has done
23 which actually may be -- they have a pretty extensive
24 policy on how to make changes in between meetings.
25 So maybe I can forward that to you, Don and take a

1 5-26-2021 - SEMAC
2 look at how that's in place.
3 But what they did was they issued
4 change notices one and two at the end of March. And
5 what those do is add intramuscular injection to the
6 E.M.T. scope of practice. It adds immunization
7 during public health emergency at the E.M.T.,
8 A.E.M.T. and paramedic levels. And it adds specimen
9 collection for nasal swab to the E.M.T., A.E.M.T. and
10 paramedic skills set. So the motion from training
11 and ed is to adopt the NHTSA change notices.
12 CHAIRMAN DOYNOW: Okay. Thanks, Mike.
13 Well, we'll need a -- a vote on that. Does anybody
14 have any discussion on this before we vote? Can we
15 have a motion to approve that? Anybody want to make
16 a motion to approve that?
17 DR. CUSHMAN: Cushman, so moved.
18 CHAIRMAN DOYNOW: Thanks, Dr. Cushman.
19 DR. DAVIDOFF: Davidoff second.
20 CHAIRMAN DOYNOW: Davidoff -- thank
21 you Dr. Davidoff. All right. Let's have a roll call
22 vote on this please, Val.
23 SECRETARY OZGA: Yes. Dr. Alexandrou?
24 DR. ALEXANDROU: Dr. Alexandrou, yes.
25 SECRETARY OZGA: Dr. Bart?

1 5-26-2021 - SEMAC
2 DR. BART: Bart, yes.
3 SECRETARY OZGA: Dr. Berkowitz?
4 DR. BERKOWITZ: Berkowitz, yes.
5 SECRETARY OZGA: Dr. Berry?
6 DR. BERRY: Yes.
7 SECRETARY OZGA: Dr. Bombard?
8 DR. BOMBARD: Bombard, yes.
9 SECRETARY OZGA: Dr. Cooper?
10 DR. COOPER: Yes.
11 SECRETARY OZGA: Dr. Cushman?
12 DR. CUSHMAN: Cushman, yes.
13 SECRETARY OZGA: Dr. Dailey?
14 DR. DAILEY: Dailey, yes.
15 SECRETARY OZGA: Dr. Davidoff?
16 DR. DAVIDOFF: Davidoff, yes.
17 SECRETARY OZGA: Dr. Doynow?
18 CHAIRMAN DOYNOW: Doynow, yes.
19 SECRETARY OZGA: Dr. Gomez.
20 CHAIRMAN DOYNOW: You have to unmute
21 Dr. Gomez.
22 UNIDENTIFIED SPEAKER: Stand by, Dr.
23 Gomez. Go Dr. Gomez.
24 DR. GOMEZ: Gomez, yes.
25 SECRETARY OZGA: Thank you. Dr.

1 5-26-2021 - SEMAC
2 Kugler?
3 DR. KUGLER: Dr. Kugler, yes.
4 SECRETARY OZGA: Dr. Lynch?
5 DR. LYNCH: Lynch, yes.
6 SECRETARY OZGA: Dr. Markowitz?
7 DR. MARKOWITZ: Markowitz, yes.
8 SECRETARY OZGA: Dr. Maynard?
9 DR. MAYNARD: Maynard, yes.
10 SECRETARY OZGA: Dr. Marshall?
11 DR. MARSHALL: Marshall, affirmative.
12 SECRETARY OZGA: Dr. Olsson?
13 DR. OLSSON: Olsson, yes.
14 SECRETARY OZGA: Dr. Walters?
15 DR. WALTERS: Walters, yes.
16 SECRETARY OZGA: Dr. Wicelinski?
17 DR. WICELINSKI: Yes.
18 SECRETARY OZGA: Motion passes.
19 CHAIRMAN DOYNOW: Great. Thank you,
20 Val. One more committee. E.M.S.C. but Ryan did
21 cover most of ... But Dr. Cooper, do you have
22 anything to add?
23 DR. COOPER: Thank you, Dr. Doynow. I
24 missed Mr. Greenberg's presentation. All I will say
25 at this point is first that Amy Eisenhauer has been

1 5-26-2021 - SEMAC
2 doing a phenomenal job supporting the committee.
3 We're great to have her on board with us. We're very
4 excited about proceeding with the pediatric readiness
5 project. We're very excited about the two working
6 groups that will be meeting. One dealing with fully
7 recognition of sepsis in the field and the other
8 dealing with excited delirium in pediatric patients.
9 And we expect to get back to you before the next
10 meeting with -- with our findings. Thank you. Amy,
11 please feel free to add anything that you feel I may
12 have neglected or that Ryan had not reported. Thank
13 you.
14 CHAIRMAN DOYNOW: Unfortunately, Amy
15 is not with us but ...
16 DIRECTOR GREENBERG: I think their
17 report is complete.
18 CHAIRMAN DOYNOW: All right. Let's
19 move on to old business. I think we pretty much
20 covered everything that was there which is basically
21 the protocol update and protocol status. Let's move
22 on to new business. I know there are a number of
23 items here.
24 First one I want to bring up and I
25 believe Ryan is going to be in agreement with this is

1 5-26-2021 - SEMAC
2 removing the -- the order that gave us personnel who
3 were vaccinated who were in the ambulance without a
4 patient ... wearing a mask. At this point it seems
5 reasonable that as long as there's no -- not a
6 patient in the rig they don't need to be wearing a
7 mask. It's obviously optional if they still feel
8 that they desire but I think that order should
9 probably be rescinded.
10 DIRECTOR GREENBERG: And we can look
11 at rescinding that and I do believe that would align
12 with the current guidance that's out there related to
13 both -- permitting both providers are vaccinated in
14 close proximity that they -- and they are a small
15 group if there's only two of them, maybe three would
16 be able to be together without having a mask on.
17 CHAIRMAN DOYNOW: Okay. Think that
18 will make our E.M.S. providers more comfortable.
19 Community paramedicine, we already touched on this.
20 I don't know, Ryan, if you want to add anything to
21 it.
22 DIRECTOR GREENBERG: I think that's
23 ... my report. Again, we'd be happy to share with
24 this group the list of agencies as well as counties
25 that they cover. And if anybody can help in covering

1 5-26-2021 - SEMAC
2 the other, you know, or encouraging their agencies to
3 become a community paramedicine program for the other
4 counties that are not covered, we do have a template
5 to help them with that process so that they can, you
6 know, not put ... a reasonable amount of work into
7 becoming a community paramedicine program. And so
8 we'll get that list out. We'll put it up on
9 Boardable.
10 CHAIRMAN DOYNOW: Okay. Ryan, you had
11 also new business you wanted to add to this?
12 CHAIRMAN GREENBERG: Yes, to the one
13 thing that I did want to add is the -- there are two
14 new committees that have been added to state council.
15 The two committees are -- the first one is our
16 quality metrics committee. So as many of you may
17 remember we developed seven quality metrics or we
18 developed six and the last one is in the process of
19 being completed. There were some things that had to
20 be determined on it, but those seven quality metrics
21 are part of our initiative going forward for
22 monitoring quality around the state and hopefully
23 growing those quality metrics as well beyond just the
24 seven that we have created.
25 And so there is now a committee and so

1 5-26-2021 - SEMAC
2 if there's anybody on the SEMAC that would be
3 interested in being part of the quality metrics
4 committee we'd love to have more participants on it.
5 It is a brand new committee and they can e-mail
6 myself and Mark and Don with their interest in being
7 part of it. And with that committee we're also
8 excited to be in the final steps of working on a new
9 analytic program that hopefully will be able to
10 provide that committee with additional information
11 related to the data and the metrics that are there
12 and see the performance around the state.
13 One of the goals of the new committee
14 and -- and also the metrics being out there is to
15 share this information -- sorry, to share information
16 about the metrics. To share opportunities for
17 agencies to further engage in using the -- the
18 metrics as well as the analytic program we're hoping
19 in the future, probably about a year out, would allow
20 agencies to see how they're doing with the metrics
21 compared to other similar like agencies.
22 So in situations beware it's a smaller
23 rural volunteer agency. How are they compared to the
24 state's overall but then also how are they compared
25 to other similar rural -- similar size rural E.M.S.

1 5-26-2021 - SEMAC
2 agencies? And hopefully, you know, pushing to
3 advance E.M.S. and the quality of care with that. So
4 excited on the quality metrics committee. Before I
5 move to the other one is there any questions related
6 to the quality metrics committee?
7 Excellent. The other committee that
8 is in the -- is and the quality metrics committee had
9 their first meeting yesterday. It's being shared by
10 Dave Violante and it -- they had a very positive
11 meeting there. The other committee that is just
12 starting and it has not even had its first meeting
13 yet but is still working on who will be on it is the
14 E.M.S. Innovation Committee
15 The E.M.S. innovation committee will
16 be focusing primarily for right now in what the
17 future of E.M.S. looks like. So their primary focus
18 will be E.T. three community paramedics and in
19 treatment and place and what does that look like in
20 the future. And then the goal of it and the reason
21 why it's called the E.M.S. innovation committee is
22 really looking at those things that they adopt and
23 change in the future whether that be with pediatric
24 care, adult care, innovation and deployment models,
25 fill in the blanks.

1 5-26-2021 - SEMAC
2 But that committee will be working and
3 looking at those different models as well as the loss
4 of, you know, on the E.T. three model be looking and
5 coordinating with the twenty-five agencies around the
6 state really in four geographic regions to see how
7 the E.T. three programs are working, and give a
8 sounding board in one place to see the things that
9 are working really positively in the -- in the other
10 locations so that, you know, maybe another area wants
11 to adopt a best practice that's being done in
12 somewhere else.
13 And so both of those committees are
14 looking for more members. We'd love to see some of
15 our physicians be a part of each of them. If anybody
16 has any specific interest or desires to be part of it
17 please, again, feel free to reach out to myself, Don
18 and Mark Phillippy. Thank you.
19 CHAIRMAN DOYNOW: Okay. Thank you,
20 Ryan. Is there any other new business from -- from
21 our committee members?
22 DR. MARSHALL: Yes, I -- Dr. Marshall.
23 I have one item of ...
24 CHAIRMAN DOYNOW: Go ahead.
25 DR. MARSHALL: Okay. So it's actually

1 5-26-2021 - SEMAC
2 probably more old business than new business. As
3 many of you know that, you know, over the years I've
4 been pushing for a statewide A.L.S. protocol so that
5 we can be consistent across the state. And we've
6 currently gotten to the point where the majority of
7 the state is using the same medicine with most of the
8 regions either participating with the collaborative
9 protocols or have adopted the collaborative protocols
10 for their region without actual participation in the
11 collaborative which is fine.
12 And New York City unified protocols
13 which we've made the -- the medicine is the same as
14 the unified protocols. I think most of our protocols
15 actually have the same name. And we have one county,
16 one region left. Suffolk County and I'm sorry to
17 call them out but I think it's -- we would like to
18 urge them very strongly to consider adopting the
19 collaborative protocols.
20 They don't have to join the
21 collaborative but, you know, that way we would have
22 essentially one set of A.L.S. protocols across the
23 state. Thank you for listening. I'll get off my
24 soap box now.
25 CHAIRMAN DOYNOW: Okay. ... Go ahead.

1 5-26-2021 - SEMAC
2 Who was that?
3 DR. DAVIDOFF: Davidoff. Right. Has
4 the bureau had a chance to go to the interstate
5 bureau act ...? And if so part of the ramifications
6 ...
7 CHAIRMAN DOYNOW: You're all broken
8 there, Jack. You're all broken up. Do you want to
9 go to the chat or do you have a better connection?
10 ... your audio was all broken.
11 UNIDENTIFIED SPEAKER: Suggest that he
12 talk without the camera on.
13 CHAIRMAN DOYNOW: Or a suggestion was
14 turn the camera off and just talk. That might make
15 your -- your audio a little bit better.
16 DR. DAVIDOFF: What about now, folks?
17 CHAIRMAN DOYNOW: Much better.
18 DR. DAVIDOFF: Okay. So has the
19 bureau had a chance -- has the bureau had a chance to
20 review the hero act that New York State has enacted
21 that is supposed to begin the first week of July?
22 And how it will or will not affect E.M.S. as we move
23 ahead with pandemics, infectious disease, et cetera?
24 Will they be releasing any suggestions for us to
25 utilize?

1 5-26-2021 - SEMAC
2 DIRECTOR GREENBERG: So I cannot --
3 I'm not answering that one but I'm happy to look into
4 it and get back to you specifically related to that.
5 I would say give me a few days and we'll see what we
6 can find out on that one.
7 DR. DAVIDOFF: I appreciate it because
8 after reading through it, unless I misunderstand it,
9 we're going to be taking one of the seats out of the
10 front of each ambulance and extending our back valve
11 mask six feet to keep people distanced properly or
12 we're going to get sued, so. Any suggestions would
13 be helpful.
14 DIRECTOR GREENBERG: Absolutely. ...
15 I -- I know that Dr. Pigut [phonetic spelling] is not
16 on the call but I do believe Dr. Winslow from Suffolk
17 County is on the call. I think, you know, Dr.
18 Winslow if you wanted to say anything from Dr.
19 Marshall's comment.
20 DR. WINSLOW: Sure. Well, as everyone
21 knows I -- I am the new medical director of Suffolk
22 County but unfortunately the state has yet to
23 complete my vetting process which has been over a
24 year. So unfortunately I'm not a member of this
25 committee yet but I would like to be.

1 5-26-2021 - SEMAC
2 DIRECTOR GREENBERG: You're not alone.
3 Don't feel like you're alone. We're working on
4 vetting of several people. I think Dr. ... is
5 shaking his heard there.
6 DR. WINSLOW: It's okay. It's been
7 thirteen months. ... So unfortunately in our area
8 the REMAC has not yet been able to move towards the
9 collaboratives because we haven't been able to meet
10 and to continue to work on the policy section in our
11 area before we could fully adopt or continue to use
12 the medicine in the collaboratives.
13 But my question of Dr. Marshall would
14 be would New York City consider adopting the
15 collaboratives as well?
16 DR. MARSHALL: That's a -- that's a
17 very good question and New York City -- I have been
18 pushing New York City to adopt the collaboratives.
19 Dr. Schenker can jump in and say what we've done as
20 can Dr. Alexandrou in terms of this -- adopting the
21 medicine of the collaborative without actually
22 joining the collaborative, and that's what I think
23 that Suffolk could certainly do as well.
24 ...
25 DR. MARSHALL: Yes. Well, they

1 5-26-2021 - SEMAC
2 considered it.
3 DR. SCHENKER: Dr. Doynow, if you
4 don't mind, can I speak to that?
5 CHAIRMAN DOYNOW: Sure.
6 DR. SCHENKER: Okay. So -- so ... I
7 think that the -- the really crux of the difference
8 and why New York City has -- has chosen not to adopt
9 the collaborative but to -- to adopt the medicine is
10 that we look at protocols a little different in New
11 York City just because of our volume. We use a more
12 operational tool ... while the rest of the state I
13 would say uses more, I would say, guidelines than
14 actual protocols.
15 We use protocols for the purpose of
16 maintaining a little bit better control over the
17 region. But the medicine and -- and I've said this
18 multiple times at this meeting, I believe very
19 strongly than the medicine should be the same because
20 E.M.S. medicine is E.M.S. medicine regardless of
21 where you are. But I think that it's very important
22 that we all as close as we can on the medicine or
23 we're almost identical on medicine going forward.
24 CHAIRMAN DOYNOW: Thank you, Dr.
25 Schenker. Dr. Winslow, anything you wanted to

1 5-26-2021 - SEMAC
2 comment on there?
3 DR. WINSLOW: Oh, no, just to put
4 everyone's mind at ease, realize our current
5 protocols are in line with medicine of the
6 collaboratives already. They're just not in the same
7 format ...
8 CHAIRMAN DOYNOW: Okay. Thank you.
9 Any comments? Any other new business?
10 DR. OLSSON: Olsson, yes, please.
11 CHAIRMAN DOYNOW: Dr. Olsson.
12 DR. OLSSON: I have -- thank you. The
13 average ... protocol, the final line at the bottom I
14 put it in the chat box. The use of tranexamic acid
15 in an E.M.S. region must be approved by the
16 corresponding RTAC. I just want to bring to your
17 attention the letter we got from our regional trauma
18 has one sentence at the bottom.
19 The committee was not strictly opposed
20 to the use of tranexamic acid but suggests that if
21 used it's used to be monitored for evidence of
22 efficacy and presence of serious side effects. Now
23 this does not seem to be a glowing endorsement of
24 tranexamic acid and we will be addressing that with
25 that group. But I wanted to bring to light the fact

1 5-26-2021 - SEMAC
2 that this statement exists in the protocol and I
3 don't know. Other regions may get a similar response
4 from their RTAC. So for the sake of general
5 information I put it out there. Thank you.
6 CHAIRMAN DOYNOW: Okay. Thank you,
7 Dr. Olsson. Any other new business?
8 DR. KUGLER: Yeah, Dr. Kugler.
9 CHAIRMAN DOYNOW: Dr. Kugler, go
10 ahead.
11 DR. KUGLER: Thank you. I have been
12 asked by the chairman of my REMSCO to pose a question
13 to Ryan. And the question is since Nassau REMSCO is
14 listed as in addition to faithfully and actually
15 performing the duties of a regional program agency,
16 why doesn't the Nassau REMSCO have access to the same
17 financial support as the other regional program
18 agencies?
19 DIRECTOR GREENBERG: Sure.
20 Absolutely. So, you know, the financial support is
21 there. It's in the training -- within the fund and
22 where all the program agencies are. Up until I
23 believe just several weeks ago there was a program
24 agency that was under contract. They have now
25 recently told us they no longer will be under

1 5-26-2021 - SEMAC
2 contract and so we are now working on solutions to
3 resolve that and determine how that program agency
4 will be -- how the support will be there for the
5 program or for the region via program agency.
6 Unfortunately, state contracting
7 process is not a quick one, so what we are working on
8 is possible solutions for both a short term and a
9 long term solution related to getting you program
10 support.
11 DR. KUGLER: Thank you, Ryan.
12 DIRECTOR GREENBERG: Yes. But the --
13 but the funding is there. The funding has never gone
14 anywhere. The -- the allocation of that funding is
15 there as well as, you know, now it's just a matter of
16 looking at means for what that new contract will look
17 like and getting that support into your area.
18 DR. KUGLER: Okay. Thank you.
19 DIRECTOR GREENBERG: Okay.
20 CHAIRMAN DOYNOW: Any other new
21 business?
22 DR. WALTERS: Dr. Doynow it's Walters.
23 CHAIRMAN DOYNOW: Hi, Dr. Walters. Go
24 ahead.
25 DR. WALTERS: I got ... new business

1 5-26-2021 - SEMAC
2 but I just have a question related to the -- the
3 comments about T.X.A. and I guess those other
4 protocols, the updates -- the collaborative updates
5 that were approved here previously. Did those -- did
6 they receive final approval from the commissioner?
7 Are we still waiting on those and if we're still
8 waiting what is the time frame for that?
9 DIRECTOR GREENBERG: I do not have a
10 time frame on that one. And we are still waiting on
11 some things and I hope we'll be able to get you ...
12 to find out what that timeline possibly would look
13 like. So I'll get back to you on the timeline for
14 that.
15 DR. WALTERS: I mean, I understand
16 COVID and everything but I think those were approved
17 some time ago, and in trying to update protocols,
18 trying to stay current with the evidence, trying to
19 move forward with our general E.M.S. care I think we
20 should strongly encourage the commissioner to look at
21 those and approve those quickly.
22 DIRECTOR GREENBERG: I do agree and we
23 also are actively looking at a change in the process
24 slightly in order to hopefully speed up that process
25 particularly ... there's no changes are made from the

1 5-26-2021 - SEMAC
2 pre -- from the time that it's submitted to the time
3 that it's approved by the state council. So we're
4 just waiting for that process to get ironically to
5 the process to get approved in the change. And then
6 that will speed up things for future changes.
7 Permitting nothing changes at the council then it
8 would have to go back.
9 CHAIRMAN DOYNOW: I agree.
10 DR. OLSSON: Dr. Doynow?
11 CHAIRMAN DOYNOW: Yes.
12 DR. OLSSON: Dr. Berry and then Dr.
13 Olsson.
14 CHAIRMAN DOYNOW: Okay. Dr. Berry?
15 DR. BERRY: Thank you. Currently ...
16 are surging across New York City with non COVID
17 patients. If we were hit with another pandemic where
18 hospitals with New York capacity with COVID patients
19 there currently is no state or reasonable plan in
20 place to handle this surge. So regarding developing
21 state disaster protocols, is there a plan in place to
22 involve the regional ... leadership and stakeholders
23 in these discussions? And will the state develop or
24 -- and will the state provide financial resources ...
25 develop an integrated system.

1 5-26-2021 - SEMAC
2 CHAIRMAN DOYNOW: Ryan pass that to
3 you.
4 DIRECTOR GREENBERG: So I would say
5 that, you know, participation and development of
6 that, especially as a member of this committee, is
7 something that -- that I believe, Don, that you would
8 welcome.
9 CHAIRMAN DOYNOW: Sure.
10 DIRECTOR GREENBERG: And then in
11 regards to the financial components or subsidies, I
12 think there would have to be an understanding of what
13 that financial support would be looking for. And
14 then we would have to propose that up to division of
15 budget to try and, you know, determine if there are
16 funds and where those funds would be coming from.
17 UNIDENTIFIED SPEAKER: ... Dr. Olsson
18 and then Dr. Dailey.
19 CHAIRMAN DOYNOW: Dr. Olsson, you're
20 up next.
21 DR. OLSSON: I've already said my
22 piece. Thank you.
23 CHAIRMAN DOYNOW: Dr. Dailey?
24 DR. DAILEY: Thanks, Dr. Doynow.
25 There is something that -- that came up last year,

1 5-26-2021 - SEMAC
2 and at this point I think it's really important just
3 for some clarification because I'm confused. There
4 was a letter sent from the bureau to the Hudson
5 Valley REMSCO regarding their A.L.S. update and
6 authority policy which I'm not really sure I
7 understand.
8 They had had a longstanding policy to
9 approve agencies for A.L.S. upgrades in order to
10 maintain their -- their regional capabilities and in
11 order to make sure that they had appropriate regional
12 oversight as granted in Article 30. And the letter
13 insinuated that they did not. I thought this was
14 something that was very specific to the process that
15 occurred in the Hudson Valley, and we had some
16 discussions about it and didn't do anything further.
17 Recently in our region we were handed
18 a letter granting advanced life support authority to
19 an agency that had not applied to our REMAC to -- to
20 perform at that level. When we asked our state reps
21 we were told that actually the authority to practice
22 at the A.L.S. level was actually something that was
23 granted by the bureau and not by the regions.
24 We then went back and asked counsel
25 about this because I thought -- we found that very

1 5-26-2021 - SEMAC
2 strange because very clearly in Three thousand and
3 four A REMACs are granted the authority to develop
4 policies, procedures and triage treatment and
5 transportation protocols consistent with the
6 standards of the SEMAC addressing local conditions.
7 And even more confusing on this is the
8 way this actually came across was that it appeared
9 that the state could grant authority for an agency to
10 operate at the advanced E.M.T. or the C.C. level
11 regardless of what region they practiced in since it
12 had nothing to do with the regional oversight and
13 regional or local conditions.
14 So I was just wondering if Steve and -
15 - and Ryan could clarify some of this for us because
16 I think the regions have spent a lot of time over the
17 years making sure that our A.L.S. systems are
18 functioning as appropriately as possible. And want
19 to make sure that they're maintaining appropriate
20 standards to meet our local conditions while working
21 in conjunction with the bureau. And any changes that
22 have been made now to interpretation of Article 30 or
23 prior precedent.
24 DIRECTOR GREENBERG: Sure. So there's
25 a couple of things on this and not only this but some

1 5-26-2021 - SEMAC
2 other things as well. So I'll let Steve talk first
3 and then I will follow up with some additional.
4 MR. DZIURA: So thanks, Mike for
5 bringing that up. You -- you are correct. The
6 letter that went out was -- was very specific to the
7 situation at Hudson Valley REMSCO specifically to the
8 fact that their policy had created a -- a pseudo
9 public need process for the establishment of A.L.S.
10 services in that area. And in reviewing with legal
11 the -- the -- their existing policy against the
12 current statute, there is no requirement or -- or
13 enabling language to allow for that type of a process
14 to occur.
15 We were in constant contact with
16 Hudson Valley REMSCO and talked through their whole
17 process. The long history of where it came from and
18 how they got there. And provided this letter
19 essentially saying, you know, the -- the only factors
20 that can be considered by law are in Thirty thirty-
21 one regarding, you know, what's required but required
22 of an advanced life support system. And that was
23 outlined in that letter in that in order to -- to
24 grant that authority the department did have to come
25 out and do an inspection to verify that that was --

1 5-26-2021 - SEMAC
2 that was all in place prior to permitting the
3 certificate.
4 So we have not gone back to re-look at
5 the entire policy yet. This was an off situation and
6 I wasn't aware of a second ... involved in this so
7 I'd be happy to talk a little more offline about that
8 particular one and if the situation was the same.
9 And we do need to revisit the entire policy to make
10 sure that -- that our current policy statements do
11 align with Article 30 and current regulations.
12 DIRECTOR GREENBERG: Before I go, Dr.
13 Dailey, do you have anything on what Steve said?
14 DR. DAILEY: No, I appreciate the
15 clarification. I think there's also two different
16 things, right. One is that an agency be granted the
17 authority to be an A.L.S. agency which I think is
18 something that falls to the bureau. And the other is
19 whether or not they're allowed to practice as an
20 A.L.S. agency which falls to the region because
21 unless that is maintained as we review these
22 policies, precedent will fall to the wayside.
23 Monroe, Livingston will end up with advanced E.M.T.s
24 as will New York -- New York City. And I'm not sure
25 either of those regions are prepared for those

1 5-26-2021 - SEMAC
2 changes.
3 MR. DZIURA: Yeah, in this particular
4 case, I had worked with Hudson Valley REMSCO, and
5 they were in support, however, were following their
6 own policy regarding the establishment of A.L.S. And
7 that policy was very lengthy and, you know, and in
8 the end what it looks like is the policy statement
9 was created by the REMSCO and instituted right around
10 the same time that advanced life support first
11 response services came into the picture.
12 And so it looks like the policy may
13 have unintentionally incorporated everybody into this
14 -- this advanced life support first response upgrade
15 as opposed to considering the difference between an
16 ambulance service seeking to change levels of care.
17 So the -- the crux of this opinion to them was that
18 their -- their policy is going through a -- a public
19 hearing and need process was arbitrary and capricious
20 and not permitted by Article 30 in its existence
21 today.
22 DIRECTOR GREENBERG: So the other
23 component -- let me back up. Dr. Dailey, do you have
24 anything else on that one or does anyone else before
25 I go?

1 5-26-2021 - SEMAC
2 DR. DAILEY: No, thank you, Ryan.
3 DIRECTOR GREENBERG: Absolutely. So
4 the other thing that I want to bring up kind of
5 related to this but, you know, more on a more global
6 thing, we also had a -- a legal question that was
7 asked in the legal review that was done most recently
8 on core sponsors. And the question that was asked
9 is, of course, what -- what gives us the authority to
10 restrict a core sponsor by a region, by a -- by a
11 geographic region. Is there a very specific
12 authority when it comes to core sponsorship and
13 there's specific authority on -- on E.M.S. agencies
14 having geographic regions. But it was not as clear
15 on core sponsors having a geographic region.
16 And so this is another legal brief
17 that -- that came out recently and determined
18 essentially that there isn't. There isn't really a
19 restriction for a core sponsor for a geographic
20 region. Now what I'll also say is further review
21 also determine that REMACs -- sorry, not REMACs,
22 REMSCOs have a very specific authority to create a
23 training and ed class. And that courses should be
24 following that training and ed class.
25 And so this is what we thought in some

1 5-26-2021 - SEMAC
2 senses at least, you know, current administration,
3 thought this would be a big change in the where, you
4 know, we need these course plans and everything else.
5 We know that regions to some extent ... in our
6 training and ed meeting yesterday when we brought
7 this up and made sure that everybody around the state
8 was aware of this pretty significant change that we
9 wanted to make sure that -- that everybody was aware.
10 But we also found out that, well, this
11 really just rolls back in some senses to the way that
12 it used to be done some time ago in where the
13 training and ed plan put their -- the -- the regions
14 put in training and ed plan and then the courses were
15 approved based on that plan, which is really just the
16 pathway that we're going back to on this.
17 I bring this up because people say,
18 well, you know, it shouldn't be this way, it should
19 change. One of the things that the bureau is working
20 on and -- and we're kind of in a -- nearing the steps
21 of it is having a clear process on how regulatory
22 change occurs. Because it hasn't happened that much
23 with us, we get deferred to the FPC ... process
24 often. FPC ... as many of you -- especially as many
25 aware on the -- in the hospital world.

1 5-26-2021 - SEMAC
2 Well, to the good or the bad,
3 indifferent we don't really align with some of those
4 -- some of those processes. So we have to kind of
5 flush out certain things to determine how we can
6 update our regs and what that process would look like
7 and be. And so those are things that -- that Steve
8 or I are working with B.L.A. on so that we can start
9 to look at some of these changes and -- and look at,
10 you know, whether it be education standards, whether
11 it be a certification period, whether it be
12 operational or regional, fill in the blank.
13 But working in collaboration,
14 obviously, with our councils to -- to update our
15 regulations doing more pertinent to not only today
16 but what does the future of E.M.S. look like. So I
17 also want to, you know, make sure that everybody here
18 is aware that as some of these changes and some of
19 the things that are looked at and reviewed and may
20 not come out to be, you know, the same as the way
21 that we've always done it, there's always the
22 opportunity, particularly in the -- in the future,
23 near future to look at things and say is this the
24 best wording, is this the best way to do it. Or
25 should it be changed.

1 5-26-2021 - SEMAC
2 And so to start to look at some of
3 those changes that would occur. So I just wanted to
4 make sure that -- that this group kind of had that
5 understanding and, you know, kind of address that
6 from there that I think there were changes in the
7 future that are coming that will be in a positive
8 way. But we should also be looking at what are the
9 things that are important to, you know, everybody on
10 this committee and are reasonable things within Part
11 Eight hundred statute much harder to change but
12 within Part Eight hundred that would make the system
13 better, so. Just wanted to bring that all up.
14 CHAIRMAN DOYNOW: Thank you, Ryan.
15 Any other new business before we close the meeting?
16 We're going a little over. Okay. I'd like to thank
17 everybody for sticking with us today. Can I have a
18 motion to close the meeting?
19 DR. MARSHALL: So moved, Dr. Marshall.
20 CHAIRMAN DOYNOW: Dr. Marshall, thank
21 you.
22 DR. KUGLER: I second.
23 CHAIRMAN DOYNOW: Dr. Kugler, thank
24 you, seconded. All -- all in favor?
25 UNIDENTIFIED SPEAKER: Aye.

1 5-26-2021 - SEMAC
2 CHAIRMAN DOYNOW: Okay. We'll see all
3 of you folks probably in October I think is when that
4 meeting is but there are no dates as of yet. Thank
5 you all for -- for staying with us.
6 (Off the record 11:06 a.m.)
7 (The proceeding concluded.)
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1 5-26-2021 - SEMAC
2 STATE OF NEW YORK
3 I, BECKY FOSTER, 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 100, is a true record of all proceedings had at
8 the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 8th day of June, 2021.
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12
13 BECKY FOSTER, Reporter
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A

A.E.M.T 69:16 71:8,9
A.E.M.T.s 69:12,13
A.L.S 46:13 69:13 80:4,22 91:5 91:9,22 92:17 93:9 94:17,20 95:6
a.m 1:8 2:2 100:6
A.T.S 16:15
ability 43:22 68:18
able 8:11 12:25 15:21 16:2 17:5 17:7,25 19:21 21:6 25:11 26:4 38:5 39:14 43:21 61:16 68:13 75:16 77:9 83:8,9 88:11
absolutely 13:18 14:2,2 30:9 40:9 41:3 82:14 86:20 96:3
accept 12:7
accepted 12:8,9
accepting 41:19
access 15:9,9,10 18:8 21:13 22:5 86:16
accessed 39:24
account 17:5 60:3
accounts 16:15
accreditation 11:6,7
accredited 11:3,5,8
achieve 17:15
achieved 17:10
acid 85:14,20,24
act 18:12,13 81:5,20
activate 52:14
actively 24:14 29:21 30:3 37:19 40:13 88:23
activities 5:23 6:2
actual 16:23 43:23 46:7 47:16 57:19 58:2 80:10 84:14
add 33:18 40:22 43:7 44:5 46:9 54:7 71:5 73:22 74:11 75:20 76:11,13
added 39:16 43:9 46:3 47:2,6,7 58:18 76:14
adding 36:9 40:19 51:7,19
addition 6:5 27:6 45:22 86:14
additional 8:23,25 24:25 26:5,7 27:13 28:3 36:7,18 42:17 44:15 77:10 93:3
address 57:4 61:5 99:5
addressed 33:2
addressing 85:24 92:6
adds 40:11 71:6,8
administered 46:25
administering 51:2
administration 6:6 8:10 70:21 97:2
administrative 65:4
adopt 71:11 78:22 79:11 83:11 83:18 84:8,9
adopted 80:9
adopting 80:18 83:14,20
adult 21:25 30:12 78:24
advance 68:7 78:3
advanced 91:18 92:10 93:22 94:23 95:10,14
advantages 26:7
advisor 65:24
advisories 66:9
advisory 9:3 24:7 55:3,17 58:14 65:22 66:5
affairs 69:8 70:12
affect 81:22
affirmative 73:11
agencies 6:8 7:7,13,17,24 8:2,3 12:8,14 18:3 26:3 29:22 35:11 35:16 36:17 46:13 54:16,23 75:24 76:2 77:17,20,21 78:2 79:5 86:18,22 91:9 96:13
agency 7:15 8:7 14:13 16:5,10 25:21 26:7,14 28:17,20,21 29:18 32:10 35:5,6,12,21 37:4 47:5 77:23 86:15,24 87:3,5 91:19 92:9 94:16,17,20
agenda 43:24
agnostic 20:23
ago 8:18 10:19 39:6 70:19 86:23 88:17 97:12
agree 36:5,12 88:22 89:9
agreed 36:21 63:14
agreement 28:5 64:16 74:25
ahead 44:25 59:11 60:21 63:13 79:24 80:25 81:23 86:10 87:24
air 58:6
airports 60:25
airway 54:13,19
Alesha 12:21
Alexandrou 2:20,21,21 48:5,5,20 48:21,21 60:18,19,22 63:20 71:23,24,24 83:20
align 75:11 94:11 98:3
allegiance 2:8,10

alleviate 56:19
allocation 87:14
allow 20:10 25:16 27:25 40:11 46:22 47:4,5 52:13,14 57:6 77:19 93:13
allowed 24:13 46:14 50:25 94:19
allowing 54:18 69:24
allows 25:15
altered 47:11
alternative 47:9
ambulance 13:15 57:6 75:3 82:10 95:16
amend 64:14
America 2:11
amount 6:10 9:23 32:8 57:23,25 58:8 76:6
Amy 12:19,25 73:25 74:10,14
analytic 77:9,18
announce 18:12
answer 23:22 26:17 34:20 38:6 40:6 42:18 43:25 61:6
answering 37:17 82:3
anybody 16:10 26:18 30:24 37:25 44:15 48:3,11 51:19 62:23 63:17 64:12 71:13,15 75:25 77:2 79:15
apologize 57:2
app 19:13 21:8,22 22:18 23:2,7 24:4 25:4,9,15 26:16,24 29:25 31:8 34:23 36:4,25 38:15,17 38:17,20 39:3,5,6 41:10,15,18 41:23 42:8,22 43:10 44:20
appear 40:3 69:4
appeared 92:8
applicable 22:15 52:5
application 23:19 31:7,12
applied 22:14 91:19
applies 23:14 34:19
appreciate 5:2 28:16 31:6 32:23 32:24 33:5 36:19 37:17 41:25 44:22 62:18 82:7 94:14
appropriate 56:5,9 57:18,19 58:8,9 91:11 92:19
appropriately 39:10 58:3 92:18
approval 5:2 28:8,8,9 31:20 32:5,15,19 39:9 54:22 67:16 88:6
approve 48:3,6 71:15,16 88:21 91:9
approved 5:9 31:19,22 54:15 85:15 88:5,16 89:3,5 97:15
approving 32:21
apps 39:24
arbitrary 95:19
area 79:10 83:7,11 87:17 93:10
areas 15:8 70:13
arrange 66:20
arrangement 34:5
arrest 54:20 57:5,23 58:11
Art 64:2,4,10,22
Article 91:12 92:22 94:11 95:20
asked 26:21 52:21 57:3 86:12 91:20,24 96:7,8
assessment 14:24
assessments 19:16
assign 63:25
assigned 5:22 70:8
assignments 5:18
assist 65:5
assume 51:21
assuming 33:10
asthma 47:2
attempt 22:8 43:15
attend 16:11
attendance 3:13
attended 59:18
attendees 3:18,24
attending 15:25 24:22
attention 40:2 85:17
audio 81:10,15
authority 28:7 69:8 70:10,12 91:6,18,21 92:3,9 93:24 94:17 96:9,12,13,22
automatic 25:19
available 17:4 19:13 24:21 25:19 26:11 27:11 33:8,23 35:19,19 36:13 40:10 65:7
average 40:17 85:13
avoid 20:15 38:13
aware 94:6 97:8,9,25 98:18
awareness 19:7,10
Aye 99:25

B

B.L.A 98:8
B.L.S 67:14
baby 13:16,20,20,21,25 14:10,14 14:15
back 2:4 8:21,22 12:24 13:17

16:21 35:25 36:17 38:7 51:21 58:25 62:22 63:7 68:15 69:17 69:20 70:14 74:9 82:4,10 88:13 89:8 91:24 94:4 95:23 97:11,16
bad 98:2
balance 17:18 18:4
balanced 18:6
Bart 2:22,23 31:2,3,5 32:23 33:5 35:4,23 37:16 48:22,23 71:25 72:2,2
base 9:17
based 14:9 21:18 34:19 45:23 46:15 47:3 52:14 56:17 59:25 68:20 97:15
basically 41:16,18 69:14 74:20
basis 66:13
bear 10:2 22:7
BECKY 101:3,13
becoming 58:23 76:7
beginning 18:15 43:9,10
behalf 31:11 35:7 36:7
believe 9:2 34:8 43:20 53:14 54:21 74:25 75:11 82:16 84:18 86:23 90:7
benefits 23:24
Berkowitz 2:24,25 48:24,25,25 72:3,4,4
Berry 3:2,3 49:2,3 72:5,6 89:12 89:14,15
best 27:20 33:25 62:5 79:11 98:24,24
better 36:11 42:19 43:22 45:13 45:24 57:7 81:9,15,17 84:16 99:13
beware 77:22
beyond 76:23
Bi 16:9
big 27:8 97:3
biggest 5:13 15:5 33:17
bit 3:7 5:14 19:11 35:25 36:8 50:19 53:6 55:8 62:22 67:14 67:23 68:7 69:6,10,18 70:5 81:15 84:16
biweekly 16:9
blank 58:18 98:12
blanks 78:25
blasted 70:18
Blocker 18:23 19:2,18,22,25 20:2 27:2,19,22 29:17 31:4 32:2 33:3 34:4 35:8 36:20 37:18 40:5 42:18 44:10,12,18
board 74:3 79:8
Boardable 17:18 70:18 76:9
body 31:20 32:21
bolus 46:9
Bombard 2:7 3:4,5 36:21 49:4,5 49:5 72:7,8,8
borderline 7:9
bottles 46:12
bottom 85:13,18
Bourbon 3:16
box 13:4 44:14 80:24 85:14
brand 77:5
bridge 11:2
brief 19:4 69:11 96:16
briefly 57:2,15 69:19
bring 6:21 13:2,15 19:21 37:13 45:5,13 58:25 61:2 62:22 63:6 68:15 70:18 74:24 85:16,25 96:4 97:17 99:13
bringing 56:14 93:5
broad 7:23
Brodie 1:9
broken 81:7,8,10
bromide 47:3
brought 14:7 23:5 29:2 38:25 45:17 47:14 58:15,15 97:6
browse 22:12 30:14,16
budget 90:15
budgets 36:8
bugs 31:10
build 34:23
building 42:22
built 41:9
bulk 7:25
bunch 13:14 16:21
burden 24:25
bureau 5:10,12 10:21 15:2 27:23 28:6 32:6,15 37:20 40:10,10 56:18 68:4,16,18 69:7 70:13 81:4,5,19,19 91:4,23 92:21 94:18 97:19
bureau's 28:8
business 18:18 33:19 45:6 74:19 74:22 76:11 79:20 80:2,2 85:9 86:7 87:21,25 99:15
busy 9:6 12:4
button 27:3,8 30:15

bypass 57:21

C

C.C 67:25 68:2 92:10
C.D.C 61:15
C.E.O 19:2 20:3
C.I.C 67:24
C.I.C.s 68:3
C.L.I.s 11:20
C.M.E 9:11 67:16
C.M.E.s 15:16
C.S.E.s 11:20
calculation 34:20
calculations 21:2 33:12 34:2 36:22
calculator 25:20 34:14,15 37:3 41:7
calculators 33:12
call 2:9,15 27:6,8 30:22 48:18 51:18 52:8 71:21 80:17 82:16 82:17
called 78:21
calls 16:8
camera 81:12,14
capabilities 15:7 29:6 30:17 60:5 91:10
capability 15:8 26:24 30:12,19
capable 29:14
capacity 89:18
capnography 69:22
capricious 95:19
caption 101:5
card 9:21 17:7,9,13
cardiac 54:19 57:5,23 58:11
cardiopulmonary 57:12
cards 10:9 16:20 17:3
care 18:9 29:13 30:22 33:19 39:25 47:20 69:15 78:3,24,24 88:19 95:16
carried 13:19
carry 46:14
carrying 34:19
case 56:8 65:25 95:4
cases 53:22 59:22
categories 44:6
category 29:7
cause 101:4
caution 8:21
center 29:10 57:16,19 58:2 61:25
centers 29:14
certain 9:23 25:18 36:13 42:8 98:5
certainly 33:24 35:5 39:20 51:2 59:15 64:2 83:23
certificate 29:21 94:3
certificates 67:24
certification 16:23 22:7 34:16 68:9 98:11
certifications 10:10,15 16:18 16:19 67:21
certified 68:12
certify 101:3
cetera 81:23
chair 1:9 14:25 15:11 63:17,25 64:9
chairman 2:3 3:21 4:25 5:5,8 18:19 26:18 30:24 38:10,13 41:13,24 42:5 44:22 47:25 48:7,10,14,17 49:16 50:18 51:5,9,14,17 52:24 54:6 55:6 55:13 59:11 60:21 62:17 63:8 63:11,16 64:7,21 65:14,20 66:11,17 67:2,9 71:12,18,20 72:18,20 73:19 74:14,18 75:17 76:10,12 79:19,24 80:25 81:7 81:13,17 84:5,24 85:8,11 86:6 86:9,12 87:20,23 89:9,11,14 90:2,9,19,23 99:14,20,23 100:2
challenge 36:16
challenging 60:16
chance 8:24 81:4,19,19
change 23:10,13,15,25 31:22 32:10 45:10 46:7 47:22 60:14 70:20 71:4,11 78:23 88:23 89:5 95:16 97:3,8,19,22 99:11
changed 45:23 46:22 47:11 98:25
changes 24:5 25:18 27:21 31:16 31:23 32:4,9 39:15 45:10,11 45:12 47:22 66:3 68:8 70:24 88:25 89:6,7 92:21 95:2 98:9 98:18 99:3,6
changing 32:14 67:23
channels 31:18
chat 29:25 38:3,6 44:14,19 81:9 85:14
checking 24:23
child 27:14

choice 11:14
choose 12:18 26:5
chosen 84:8
circle 38:7
circumstance 60:4
City 30:17,18 45:7 53:23 56:18 60:23 61:4 80:12 83:14,17,18 84:8,11 89:16 94:24
clarification 91:3 94:15
clarified 69:20
clarify 58:22 92:15
class 25:10 96:23,24
classes 68:2 70:7
clear 32:3,9 33:4 56:8 68:6,23 96:14 97:21
clearly 92:2
click 41:6
clinical 60:2,4,13
close 75:14 84:22 99:15,18
closely 61:3
closer 59:2 61:22 62:22
closest 30:14 56:5 57:18,18 61:14
coding 20:10
coin 21:8
collaboration 15:14 98:13
collaborative 36:4 38:15,17 41:21 45:14 80:8,9,11,19,21 83:21,22 84:9 88:4
collaboratives 83:9,12,15,18 85:6
collection 71:9
combination 16:25
Combine 21:18
combined 29:23
combines 21:9
come 13:17,21 15:14 38:4 41:5 55:3 65:24 66:5 67:2,18 93:24 98:20
comes 13:15 24:7 33:13,18 36:8 47:23 96:12
comfortable 62:19 64:15 75:18
coming 11:16 21:17 31:6 67:15 90:16 99:7
comment 58:20 60:19 62:16 82:19 85:2
comments 19:17 52:23,25 62:23 85:9 88:3
commerce 17:5
commissioner 54:22 88:6,20
committee 1:6 14:24,25 62:21 63:4 64:10 66:7 73:20 74:2 76:16,25 77:4,5,7,10,13 78:4 78:6,7,8,11,14,15,21 79:2,21 82:25 85:19 90:6 99:10
committees 7:20 37:14 39:23 76:14,15 79:13
community 6:20,23,24,25 7:5,8 7:10,11,12,14,16,20,25 8:3,4 8:6,7,12 12:24 55:2 75:19 76:3,7 78:18
company's 42:9
compared 77:21,23,24
compatible 52:9
complete 42:10 69:3 74:17 82:23
completed 68:19 76:19
completely 22:20 26:11 28:25 34:21
complex 34:14 39:25 43:6 59:14 59:16 63:2
compliance 26:8 35:14
component 95:23
components 58:7 90:11
computer 9:16 68:20,21
concentration 32:12 34:18
concerned 6:14
concerns 56:20 61:5,7
concluded 100:7
conditions 52:15 92:6,13,20
conference 15:18,24 16:3 52:8
conferences 13:2
confused 91:3
confusing 92:7
confusion 38:14 55:18
conjunction 92:21
connect 62:9
connected 23:11
connection 22:22 81:9
consider 80:18 83:14
considerable 68:21
consideration 47:24
considered 84:2 93:20
considering 12:13 52:11,18 95:15
consistent 53:10 80:5 92:5
consisting 101:6
consolidated 47:21
constant 93:15

contact 27:20 44:14 54:24 65:10 93:15
contacts 17:24
contaminated 59:2
contamination 62:12
content 24:14
continually 43:7
continue 16:9 40:12,12 44:5 57:6,8 60:13 61:9,23,25 83:10 83:11
continued 44:5
continues 9:12,13
continuing 12:12,22 59:3,5 68:3
contract 86:24 87:2,16
contracting 87:6
contracts 6:11
contributed 42:14
control 19:14 26:23 27:13,18 47:20 84:16
conversation 36:24
conversations 37:10,12,23 40:7 43:20 56:17
Cooper 3:7 49:6,7,7 63:10,12,14 64:22,22 72:9,10 73:21,23
Cooper's 64:2
coordinate 65:2
coordinating 65:3 79:5
coordination 65:5
coordinators 67:24 68:12
copy 23:8
core 10:8 11:19 70:6,9 96:8,10 96:12,15,19
correct 21:16 46:12 65:10 93:5
corresponding 85:16
cost 42:15,16
costs 42:17
council 76:14 89:3,7
councils 14:25 16:14 98:14
counsel 91:24
counties 7:13 75:24 76:4
county 7:15 8:7,10 20:19 22:12 22:13 23:14 24:17 27:10,23,24 69:14,17 80:15,16 82:17,22
couple 8:18 16:13 28:17 38:23 51:3 92:25
course 31:10 68:19 69:3 96:9 97:4
courses 96:23 97:14
cover 45:9 70:7 73:21 75:25
covered 55:2 74:20 76:4
covering 7:13 75:25
COVID 5:14,15,18,22 6:11 7:22 25:24 26:2 43:9,11 60:6 88:16 89:16,18
COVID-19 33:8
crazy 17:12
create 60:3 96:22
created 14:24 53:6,25 76:24 93:8 95:9
creating 53:5
credential 26:14
crew 14:8 57:6 60:12
crews 13:14
crickets 63:18
crisis 66:25
crux 84:7 95:17
current 36:3 38:16 47:14,14 75:12 85:4 88:18 93:12 94:10 94:11 97:2
currently 69:10 80:6 89:15,19
Cushman 3:8,9,9 49:8,9,9 59:9,9 59:12 71:17,17,18 72:11,12,12
customize 24:13
customized 22:7

D

D.O.H 23:24 61:4
D.O.S 11:12
Dailey 3:10,11,11 38:14,18 40:5 41:3,20 49:10,11,11 72:13,14 72:14 90:18,23,24 94:13,14 95:23 96:2
data 12:3,5,11 68:23 77:11
database 16:24
date 1:8 11:17 41:17
dates 100:4
Dave 59:9,12 78:10
David 56:22
David's 61:7
Davidoff 3:12,13 26:20,20 27:16 27:20 42:3,3,6,6 49:12,13,13 62:24,24 63:15,21,23 64:17 71:19,19,20,21 72:15,16,16 81:3,3,16,18 82:7
day 6:4 11:16,17,21 16:4,5,7 40:19 101:10
days 82:5
deadline 68:18
deal 20:4

dealing 74:6,8
death 59:23
deceased 58:23 61:23
decedent 59:4
decided 32:25
decides 22:3
decision 60:2,16
decisions 59:21 63:3
decompensating 56:4,14
decompensation 56:6
defer 55:10 58:11
deferred 97:23
define 15:7
definitely 15:12 43:24
delay 68:22
delays 39:8
delirium 74:8
delivers 34:20
delivery 33:19
department 1:3 5:16,24 46:17 55:16 60:19 93:24
departments 8:10 42:23
dependent 54:5
depending 53:12 67:18
deployment 78:24
design 25:2
designated 61:24
desire 75:8
desires 79:16
detail 62:4
details 59:25
determine 54:4 87:3 90:15 96:21 98:5
determined 76:20 96:17
Detraglia 3:17,19 49:14
develop 52:20 89:23,25 92:3
developed 76:17,18
developing 52:11 89:20
development 31:9 90:5
device 13:24,24,25 14:4,5
devices 13:3,6
dexamethasone 47:7,8
dial 26:24
died 61:9
difference 14:19 53:11 61:12 84:7 95:15
different 6:2 7:24 10:8,9 13:6 15:10 16:7 20:21 33:7 50:25 50:25 79:3 84:10 94:15
difficulty 28:20
digested 40:15
digital 17:4,6 20:5,8,9,9,14
digitizing 20:14
direct 23:8,12 28:7 32:5,14
direction 11:11 12:17
directly 16:23 24:8 27:22 28:2 32:21 43:11 59:18
director 5:11 11:25 18:21,24 20:3 28:3 37:9 38:2 40:21 41:11 44:7 53:2 55:9 57:14 64:25 65:6,8,16,21 66:16,22 74:16 75:10,22 82:2,14,21 83:2 86:19 87:12,19 88:9,22 90:4,10 92:24 94:12 95:22 96:3
directors 14:13 17:21 18:11 19:14 47:5
directory 27:9 29:2
disaster 52:11,12,18 53:5,16 89:21
disasters 52:6,10
discuss 37:14 41:20 42:12
discussed 42:11 54:12 63:4 65:9
discussing 41:4
discussion 9:3 46:10 48:2 50:21 51:4,24 52:4,7 54:25 64:5 67:20 68:17 69:11 71:14
discussions 38:24 64:3 89:23 91:16
disease 81:23
disparage 29:7
distance 30:20 60:4
distanced 82:11
distress 46:8
divert 61:14
diverted 61:22
division 69:8 70:11 90:14
document 21:3 52:17 70:22
documents 23:3
doing 7:17 8:2 12:20 13:8 14:21 15:16 18:17,17 24:14 74:2 77:20 98:15
Don 18:16 38:19 39:17 60:18 62:24 63:10 64:22 65:16 70:25 77:6 79:17 90:7
donations 39:7
Donna 12:20
dosage 37:3

dose 22:8 34:2,17
doses 22:2
dosing 25:20 33:11 34:13 36:22 41:5,7 45:23 46:9
download 17:6 26:16
downloaded 21:22
Doynow 2:3 3:20,21,21 4:25 5:5 5:8 18:19 26:18 30:24 38:10 38:13 41:13,24 42:5 44:22 45:3 47:25 48:7,10,14,17 49:15,16,16 50:18 51:5,9,14 51:17 52:24 54:6 55:4,6,13 59:11 60:21 62:17 63:8,10,11 63:16 64:7,21 65:14,20 66:11 66:17 67:2,9 71:12,18,20 72:17,18,18,20 73:19,23 74:14 74:18 75:17 76:10 79:19,24 80:25 81:7,13,17 84:3,5,24 85:8,11 86:6,9 87:20,22,23 89:9,10,11,14 90:2,9,19,23,24 99:14,20,23 100:2
Dr 2:20,21,22,23,24,25 3:2,3,4 3:5,6,8,9,10,11,12,12,17,19 3:20,22,23,23,24,25,25,25 4:3 4:4,5,7,7,8,9,9,10,11,11,12 4:12,14,15,15,17,17,20,22 5:4 5:5,7 20:2 26:20 27:16,20 31:2,5 32:23 33:5 35:4,23 36:21 37:16 38:14,18 40:5 41:3,20 42:3,6 44:25 45:3,3 48:5,5,19,21,21,22,23,24,25 49:2,3,4,5,6,7,8,9,10,11,12 49:13,14,14,17,17,18,19,20,22 49:22,23,23,24,25,25 50:2,3,3 50:4,5,5,6,7,8,9,10,11,13,14 50:15,22 51:6,11,11,12,15,21 51:23 54:8 55:4,23,25 56:22 56:25 58:21 59:9,12 60:18,22 62:24 63:10,12,14,20,23 64:17 64:22 67:5,7 71:17,18,19,21 71:23,24,24,25 72:2,3,4,5,6,7 72:8,9,10,11,12,13,14,15,16 72:17,19,21,22,23,24,25 73:3 73:3,4,5,6,7,8,9,10,11,12,13 73:14,15,16,17,21,23,23 79:22 79:22,25 81:3,16,18 82:7,15 82:16,17,18,20 83:4,6,13,16 83:19,20,25 84:3,3,6,24,25 85:3,10,11,12 86:7,8,8,9,11 87:11,18,22,22,23,25 88:15 89:10,10,12,12,12,14,15 90:17 90:18,19,21,23,24,24 94:12,14 95:23 96:2 99:19,19,20,22,23
draft 58:20 68:15
drafted 56:16
driving 66:14
duties 86:15
dying 61:8
dysrhythmia 46:4
Dziura 55:11,14,15,24 56:2 65:6 65:9 93:4 95:3

E

e- 64:12
e-mail 28:14 44:15 64:18 77:5
E.D 28:3
E.M.C 16:18,19
E.M.S 7:7 13:10,11 15:10 16:8 17:19,25 18:14 37:4 59:18 60:11 68:19 75:18 77:25 78:3 78:14,15,17,21 81:22 84:20,20 85:15 88:19 96:13 98:16
E.M.S.C 12:19 15:2 73:20
E.M.T 17:6 22:9 47:3 54:19 70:6 71:6,7,9 92:10
E.M.T.s 94:23
E.P.C.R 12:10
E.R 14:16
E.R.s 13:14
E.T 78:18 79:4,7
early 15:25 28:16
ease 85:4
easier 26:24 66:14
easy 21:12 23:17
Ebola 8:17,20,23 9:4 55:4,8,18 55:19,21 56:3,8,9,15 57:6,12 57:16,19 60:8 61:10,16,24 62:16 66:4
ed 67:11 68:4 71:11 96:23,24 97:6,13,14
edited 58:16
education 9:5,8 10:6 11:16,17 11:18,21 12:2 16:4 39:19,23 40:4 67:10 98:10
educator 11:18
effects 85:22
efficacy 85:22
effort 7:15 56:12
efforts 7:4
eight 11:18,21,21 99:11,12

Eisenhauer 12:20 73:25
either 11:12,13 30:10 80:8 94:25
electronic 12:9,14
electronically 45:8
eligible 11:9
emergency 53:12 55:16 56:17,18 61:3 65:13 71:7
emergent 66:13,19
employ 38:22
employees 28:20
enabling 93:13
enacted 81:20
encourage 60:9 88:20
encouraging 76:2
ended 5:16
endorsement 85:23
engage 77:17
engaged 39:3 59:19
engagement 60:10
engineers 24:19
ensure 31:21
enter 21:20
entice 69:5
entire 94:5,9
entirely 22:18
equipment 21:20 22:10 32:13 42:8,9,10,13,13,14,22,25 43:5 44:4
equivalent 58:4
errors 33:17 37:6
especially 6:19 44:3 60:24 61:7 90:6 97:24
essence 38:6
essentially 53:3,25 57:17 80:22 93:19 96:18
establishment 93:9 95:6
et 81:23
ethical 63:3
ethics 42:12 64:3
everybody 17:18 40:25 54:14 59:15 64:15 66:15 95:13 97:7 97:9 98:17 99:9,17
everyone's 24:23 85:4
everything's 33:8
evidence 85:21 88:18
exact 11:17
exam 10:13,16,20 11:14 68:20,24
example 21:14 36:10 40:25 41:4 43:8
exams 10:22,24 11:11,12 68:21 68:21
exceeds 59:23
Excellent 5:8 18:25 78:7
excited 6:18,20 8:11 15:13,18 18:12,16 74:4,5,8 77:8 78:4
executive 7:2 8:13 46:15,16
existence 95:20
existing 93:11
exists 86:2
expand 9:12 12:23
expect 9:23 35:19 74:9
expensive 34:22
expertise 61:10
expired 57:9
expires 46:16
explain 40:25
exposure 56:13,14 59:3,5
extend 65:12
extended 67:14
extending 82:10
extension 10:8
extensive 70:23
extent 97:5
external 10:21
extraordinarily 59:14,16
extremely 38:24

F

F.D.N.Y 56:19
faced 9:20
facilities 29:14 43:16
facility 55:20 56:6,9,10 57:7 59:2 60:4,5 61:10,24
fact 35:12 59:13 85:25 93:8
factors 63:6 93:19
fail 68:25
fairly 58:4
faithfully 86:14
fall 2:4 94:22
falls 37:3 94:18,20
fantastic 65:15
far 20:5 30:2 32:4 33:6 40:16 42:19 52:22 59:23 62:3
fast 21:12
favor 99:24
features 25:19 26:5 33:18,23 35:13 36:13
feedback 19:12 31:8,10,11,25 40:13

feel 6:15 36:14 58:12,20 62:19 64:15 74:11,11 75:7 79:17 83:3
feeling 14:3
feels 58:17
feet 82:11
felt 43:5
Fentanyl 32:12
fewer 9:13
field 74:7
fifteen 15:24
fifty 7:11,12
figure 34:18 37:7 69:5
filed 20:20
fill 58:18 78:25 98:12
filters 43:8
final 34:20 70:2 77:8 85:13 88:6
financial 86:17,20 89:24 90:11 90:13
financing 34:7
find 18:8,9 21:11,15 29:24 36:17 82:6 88:12
finding 22:10 28:21 30:2
findings 74:10
fine 18:20 38:11 80:11
fire 42:23 60:19
first 21:8 40:6 42:19,20 43:25 46:13 52:2 58:19 63:12 73:25 74:24 76:15 78:9,12 81:21 93:2 95:10,14
five 7:3 64:18
flag 2:8,10
fluid 45:21
flush 98:5
focus 78:17
focused 26:9
focusing 78:16
folks 38:22 41:16 65:12 69:16 69:21 81:16 100:3
follow 93:3
following 95:5 96:24
foregoing 101:3,6
form 32:7 50:24 68:5
format 85:7
formatting 45:12
formulary 22:3 41:8 46:19 47:10 50:20,23,25 51:8,20
forty 7:13
forward 15:13 39:3,13 45:5,11 47:23 70:18,25 76:21 84:23 88:19
FOSTER 101:3,13
found 28:16 42:24 91:25 97:10
four 6:10 7:6 12:4,5 15:21,22 19:5 65:23 79:6 92:3
FPC 97:23,24
frame 38:16 88:8,10
free 6:15 12:17 25:24 26:12 33:15 34:3 58:20 74:11 79:17
front 6:18 8:15 9:5,11 16:22 82:10
full 24:18
fully 20:11 74:6 83:11
functional 31:23
functioning 92:18
functions 6:11 7:18,22
fund 86:21
funding 87:13,13,14
funds 36:14 90:16,16
further 37:14 58:22 59:4,4 77:17 91:16 96:20
future 17:2 77:19 78:17,20,23 89:6 98:16,22,23 99:7

G

G.O.P 47:18
G.P.S 30:20
gap 31:14
geared 16:7
gel 54:13
general 9:4 23:5 25:3 39:21 45:20 47:13,15,20 61:6 86:4 88:19
generations 39:6
generic 53:7
gently 69:6
geographic 70:5,13 79:6 96:11 96:14,15,19
geographically 8:6
geography 70:8
getting 20:18 40:17 59:13 66:15 87:9,17
give 11:12 19:4,7 20:11 28:3 31:11 46:23 69:2 79:7 82:5
gives 22:20 96:9
giving 5:19
glad 40:7
glance 29:6

glass 46:11,14
global 66:23 96:5
glowing 85:23
go 9:9 10:23 13:5,11,16 14:16 16:9,9 17:5,13 18:24 25:10 26:12 30:5,15 31:18,20 42:15 44:24 51:18 54:21 57:22 58:2 59:11 60:21 63:5,13 69:17 72:23 79:24 80:25 81:4,9 86:9 87:23 89:8 94:12 95:25
goal 7:13 35:8,10,15 78:20
goals 77:13
God 2:12
goes 10:7,8,9 16:2 21:2 32:5
going 2:16 5:12,24,25 8:21 9:6 9:25 10:3 12:2,6,11,14 14:10 14:20 15:12,15 16:16,19,19,25 17:11,17 18:25 19:4 24:23 27:24,24 31:9 34:7 36:16,25 37:5,6 38:5 39:18 44:13 53:12 54:5,11 55:10,12 67:17 68:5 68:14 69:7,17 70:13 74:25 76:21 82:9,12 84:23 95:18 97:16 99:16
Gomez 3:22,23,23 38:12 49:17,18 49:18,19,19 72:19,21,23,23,24 72:24
good 2:19,23 3:6 14:3 18:8 19:12 31:5,17 45:4 55:14 83:17 98:2
gotten 11:2 19:12 80:6
governor's 46:15
gradually 38:22
grant 92:9 93:24
granted 91:12,23 92:3 94:16
granting 91:18
great 14:3,3 19:22,25 20:9 28:14 39:15 41:11 62:4 65:14 73:19 74:3
greater 40:11
Greenberg 5:11 11:25 18:21,24 20:3,3 37:9 38:2 40:21 41:11 44:7 53:2 55:9 57:14 64:25 65:6,8,16,21 66:16,22 74:16 75:10,22 76:12 82:2,14 83:2 86:19 87:12,19 88:9,22 90:4 90:10 92:24 94:12 95:22 96:3
Greenberg's 73:24
group 5:14 39:22 52:17 58:12,17 62:19 63:24 64:18 66:12 75:15 75:24 85:25 99:4
groups 74:6
grow 40:12
growing 76:23
grows 30:5 43:20
guess 51:9 62:18 88:3
guidance 8:23 9:4 57:17 60:12 60:13 75:12
guidelines 47:14 61:15 84:13
guys 19:23 35:2 44:23 64:18

H

hand 5:19
handed 91:17
handle 14:17 24:5 56:6 89:20
handling 31:24 62:15
happen 24:2 65:24 66:9
happened 19:15 97:22
happening 11:22
happens 11:2,3 23:13
happy 24:16 26:17 28:10 34:9,25 37:9,12,15 63:23 64:11,23 65:2,5 75:23 82:3 94:7
hard 60:6
harder 99:11
he'll 3:7
heads 37:7
health 1:3 5:16,24 8:10 17:4,19 17:20,23 18:3 55:15,17 56:16 65:13 71:7
hear 19:19 48:10 55:24
heard 6:13 51:20 63:20,20 83:5
hearing 63:18 95:19 101:8
held 14:11
Hello 55:23
help 7:15 9:11 17:25 18:7 29:24 29:24 30:2 36:17 43:22 64:14 75:25 76:5
helped 10:23
helpful 82:13
helping 15:7
helps 12:21
hereof 101:5
hereto 101:5
hereunto 101:9
hero 81:20
hey 13:17 24:9
Hi 19:25 26:20 31:4,5 87:23
hide 33:10,20,21 39:20
high 19:6,10

higher 69:15
Highway 70:20
history 93:17
hit 89:17
Hold 63:11
holding 13:23
hope 17:21 35:16 39:20 88:11
hopefully 16:2 27:25 39:15 64:11 76:22 77:9 78:2 88:24
hoping 2:4 77:18
hospital 13:14,21,22 21:14,15 21:16 23:14 24:12 25:12 27:3 27:4,5,7,13 28:7,24 29:8,8 30:7,8,11,22 55:19,20 56:10 56:13 57:22 61:14,15,19,22 97:25
hospitals 20:20 26:23 27:17 29:3 30:10,15,16,20 57:21 89:18
hotels 15:17
hour 11:21
hours 6:4 11:18
Hudson 54:13,24 69:21 91:4,15 93:7,16 95:4
hundred 15:21,23,24 29:3 33:3 40:18,18,19 99:11,12
hybrid 15:19,20
hyperlink 40:24 41:2
hyperlinks 39:4,9

I

i- 54:12
i-gel 69:19,25
I.O 45:19 62:8
I.V 45:19 46:9,10,18 50:20,24 51:7,19 62:9
I.V.s 62:7
I’m 18:23
idea 29:3 36:3,9 62:5
identical 84:23
identification 28:18
identifies 34:16
identifying 26:13
immediate 29:13
immediately 23:15,22 24:4 25:6 25:6 27:8 30:13,18 32:18
immunization 71:6
impact 43:21
implement 22:3
important 10:10 17:8,20 20:14 29:9 39:18 53:19 84:21 91:2 99:9
importantly 7:10 14:23 37:2
improved 47:15
inclined 58:25
included 24:11 26:6 34:3
including 6:7 19:13
incorporated 95:13
incorporating 26:22
increase 12:12,13
incredibly 34:9,14,22
independently 22:20,24
indifferent 98:3
individual 17:5 25:21 35:15 37:4 43:14
individual's 60:2
individually 22:25 32:10 35:10
individuals 26:4 35:17 68:4
indivisible 2:12
infectious 81:23
information 16:21 20:18,20,20 21:13 22:4 23:9,20 28:6 29:12 30:7 41:7,22 44:14 70:16 77:10,15,15 86:5
informed 3:7
initial 10:14,14 55:20
initially 42:21,22
initiative 76:21
initiatives 14:18
injection 71:5
innovation 78:14,15,21,24
inordinate 32:8
input 19:17 28:9 43:13
inside 23:7
insight 35:14 40:11
insights 26:8
insinuated 91:13
inspection 93:25
instance 28:19
instantaneously 24:6
instituted 95:9
instructions 16:14,24
instructor 67:21,22,24 68:9,12
instructors 11:20
integrate 25:9
integrated 22:17 89:25
intentionally 8:9
interactions 28:14
interchangeable 45:21

interest 77:6 79:16
interested 77:3
interesting 8:5
interfacility 59:14,16 60:24 62:14
internal 10:20
Internet 22:22 23:11
interpretation 70:11 92:22
interstate 81:4
intramuscular 71:5
intubations 62:7
invasive 62:3,6,10
inventory 32:11 34:17
invoices 6:7,11
involve 89:22
involved 36:24 63:6 94:6
involves 36:6 63:3
ipratropium 47:2
ironically 89:4
isolate 61:20
issue 4:18 69:14
issued 71:3
issues 24:15 28:17 29:24 30:3,4 56:4 66:18 69:17
it's 9:20
item 34:3 45:5,6 54:12,25 70:4 79:23
items 22:14 51:3 67:13 74:23

J

Jack 63:13,15 64:8,12,21,25 81:8
January 5:3
jargon 23:21
Jersey 60:25
job 12:20 74:2
Joe 31:3 36:21
John 38:4
join 16:10,11 64:10,11 80:20
joining 15:17 44:10,13 83:22
joint 14:25 55:4
Josh 4:4
Joshua 2:6
July 81:21
jump 83:19
June 11:17,18,22 12:2 16:20 101:10
justice 2:13

K

keep 8:12 11:6 19:6 82:11
keeper 38:15
keeping 6:9 15:23 58:5
kept 34:8
key 23:24 25:18
keyed 24:11
kind 7:6,8 33:9 58:19 96:4 97:20 98:4 99:4,5
know 3:13,14,23 6:18 8:20,25 9:15,18,21,25 13:7 14:4,16,18 15:9,14,22 16:12,17 18:7 23:15 28:23 29:4 30:8 31:9 33:6,22 36:6 37:5,6,19,19 38:2,3 39:23 41:16 43:3,25 44:3 46:17 52:8 53:9,14,15,17 53:24 54:4 55:7 57:8,20 58:5 58:12,15,16,18 59:5,12,15 60:2,7,9,11 62:20 63:21 65:16 65:17,25 66:2,9 74:22 75:20 76:2,6 78:2 79:4,10 80:3,3,21 82:15,17 86:3,20 87:15 90:5 90:15 93:19,21 95:7 96:5 97:2 97:4,5,18 98:10,17,20 99:5,9
knowing 29:7,9
known 55:18 56:3 57:12
knows 82:21
Kugler 3:24,25,25 4:2,4 5:7 49:21,22,22 51:11,11 56:22,22 56:25 58:21 73:2,3,3 86:8,8,9 86:11 87:11,18 99:22,23

L

L.D.L 47:15
language 25:20 56:15 57:11 60:10 93:13
larger 43:21 66:4
late 3:7
launched 18:14,15
law 93:20
leadership 11:24 16:5,6,11 89:22
lean 35:25
leave 56:20
left 5:15 9:10 80:16
legal 70:11 93:10 96:6,7,16
lengthy 57:9 64:5 95:7
lessen 59:3
let's 64:17,18,19,20 66:3,3 67:3 71:21 74:18,21
letter 85:17 91:4,12,18 93:6,18

93:23
level 19:6,10 21:5,18 22:7 26:14 29:9 31:16 35:3 52:20 67:25 68:8,10 69:16 91:20,22 92:10
levels 71:8 95:16
Lew 54:7
liberty 2:13
licensing 28:22
Lidocaine 46:3
life 91:18 93:22 95:10,14
light 85:25
limit 52:6 58:7
limited 52:12,12
line 45:13 85:5,13
lines 70:16
lingo 23:21
link 41:6
list 29:4,15,19 30:16 43:24 75:24 76:8
listed 27:17 42:9 86:14
listening 17:13 44:2 80:23
listing 42:10,12,13
little 3:7 4:18 5:14 13:20 19:11 35:25 50:19 53:6 55:8 62:21 67:14,23 68:7 69:6,9,18 70:5,19 81:15 84:10,16 94:7 99:16
live 29:24 44:19
Livingston 94:23
loading 25:3
local 8:9 13:2 57:22 92:6,13,20
locally 42:23
location 21:9,10 25:16
locations 79:10
long 8:13 25:25 34:24 38:24 57:8 65:19 70:21 75:5 87:9 93:17
longer 12:7 19:9 41:15,18 68:24 86:25
longstanding 91:8
look 6:17 8:24 15:12 16:20 21:24 22:7 27:4,7 30:9 37:10 38:4 39:19,25 53:17,22,23 62:21 65:18 66:8 70:14 71:2 75:10 78:19 82:3 84:10 87:16 88:12,20 98:6,9,9,16,23 99:2
looked 39:12 43:11 98:19
looking 11:20 12:13 21:16 23:23 28:23 39:3,13 53:4 58:6 78:22 79:3,4,14 87:16 88:23 90:13 99:8
looks 25:13 34:15,17 78:17 95:8 95:12
loss 79:3
lot 5:12 6:4,7 7:17 9:5 14:21 15:15 40:2 42:25 45:12 60:22 60:23 63:3,18 64:3 92:16
Lots 5:25
Lou 48:2 50:19 55:7
loud 32:24
love 64:3 77:4 79:14
loving 40:7
low 34:9 40:18
Lynch 2:6 4:3,4 49:23,24 50:13 50:13,14,15 73:4,5,5
Lynn 6:16

M

magnesium 46:23,25
mail 12:8 64:13
main 27:17
maintain 24:13 91:10
maintained 94:21
maintaining 84:16 92:19
major 18:5 20:15
majority 80:6
making 14:18 20:5 24:20 32:8 37:21 40:14 55:11 60:15 92:17
manage 57:7
managed 17:14
management 31:22 33:25 47:13,15 56:19 61:3
manual 43:3 54:2
manuals 21:21
manufacturer 20:19 42:9
manufacturer's 21:20,21 24:24 43:4
manufacturers 42:14 43:12,19,22
March 71:4
Mark 28:11 77:6 79:18
Markowitz 4:6,7,7 49:24,25,25 73:6,7,7
Marshall 4:10,11,11 5:4,6 44:25 45:3 50:4,5,5,22 51:6,22,23 54:8 55:23,25 67:5,7 73:10,11 73:11 79:22,22,25 83:13,16,25 99:19,19,20
Marshall's 82:19
mask 75:4,7,16 82:11

material 28:15
matter 22:18,22,23 23:20 35:12 87:15
max 40:18
Maynard 4:8,9,9 50:2,3,3 73:8,9 73:9
McEvoy 67:10,11
mean 33:19 35:5 50:22 57:20 59:6 64:17 88:15
meaning 20:24 23:3,13,18
means 87:16
meant 43:14
med 21:24 26:22 27:18 39:19,22 45:2 50:19
medic 23:21
medical 14:12 17:21 18:11 19:14 19:14 20:19 27:13 31:22 33:17 33:25 45:4 47:5,19,23 58:7 82:21
medically 33:16
medication 34:19 47:6
medications 21:23 22:10 47:9,9 50:24
medicine 45:16 80:7,13 83:12,21 84:9,17,19,20,20,22,23 85:5
meds 21:24
meet 4:23 43:6 65:23 83:9 92:20
meeting 1:6 2:5 7:4 9:2 15:3,6 45:15,18 51:24 54:11,15 62:22 64:14 66:10 74:6,10 78:9,11 78:12 84:18 97:6 99:15,18 100:4
meetings 24:22 32:17 64:19 70:24
member 14:8 82:24 90:6
members 2:7 18:4 62:11 79:14,21
mental 17:18,20,23 47:11
mention 2:16 45:25 55:7
mentioned 31:7 33:6 45:14 48:2
mentions 45:19
met 15:3 44:6 45:4 67:11
method 36:15
methods 45:20
metrics 76:16,17,20,23 77:3,11 77:14,16,18,20 78:4,6,8
middle 6:19 53:15 60:16
Mike 40:24 41:13,24 67:9 71:12 93:4
mind 6:9 8:12 11:7 15:23 19:6 33:13 58:5 84:4 85:4
minimal 23:17 24:17 34:7
minute 19:4 45:9
minutes 5:3,9 13:18
missed 73:24
missing 28:25 30:8
mistaken 46:13
misunderstand 82:8
model 79:4
models 78:24 79:3
monitor 43:16
monitored 85:21
monitoring 76:22
Monroe 94:23
months 7:3 83:7
morning 2:19,23 5:11 13:13 45:4 45:5 55:14
motion 47:23 48:3,6 50:17 51:10 51:13 70:17 71:10,15,16 73:18 99:18
move 15:13 36:11 44:8,23 56:20 67:4,6 74:19,21 78:5 81:22 83:8 88:19
moved 5:4 46:6 47:17 71:17 99:19
moving 11:11 12:16 53:3
multiple 84:18
Murphy 4:12
Muru 18:13 19:3,8 20:4 21:7 25:11 26:5,11 39:3,13 41:17
Murumed.com 26:12
mute 3:18

N

N.R.B 43:3
name 2:17 20:2 27:4 28:22 48:11 80:15 101:10
names 29:21,23 44:11 45:15 55:11
naming 30:11
nasal 71:9
Nassau 86:13,16
nation 2:12
national 10:12,15,16,18 11:13 47:4 70:20
natural 25:20
nature 66:10
near 17:2 98:23
nearby 29:10
nearest 30:15
nearing 97:20

necessarily 63:24 65:17
necessary 60:12 64:9
need 3:19 15:8 18:7 21:11 24:9 25:9 28:9,10 29:4,12,21 34:24 36:23,23 39:23 41:17 44:23 48:18 51:10 63:25 65:2 66:9 66:24 71:13 75:6 93:9 94:9 95:19 97:4
needed 13:20 14:16 62:9
needs 14:24 24:2 42:11 52:15 54:21 64:5 65:23
neglected 74:12
neighboring 60:25
never 9:18 32:22 87:13
new 1:2 2:7 16:8,17,18 17:6,22 18:12,13,18 24:6,7 30:17,18 31:3,8 40:19 43:19 45:7 46:3 46:5 47:2,12 53:23 56:18 60:23,25 61:4 67:14 74:22 76:11,14 77:5,8,13 79:20 80:2 80:12 81:20 82:21 83:14,17,18 84:8,10 85:9 86:7 87:16,20,25 89:16,18 94:24,24 99:15 101:2
NHTSA 70:22 71:11
nice 29:4
nicely 9:13
Nick 60:18 62:17 63:18 64:11
nickname 27:7
night 9:19
Nineteen 67:22 68:13
ninety-nine 29:3
nitro 50:20 51:19
nitroglycerin 46:9,11,11,18,19 50:23 51:7
non 89:16
norepinephrine 41:5,8
normally 15:23
notice 28:24 42:7 70:19
notices 71:4,11
notification 23:12 24:8 26:8
notifications 25:12,17
number 10:7 12:14 16:7 17:24 27:5,16 28:12 38:3 52:12 74:22
numbers 26:23 27:10,10,13,17,18 28:4,9

O

o 6:22 8:16,22 10:5 12:4,5
o'clock 13:13
obstetric 46:21
obviously 6:2 31:8 42:10 75:7 98:14
occur 93:14 99:3
occurred 91:15
occurs 97:22
October 100:3
offer 65:12
office 9:8,19 55:15 56:16 61:3 65:12
official 7:9 23:6
officially 23:3
offline 22:18 25:17 34:21 37:14 42:12 94:7
Oh 63:16 85:3
okay 2:14 3:6 4:20,23,25 13:22 18:21 19:22,24,25 33:19 37:7 38:12 41:24 44:22 47:25 48:15 50:16,18 51:5,9,17,20,21,23 55:6 56:25 63:8,16,16 64:21 67:9 71:12 75:17 76:10 79:19 79:25 80:25 81:18 83:6 84:6 85:8 86:6 87:18,19 89:14 99:16 100:2
old 46:3 74:19 80:2
Olsson 4:13,14,14 50:6,7,7 73:12,13,13 85:10,10,11,12 86:7 89:10,12,13 90:17,19,21
once 11:7 17:10,14 26:15,15 46:15,16
ones 30:14
open 15:17 16:2 37:20 54:16 69:23
opened 33:9
operate 92:10
operating 45:20
Operation 8:15
operational 84:12 98:12
operations 8:15
opinion 95:17
opportunities 12:23 77:16
opportunity 98:22
opposed 51:19 85:19 95:15
opposite 21:10
option 11:12 32:6 35:19 36:16 37:2 46:3
optional 11:14 75:7
options 37:11
order 7:2 8:13 46:15,16 61:20 62:9,11 69:23 75:2,8 88:24

91:9,11 93:23
orders 46:23
organization 21:19,19 34:18 47:16
organize 64:10
original 23:8 68:2
outbreak 8:20 66:4
outlined 93:23
overall 77:24
Overdose 47:10
overnight 13:12,12
overseeing 68:3
oversight 91:12 92:12
overwhelming 42:25
OZGA 2:19,22,24 3:2,4,6,10,12 3:17,22 4:3,5,8,10,12,15,20 4:23 11:23 48:12,19,22,24 49:2,4,6,8,10,12,14,17,20,23 50:2,4,6,8,10,12,14,16 51:15 71:23,25 72:3,5,7,9,11,13,15 72:17,19,25 73:4,6,8,10,12,14 73:16,18

P

P.C.I 29:14
P.C.R.s 12:7
P.D.F 23:9
P.D.F.s 20:16,17,17
P.S.C 10:16,18,19
P.S.I 9:12,16
pace 12:15 40:8
package 70:2
page 16:16 17:17,22 21:15 23:7 101:5
pages 101:6
paid 12:18 39:7
pain 47:15
pandemic 6:19 51:25 52:3,6,25 53:3,18 89:17
pandemics 81:23
paper 9:18 12:7 20:8,8,9,9,16
paramedic 10:12,14,14,24 11:4 11:11 20:7 22:8 46:22 60:15 70:7 71:8,10
paramedicine 6:21,24,25 7:5,8 7:10,11,12,14,16,20 8:2,3,6,7 8:12 55:3 75:19 76:3,7
paramedics 24:19 78:18
paramount 36:22
parent 14:11
part 8:5 9:9 15:5,20 16:17 17:8 28:23 29:13 31:25 33:15 34:22 34:25 42:19,20 53:8 57:16,21 63:24 76:21 77:3,7 79:15,16 81:5 99:10,12
participants 77:4
participate 54:17,25 65:13
participating 14:22 80:8
participation 80:10 90:5
particular 29:7 33:11 39:2,19 41:14 65:17,25 94:8 95:3
particularly 18:11 88:25 98:22
partner 8:9 19:3
partnership 18:13 25:15 26:2,6
parts 8:19 52:18
pass 90:2
passes 50:17 51:21 73:18
passionate 63:21
pathway 8:20 66:8 97:16
patient 5:25 6:12 20:23,23,25 33:18 45:24 55:21 56:7,8,15 57:5,7,13,23,25 58:11,25 59:19,22 60:9 61:7,11,12,17 61:18,21,21,22,23 75:4,6
patients 33:13 55:5,19 56:3,5 58:23 60:6 61:2 62:6 74:8 89:17,18
pay 33:10,21,21 35:20 36:18 37:5,8 39:20
payment 36:7
payments 6:14
pediatric 13:3,6 21:25 30:13 33:13 34:2 44:4 46:4 74:4,8 78:23
pediatrics 47:19
people 9:15,21 15:24 19:16 29:24 37:2,15 64:2,4 68:18,22 69:6,24 82:11 83:4 97:17
percent 5:17,21 9:7 29:25 33:4
Perfect 51:5
perform 91:20
performance 77:12
performing 86:15
period 98:11
permissions 32:9
permits 8:14
permitted 6:25 53:13 95:20
permitting 75:13 89:7 94:2
person 2:5 15:19 65:10 68:8 69:3

personalized 22:25
personnel 75:2
perspective 33:20
perspectives 15:11
pertaining 67:13
pertinent 98:15
Peter 1:9 5:19
phase 67:17
phenomenal 12:20 74:2
Phillippy 28:11,12 37:24 79:18
phone 22:20,23 23:10,11 24:9 26:23 27:5 28:3 30:21
phonetic 6:16 82:15
physical 7:7
physician 59:18 60:11,11
physicians 19:14 79:15
pick 25:3 30:18 42:16
pick-ups 10:2
Pickett 4:15
picking 41:16
picture 95:11
piece 32:13,20 34:14 42:21 90:22
pieces 22:16 23:16 42:8 44:4
Pigut 82:15
pilot 54:13,14,17 69:20
place 7:2 8:13,14 10:17 18:8 52:2,13 53:19 58:8 62:14 71:2 78:19 79:8 89:20,21 94:2 101:4
placed 39:10
places 20:21
plan 15:25 31:14 59:19 89:19,21 97:13,14,15
planning 15:25 54:11
plans 97:4
platform 12:10,17,18 24:14
platforms 33:7
play 68:14
please 2:16 5:25 6:12,15 8:12 8:23,25 14:13,13,13 16:11,12 19:17 54:9 58:20 71:22 74:11 79:17 85:10
pleasure 36:20
pledge 2:8,10
plenty 5:15
point 17:3 33:10 37:25 47:18 52:10 67:6,19 70:3 73:25 75:4 80:6 91:2
points 29:18
policies 62:14 92:4 94:22
policy 6:21,23 8:16,22 10:5 11:4 12:3,4,5 57:4 60:3 67:22 67:23 68:14 70:14,24 83:10 91:6,8 93:8,11 94:5,9,10 95:6 95:7,8,12,18
poor 60:14
portal 12:9 40:9 67:16
pose 86:12
positive 15:3 78:10 99:7
positively 79:9
possibility 33:4
possible 87:8 92:18
possibly 53:5 57:20 60:3 88:12
post 43:12
potential 33:17 55:21 56:13 59:24
power 20:11
practice 38:23 47:4 71:6 79:11 91:21 94:19
practiced 92:11
pre 89:2
precedent 92:23 94:22
preferred 36:15
prepare 55:17 57:24 61:4
prepared 58:3 61:16 94:25
Preparedness 55:16 56:17 65:13
presence 85:22
present 2:21,23,25 3:3,5,9,11 3:25 4:2,7,9,11,22 19:23
presentation 18:17 19:5,7,9,24 28:15 55:21 73:24
presenter 19:2,20
presently 67:16
pretty 7:23 12:15,15 68:23 70:21,23 74:19 97:8
previous 45:15
previously 46:5 47:10 88:5
price 25:21 34:8 35:2 37:3
pricing 34:11
primarily 9:8 78:16
primary 27:4 78:17
prior 2:17 92:23 94:2
priority 17:13
probably 5:12 10:20 13:16 17:2 29:8 34:3 41:17 58:4 62:8 70:15 75:9 77:19 80:2 100:3
problem 4:5 20:14 37:18

problems 9:14,18,21,23 20:15
procedural 47:17,18
procedure 45:20
procedures 62:3,11 92:4
proceeding 74:4 100:7
proceedings 101:7
process 11:6,8 31:21 65:22 67:16 76:5,18 82:23 87:7 88:23,24 89:4,5 91:14 93:9,13 93:17 95:19 97:21,23 98:6
processed 6:15
processes 98:4
processing 6:7,9
procrastinating 68:22
proctor 10:21,24
proctors 10:18,22
product 35:16 40:12 43:15,23
productive 12:15
program 6:8 7:8 9:11,12 11:2,3 12:8,22 35:5 76:3,7 77:9,18 86:15,17,22,23 87:3,5,5,9
programing 6:24
programs 7:10,12,21 11:5 13:4,8 18:2 68:4 79:7
progress 17:7
progressing 12:19
project 19:3 54:13,14,17 74:5
properly 21:18 82:11
propose 90:14
proposed 58:19
proposing 58:14
protect 62:11
protective 27:14
protocol 18:12,13 21:4 23:25 24:7 31:15,21 32:5,14,20 34:16 36:4 41:4,6,15,18 46:2 46:4,7,7,9,22,24 47:2,6,8,10 47:11,13,16,20,22 51:25 52:4 52:25 53:3,18 54:2 55:8 56:4 61:8 74:21,21 80:4 85:13 86:2
protocols 20:5,7,22 21:17,25 31:12,15 39:4 40:3,15 41:9 45:7,8,10,13,14,15,18,23,25 52:11,13,19 53:5,9,24 61:5 80:9,9,12,14,14,19,22 84:10 84:14,15 85:5 88:4,17 89:21 92:5
provide 34:6 35:22 39:15 43:2 60:12,13 77:10 89:24
provided 36:10 56:16 93:18
provider 10:9 13:7 21:5 23:11 23:14 25:3,10 31:16 34:6 35:3 35:9,20,21 37:4 41:19
provider's 21:3
providers 9:10,25 17:19,25 18:5 21:11 24:3 25:5 26:25 27:11 29:2,16 31:11 35:7,11,13 37:22 38:21 39:11,16 40:2,19 42:17 43:10 53:9 58:24 69:13 75:13,18
provides 23:24
providing 35:11 45:21
proximity 75:14
pseudo 93:8
public 43:14 71:7 93:9 95:18
publish 32:18
pull 30:13
pulled 23:4,9
pulling 24:24
pulls 23:2 30:16
purchase 26:4 35:6,10,16
purchased 35:15
purchases 35:12 43:15
purpose 25:23 84:15
push 7:3 23:12
pushing 78:2 80:4 83:18
put 3:13 8:21 10:17 13:24,25 28:2,6,10 29:19 43:15 52:2 53:21 54:2,2 61:8 62:14 69:9 69:25 76:6,8 85:3,14 86:5 97:13,14
puts 27:11
putting 17:22 43:2 65:3

Q

Q.A 35:14
quality 37:22 76:16,17,20,22,23 77:3 78:3,4,6,8
question 7:19 23:19,22 26:21 38:20 40:6 42:4,7,19,20 56:23 57:3,10 58:22 59:7 62:18 69:12 70:9 83:13,17 86:12,13 88:2 96:6,8
questions 6:13 8:25 10:25 26:13 26:17,19 30:25 37:17,25 38:3 40:22 44:15 63:3 78:5
quick 5:10 56:23 87:7
quickly 24:2 67:4 88:21
quite 9:13

quorum 4:24 66:20

R

raised 69:12,16
ramifications 63:6 81:5
rapid 22:5
re-look 94:4
reach 6:15 24:2 43:19,21,23 44:19 79:17
reaching 27:23
read 21:5 24:9
readiness 74:4
reading 82:8
ready 32:18 61:20
real 29:16
realize 85:4
really 5:17 7:2 10:3 12:22 15:3 17:20 19:9 20:10 21:7,12 23:24 24:17 25:2 26:10 28:16 29:4 35:18 36:25 40:22 43:3,5 44:3,23 53:14 60:10,15,15 63:4 70:12 78:22 79:6,9 84:7 91:2,6 96:18 97:11,15 98:3
reason 78:20
reasonable 18:8 63:9 75:5 76:6 89:19 99:10
receive 61:11,16,20 88:6
recognition 74:7
recognizes 18:5
recommend 51:6,7 65:11
recommendations 21:21 24:24 43:4,13
record 2:2 100:6 101:7
rectified 28:18
rectify 30:9
reduce 56:13
reducing 35:2
redundancies 47:21
reflect 45:13 67:25
regarding 52:4,8 57:11 89:20 91:5 93:21 95:6
regardless 84:20 92:11
regards 53:4 58:10,22 90:11
region 8:8 13:5 24:4 27:5,10,12 28:2,25 29:5,8 34:10 35:4,6 42:17,24 53:7,13 54:3 80:10 80:16 84:17 85:15 87:5 91:17 92:11 94:20 96:10,11,15,20
region's 28:8
regional 29:5 52:15,15 85:17 86:15,17 89:22 91:10,11 92:12 92:13 98:12
regions 21:17 24:12 27:25 34:13 35:16 41:22 52:14 79:6 80:8 86:3 91:23 92:16 94:25 96:14 97:5,13
registry 10:12,16,16,18
regs 69:10 98:6
regulations 15:22 69:2 94:11 98:15
regulatory 97:21
related 5:18,22 6:11 7:22 8:17 9:3 10:6 17:23 75:12 77:11 78:5 82:4 87:9 88:2 96:5
relates 6:24 55:22 56:2
releasing 66:8 81:24
reliability 22:21
REMAC 32:16 83:8 91:19
REMACs 6:8 19:8 92:3 96:21,21
remember 76:17
remind 54:14,18
REMO 39:7
remove 47:21 55:17
removing 75:2
REMSCO 32:17 86:12,13,16 91:5 93:7,16 95:4,9
REMSCOs 6:8 19:8 96:22
remuted 57:3
renewals 67:13
report 5:10,12 55:5 67:12 74:17 75:23
reported 74:12 101:4
Reporter 101:13
reps 91:20
republic 2:11
request 55:15
requests 29:25
require 10:15 45:6
required 69:21 93:21,21
requirement 41:14 93:12
requirements 68:10
requires 47:19 60:10
rescinded 75:9
rescinding 75:11
research 53:21
resolve 87:3
resources 17:24 89:24
respiratory 46:8
response 46:13 86:3 95:11,14

responsive 28:13 38:24 39:14
rest 84:12
restrict 96:10
restricted 7:22
restriction 96:19
restrictions 70:5
resulted 70:10
results 67:18
resuscitation 57:12
retention 68:11
review 64:14 81:20 94:21 96:7 96:20
reviewed 98:19
reviewing 63:21 93:10
reviews 40:3
revising 52:9
revision 69:22
revisions 70:15
revisit 94:9
rig 75:6
right 3:23 8:2 14:21 18:23,25 20:6,17,18,24 22:11 23:18,25 24:3,9,18 26:16 27:6,8 30:5,8 30:23 31:18 32:11 33:13 34:17 38:5 41:25 43:2 44:7,21,23 48:17,19 54:6 60:7 67:3 71:21 74:18 78:16 81:3 94:16 95:9
risk 59:22
risks 59:3,5
road 12:25
Rob 48:9,12,14
roll 2:9,15 48:18 51:18 71:21
rolls 97:11
RTAC 85:16 86:4
rules 69:9
running 26:16 38:20 44:24 67:4
runs 70:6
rural 77:23,25,25
Ryan 5:9 20:2 36:2,22,24 38:14 46:12 51:18 52:22,24 54:7 55:7 58:21 65:6 73:20 74:12 74:25 75:20 76:10 79:20 86:13 87:11 90:2 92:15 96:2 99:14

S

safe 18:6 70:21
safety 45:24
sake 86:4
Save 51:20
saw 13:19
saying 7:20 24:9 32:11,24 93:19
scattered 20:18
schedules 65:3
Schenker 83:19 84:3,6,25
scope 47:4 71:6
screen 19:21
search 25:20 30:11 37:2
seats 82:9
second 5:6,7 42:20 48:4 51:14 57:10 63:11 71:19 94:6 99:22
seconded 47:23 70:17 99:24
seconding 48:8
seconds 51:11
SECRETARY 2:19,22,24 3:2,4,6,10 3:12,17,22 4:3,5,8,10,12,15 4:20,23 11:23 48:12,19,22,24 49:2,4,6,8,10,12,14,17,20,23 50:2,4,6,8,10,12,14,16 51:15 71:23,25 72:3,5,7,9,11,13,15 72:17,19,25 73:4,6,8,10,12,14 73:16,18
section 9:8 54:3 83:10
sedation 47:17,19
see 16:14,18 19:23,23 21:24,25 22:12 23:8 38:22 40:13 64:9 70:2 77:12,20 79:6,8,14 82:5 100:2
seeing 9:22 25:4
seeking 95:16
seen 2:6
seizure 46:24
SEMAC 1:1,6 2:1,7 3:1 4:1 5:1 6:1 7:1 8:1 9:1,3 10:1 11:1 12:1 13:1 14:1 15:1,2 16:1,14 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 28:13 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1,24 41:1 42:1 43:1 44:1 45:1 46:1 47:1,24 48:1 49:1 50:1 51:1 52:1 53:1 54:1 54:15 55:1,3,17 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1,22,24 66:1 67:1 68:1 69:1 70:1 71:1 72:1 73:1 74:1 75:1 76:1 77:1,2 78:1 79:1 80:1 81:1 82:1 83:1 84:1 85:1 86:1 87:1 88:1 89:1 90:1 91:1 92:1,6 93:1 94:1 95:1 96:1 97:1 98:1 99:1 100:1

101:1
SEMSCO 15:2 54:22
send 19:18 62:21 64:12
sending 58:25
sense 33:16 34:2
senses 97:2,11
sent 45:8,11 91:4
sentence 85:18
separate 46:6 54:3
sepsis 41:4,5 74:7
September 66:5
septic 46:6
serious 85:22
service 95:16
services 15:9,10 27:15 46:12 93:10 95:11
set 21:4 34:16 35:21 54:10 61:11 64:19 65:7 68:18 70:12 71:10 80:22
setting 52:17
seven 24:20 40:17,19 76:17,20 76:24
seventy 5:17,21
shaking 83:5
shape 32:7
share 17:17 44:14 75:23 77:15 77:15,16
shared 78:9
sheets 67:15
shock 46:6 47:12
short 87:8
shout 14:6
show 10:11 27:8 30:19
showed 62:20
shows 14:18
side 6:6 16:12 21:3,8,10 22:5 23:24 24:18 65:4 85:22
sides 21:7
sign 15:25 16:15 26:12
signals 5:20
signed 25:5
significant 10:11 97:8
significantly 12:15 35:13
signing 68:22
signs 15:15,16,18
SIM 9:21
similar 9:20,22 14:15 46:24 53:17 77:21,25,25 86:3
simply 22:9 30:11
single 21:5 27:3 36:5,6
sit 17:11
sites 5:23,23
situation 8:19 14:15 19:10 54:5 63:2 93:7 94:5,8
situational 19:7
situations 8:18 33:25 39:25 77:22
six 10:20 64:19 76:18 82:11
size 77:25
skill 47:3
skills 71:10
slides 19:6
slightly 88:24
small 28:17 75:14
smaller 16:13 77:22
smarter 59:7
soap 80:24
software 20:10
solution 87:9
solutions 87:2,8
solve 21:6
somebody 36:14 59:7
somewhat 70:10
soon 30:21 32:19
sooner 69:6
sophisticated 43:6
sorry 5:19 77:15 80:16 96:21
sort 29:11,15,15 31:13 34:10
sorted 30:20
sounding 79:8
sounds 17:12 38:10
sources 23:2,6,6
southern 12:21
space 16:3
speak 2:16 3:19 43:18 84:4
SPEAKER 3:15 72:22 81:11 90:17 99:25
speaking 2:17,18
specialized 53:23
specific 8:8 22:13 34:25 79:16 91:14 93:6 96:11,13,22
specifically 17:24 23:23 46:2 46:19 82:4 93:7
specimen 71:8
speed 22:21 88:24 89:6
spelling 6:16 82:15
spent 32:7 67:21 68:11 92:16
splint 44:2

spoke 16:4
spoken 39:21
sponsor 10:8 33:15 67:13 70:6 96:10,19
sponsors 11:19 70:9 96:8,15
sponsorship 36:3 96:12
spots 15:21,23
squad 2:18
stable 14:15
staff 5:10,12,18,22 6:4 28:20 67:12
stakeholders 89:22
Stand 72:22
standard 34:15
standards 10:6 39:19,22 45:2,4 47:24 50:20 92:6,20 98:10
standing 46:23 68:8
stands 2:12
start 10:11 18:3 38:21 52:18 54:11 62:9 98:8 99:2
started 12:24 20:4 53:20
starting 14:12 25:6,7 78:12
starts 26:2
state 1:2 2:17 7:6 11:14 12:18 15:8 20:19 21:18 22:3,14 23:13 24:3,12,18 25:2,15,25 26:6,11 27:10 28:22 30:17 32:18,19 33:15 34:5,7,10,13 36:17 43:20 47:9 51:7 52:19 53:22 54:16 60:25 61:24 65:7 76:14,22 77:12 79:6 80:5,7,23 81:20 82:22 84:12 87:6 89:3 89:19,21,23,24 91:20 92:9 97:7 101:2
state's 29:20 36:15 77:24
stated 101:5
statement 6:22,23 8:16,22 10:5 11:4 12:3,5 70:14 86:2 95:8
statements 12:4 94:10
states 2:11 53:21
statewide 7:12 52:11,12,20 53:8 53:10 69:23 80:4
statistics 39:22
status 47:11 60:14 74:21
statute 93:12 99:11
stay 70:15 88:18
staying 9:6 100:5
steps 36:12 77:8 97:20
Steve 14:21 18:21,25 19:2,18,20 26:19 36:2 37:25 38:23 42:7 44:9,10,12 55:10,13,15 56:22 92:14 93:2 94:13 98:7
Steve's 38:20 44:12
Steven 20:2 28:11,15,23 31:2 36:19,23 37:16
Steven's 28:13
sticking 99:17
stop 31:13 36:6,6
strange 92:2
straps 13:24
stretcher 13:22,23,23,25
strictly 85:19
stroke 29:13 47:13
strongly 80:18 84:19 88:20
stuck 43:5 60:15
stuff 16:13 29:12,14 44:16 69:25
subcommittees 44:25
submitted 89:2
subscribed 101:10
subsidies 90:11
subsidy 34:10
sued 82:12
Suffolk 69:14,17 80:16 82:16,21 83:23
Suggest 81:11
suggested 31:16
suggestion 33:14 81:13
suggestions 19:17 31:21 81:24 82:12
suggestive 33:24
suggests 85:20
suit 40:4
sulfate 46:23,25
summer 17:3
sunset 41:14
supervisor 16:8
support 86:17,20 87:4,10,17 90:13 91:18 93:22 95:5,10,14
supporting 74:2
supposed 61:16 81:21
supraglottic 54:13,19
supraglottics 69:24
sure 3:18 9:10 13:18 14:9 18:3 18:6 19:17 24:20 27:2 29:17 30:5 31:13,18 32:2,2,8,25 37:9,21,22 40:14 42:5 43:16 44:8,11 55:11 58:13 59:11 65:8,20 66:16,22 82:20 84:5 86:19 90:9 91:6,11 92:17,19

92:24 94:10,24 97:7,9 98:17 99:4
surge 89:20
surging 89:16
surprising 70:11
surrounding 59:19
survival 59:24
swab 71:9
switch 68:20
switched 29:22
switching 38:16,19 40:16
system 20:10 22:11 25:18 29:19 30:10 32:4 35:6 44:3 59:17 89:25 93:22 99:12
systems 92:17

T

T.C.I 23:17
T.X.A 88:3
tach 46:2
tailor 40:4
take 3:18 8:23,24 10:15 11:13 11:13 20:16 21:3,14 30:22 37:14 40:13,23 45:9 52:17 57:24,25 68:19,24 69:6 70:14 70:25
taken 20:8 58:18
takes 41:6
talk 9:6 11:4 13:17 36:23 37:15 40:24 50:19 55:12 57:15 69:7 69:18,19 81:12,14 93:2 94:7
talked 22:24 51:25 52:16 62:4 67:23 68:7 70:4 93:16
talking 13:14 34:12 60:8 63:2 68:11
talks 12:6 56:4
targeted 17:25
team 24:18 44:21 60:11
technical 4:18
technology 22:17 36:12
tell 14:2,9 34:24
telling 31:6
template 76:4
ten 10:21 19:4
term 65:19 87:8,9
terms 39:9 46:8 83:20
territory 70:6
test 68:23 69:4,6
testing 5:23 7:17,21 9:12,24 42:23 67:15
thank 2:14 4:25 5:8 8:14 10:22 12:16 14:17 28:12 37:16 41:11 44:12 49:20 50:16,18 51:23 54:6 55:6 56:25 58:21 64:23 67:8 71:20 72:25 73:19,23 74:10,12 79:18,19 80:23 84:24 85:8,12 86:5,6,11 87:11,18 89:15 90:22 96:2 99:14,16,20 99:23 100:4
thanks 31:5 41:13,24 44:9 45:3 62:17 64:21 71:12,18 90:24 93:4
they'd 53:8
thing 5:13 10:11 17:12 18:5,10 21:2,17,23 22:10 32:14 38:19 39:2,18 76:13 96:4,6
things 5:24 6:3 7:17,24 10:8,9 13:11 15:6,10 17:16 20:18,25 22:13 25:24 26:14 27:14 32:16 33:6,20 38:25 39:7 53:17 58:17 66:23 76:19 78:22 79:8 88:11 89:6 92:25 93:2 94:16 97:19 98:5,7,19,23 99:9,10
think 5:13 14:7 18:14,16 19:5 28:18 35:24 36:12 37:11,13 38:19 39:17,18,22 41:19 48:12 51:15 57:17 59:13 63:4,8,12 63:24 65:10,25 66:2,11,17,24 74:16,19 75:8,17,22 80:14,17 82:17 83:4,22 84:7,21 88:16 88:19 90:12 91:2 92:16 94:15 94:17 99:6 100:3
thirteen 83:7
thirty 9:7,24 29:25 93:20
thirty- 93:20
thirty-eight 14:8
thought 14:9 66:19 91:13,25 96:25 97:3
thousand 9:24 43:9 92:2
thousands 25:4
three 7:6 10:5 15:16 20:15 25:14 65:23 75:15 78:18 79:4 79:7 92:2
Thursday 9:19
tier 12:21
Tiffany 2:7 3:5
tight 33:25
tighter 69:10
till 20:7 66:5 69:4

time 5:15 16:2 24:18 25:25 29:16 32:8 33:9 38:6,8,15 40:23 41:14 44:24 51:20 53:15 57:24,25 58:8,9 62:15 63:5 66:2,20 67:4,21 68:11 69:3 88:8,10,17 89:2,2 92:16 95:10 97:12 101:4
timeline 88:12,13
times 6:10 31:7 39:24 61:20 65:23 84:18
today 15:22 95:21 98:15 99:17
told 44:10 86:25 91:21
tool 84:12
top 17:12 27:9 29:15 37:21
topic 17:20
topics 16:7
touch 28:2 29:18
touched 75:19
tour 12:25
tracking 32:16
Traffic 70:21
training 23:17 25:8,10 26:9 35:14 67:11 69:23 71:10 86:21 96:23,24 97:6,13,14
tranexamic 85:14,20,24
transcription 101:6
transfer 55:4,8,22 56:3 59:20 59:22 60:5,6,14 69:15
transition 10:12,13,23 12:6 14:12 36:2,4
transitioning 12:10
transport 13:3,6 14:14 55:18 57:9,15 58:24 59:4,15,23 61:8 61:9,14
transportation 92:5
transported 56:5
transports 58:6 59:17 60:24 62:15
trauma 14:20,23 15:2,9 29:9 30:12,13 47:20 85:17
treat 57:24 58:3,4,10 61:21
treatment 55:19 56:10 57:16 61:25 78:19 92:4
trepidation 36:8
triage 51:25 52:4 53:18 92:4
trial 67:17
tried 42:21
true 101:7
trusted 23:3
try 9:15 13:5 43:16 56:12 66:12 67:2,3 90:15
trying 22:8 34:5 53:16 61:4 88:17,18,18
tuned 70:15
turn 18:25 53:7,7 54:4,4 81:14
turned 69:14
tweak 68:13
tweaked 24:16
tweaks 68:5
twenty 6:22,23 8:16,22 9:24 12:3
twenty-five 79:5
twenty-four 24:19
twenty-one 8:16 10:5 12:5
two 8:16,22 10:18,19,25 17:16 20:22 21:7 39:5,6 45:20 52:21 55:2 71:4 74:5 75:15 76:13,15 94:15
two-month-old 13:16
twofold 30:10
type 30:19 33:15 93:13
types 52:5
typewritten 101:6

U

ultimate 7:13
ultimately 31:17,19
understand 5:14 19:11 23:21 25:7,11 35:23 40:15 88:15 91:7
understanding 11:10 33:7 90:12 99:5
understood 23:21
Undifferentiated 47:12
unfortunately 56:7 74:14 82:22 82:24 83:7 87:6
UNIDENTIFIED 3:15 72:22 81:11 90:17 99:25
unified 45:7 80:12,14
unintentionally 95:13
United 2:11
unlimited 24:3
unmute 72:20
unmuted 49:18 57:2
unstable 61:13,13,21
update 74:21 88:17 91:5 98:6,14
updated 24:6 32:20 39:8 41:15
updates 43:17 88:4,4
upgrade 68:9 95:14

upgraded 33:23
upgrades 91:9
upset 39:12
upwards 9:24
urge 80:18
urgent 24:8 66:3
use 13:7 20:22 25:6,7,11 32:11 38:21 42:11 43:4 47:5 52:9 54:19 55:11 69:24 83:11 84:11 84:15 85:14,20
useful 44:3
users 43:23
uses 84:13
utilize 20:11 81:25

V

V-fib 46:2
vaccinate 8:3
vaccinated 75:3,13
vaccination 5:23 7:4,18
vaccinations 7:21
Val 2:14,18 5:2 48:17 50:19 65:4 71:22 73:20
Valerie 54:10
validating 16:23
Valley 54:14,24 69:21 91:5,15 93:7,16 95:4
value 39:16 43:2
valve 82:10
verify 93:25
version 17:4,6
versions 25:14
versus 57:25 59:3
vetted 23:5 31:19
vetting 82:23 83:4
vials 46:11,14
video 4:18 66:14,21
viewable 23:7
Violante 78:10
viral 43:8 51:25
virtual 11:21 14:21
visits 14:21
vital 15:15,15,18
volume 84:11
volunteer 42:24 54:9 63:17 64:2 77:23
volunteers 52:21,22
vote 45:6 48:18 51:18 71:13,14 71:22
voting 62:19

W

W 14:8
wait 66:5 68:24
waiting 88:7,8,10 89:4
waiver 46:14,16,17
walking 14:10
walks 26:12 61:19
wall 33:11,21,22 39:21
Walters 4:16,17,17 50:8,9,9 73:14,15,15 87:22,22,23,25 88:15
want 11:15 18:6 22:11,21 23:19 25:8 28:6 30:12,19 31:13 33:3 35:20 36:11 40:13,23 44:8,8 47:18 48:3 50:19 58:13 62:20 63:17,25 64:12 65:18 66:5,7 71:15 74:24 75:20 76:13 81:8 85:16 92:18 96:4 98:17
wanted 32:25 55:7 58:22 62:16 76:11 82:18 84:25 85:25 97:9 99:3,13
wanting 60:25
wants 79:10
wash 17:10,14
wasn't 14:11 43:3 44:3 94:6
watch 13:16
wave 52:2
way 10:2 21:15 26:22 27:14 29:11,16 30:9 32:7,17 36:17 56:11 65:11 69:5 80:21 92:8 97:11,18 98:20,24 99:8
ways 51:2 68:12
wayside 94:22
we'll 2:9 15:19,21 16:2,6 20:16 30:5 37:23 38:7 40:12 41:17 41:20 44:24 48:18 51:9 64:19 70:2 71:13 76:8,8 82:5 88:11 100:2
we're 9:22 12:6 13:8 14:12,20 15:13,16 17:11 24:16,23,23 27:22,24 28:9 30:4 34:9,25 37:6,19,19,19 38:5 40:17 42:16 44:13 53:3,16 54:11 58:14,14 60:8 63:2 65:2 68:14 74:3,3,5 77:7,18 82:9,12 83:3 84:23 88:7 89:3 97:16,20 99:16
we've 12:4 17:14 25:4,24 26:21 28:14,18 29:21 34:12 39:21

47:6 50:25 52:3,7 60:22 66:17 80:5,13 83:19 98:21
wearing 75:4,6
web 16:16 17:22 23:4 67:17
WebEx 1:5 65:3
website 6:23 10:7 16:16,25 17:17,23 25:22 29:20 44:20
websites 24:23 43:12
week 10:19 13:10,10,11 15:16 18:14,15,15 25:5 81:21
weekly 16:8
weeks 8:18 10:19 86:23
weight 34:19 45:23
welcome 2:3,6,8 40:22 90:8
wellbeing 17:19 18:4
went 3:15 13:10,12 67:12 91:24 93:6
western 31:3
wet 57:23
WHEREOF 101:9
Wi-Fi 22:23
Wicelinski 4:21,22,22 48:9,9,13 48:14,16 50:10,11,11 51:12,16 51:17 73:16,17
wide 23:14 33:9
willing 64:4
winding 26:3
Winslow 82:16,18,20 83:6 84:25 85:3
wise 66:21 69:5
wish 52:19 54:17,24
WITNESS 101:9
wondering 31:24 92:14
wording 68:15 98:24
work 19:19 22:9,20 24:17 27:25 31:9 34:9,25 35:3 38:9 40:14 52:17 59:24 60:23 64:4,23 76:6 83:10
worked 61:2 95:4
working 4:18 9:16,17 14:22 15:6 16:6 24:19 29:22 30:4 37:20 37:21 40:8,8,9 46:18 52:18 74:5 77:8 78:13 79:2,7,9 83:3 87:2,7 92:20 97:19 98:8,13
works 22:18,18
world 6:19,20 8:19 12:3,5,11 14:20,23 97:25
write 2:18 21:4
writing 40:14
written 68:20

X

Y

yeah 13:20 27:19 31:2 32:2,23 33:19 35:23 44:8 53:2 60:21 86:8 95:3
year 9:25 15:19 26:3 65:23 67:19 69:3 77:19 82:24 90:25
years 10:18 70:7 80:3 92:17
yesterday 7:19 26:21 36:2 45:5 45:17 46:10 50:21 52:16 67:12 78:9 97:6
York 1:2 30:17,18 31:3 43:19 45:7 53:23 56:18 60:23 61:4 80:12 81:20 83:14,17,18 84:8 84:11 89:16,18 94:24,24 101:2

Z

zero 30:4 67:22 68:13
Zoom 64:19

0

1

1 101:5,6
100 101:7
11:06 100:6
11th 11:18,22 12:2
13th 5:3
18th 11:23

2

2020 1:8
2021 10:13 101:10
2022 10:13 11:6
26 1:8

3

30 91:12 92:22 94:11 95:20

4

5

5-26-2021 1:1 2:1 3:1 4:1 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1

30:1 31:1 32:1 33:1 34:1 35:1
36:1 37:1 38:1 39:1 40:1 41:1
42:1 43:1 44:1 45:1 46:1 47:1
48:1 49:1 50:1 51:1 52:1 53:1
54:1 55:1 56:1 57:1 58:1 59:1
60:1 61:1 62:1 63:1 64:1 65:1
66:1 67:1 68:1 69:1 70:1 71:1
72:1 73:1 74:1 75:1 76:1 77:1
78:1 79:1 80:1 81:1 82:1 83:1
84:1 85:1 86:1 87:1 88:1 89:1
90:1 91:1 92:1 93:1 94:1 95:1
96:1 97:1 98:1 99:1 100:1
101:1

6

7

8

8th 101:10

9

9:10 1:8 2:2