

1-4-2022 - SEMAC - WebEx
NEW YORK STATE
DEPARTMENT OF HEALTH
BUREAU OF EMS

SEMAC MEETING

DATE: January 4, 2022
TIME: 12:02 p.m. to 3:08 p.m.
CHAIR: DON DOWNOW
VENUE: WebEx

- 1 1-4-2022 - SEMAC - WebEx
- 2 BILL HUGHES
- 3 BILL LIDDLE
- 4 BRETT ROBERTS
- 5 BRIAN LEVINSKY
- 6 BRIAN WIEDMAN
- 7 CARL GANDOLFO
- 8 CARLA SIMPSON
- 9 CAROL BRANDT
- 10 CECILY SWIMBURNE
- 11 CHARLOTTE CRAWFORD
- 12 DAMON WEST
- 13 DANA JONAS
- 14 DANIEL CLAYTON
- 15 DAVID BUTLER
- 16 DAVID COLE
- 17 DAVID SIMMONS
- 18 DEAN ROMANO
- 19 DAVID VIOLANTE
- 20 DEAN ROMANO
- 21 DONALD HUDSON
- 22 EDWARD MAGER
- 23 GENE MYERS
- 24 GREGORY GILL
- 25 HOWARD HUTH
- JAMES O'MELIA
- JASON ALLEN WINSLOW
- JASON HAAG
- JEAN TAYLOR
- JEFF CALL
- JILL BRAUNER
- JOHN MACMILLAN
- JOSEPH TINKLEPAUGH
- KAREN BRODERICK
- MARK FORREST
- MELISSA LOCKWOOD
- MICHAEL BENENANTI
- MICHAEL BENNETTE
- MICHELE FORNESS
- NICK ECKERT
- NICKOL O'TOOLE
- PETER CHIAVETTA
- RICHARD BRANDT
- RICAHRD PARRISH

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- 2 **APPEARANCES:**
- 3 VALERIE OZGA
- 4 NIKOLAOS ALEXANDROU
- 5 JOE BART
- 6 JONATHAN BERKOWITZ
- 7 JEREMY CUSHMAN
- 8 MICHAEL DAILEY
- 9 JOHN DETRAGLIA
- 10 DAVID KUGLER
- 11 YEDIDYAH LANGSAM
- 12 JOSHUA LYNCH
- 13 DAVID MARKOWITZ
- 14 LEWIS MARSHALL
- 15 PAMELA MURPHY
- 16 DAN OLSSON
- 17 MATTHEW TALBOTT
- 18 BRIAN WALTERS
- 19 ROBERT WICELINSKI
- 20 OREN BARZILAY
- 21 MARK PHILIPPY
- 22 MARYANNE PORTORO
- 23 MIKE MCEVOY
- 24 STEVEN KROLL
- 25 RYAN GREENBERG
- AMY EISENHAEUER
- ARTHUR COOPER
- TIFF BOMBARD
- JEFF RABRICH
- JASON ALLEN WINSLOW
- JONATHAN WASHKO
- GREGORY YOUNG
- AIDAN O'CONNOR
- BRIAN CLEMENCY
- PATTY BASHAW
- PETER BRODIE
- ALAN BELL
- ALAN LEWIS
- ALEXANDER
- KOCZOR
- ALICIA BROADBENT
- ANDREW KNOELL
- A. SMITH
- BEN SENSENBACH

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- 2 ROBERT KUHN
- 3 ROBERT MARSHAL
- 4 ROBERT MCCARTIN
- 5 RON HASSON
- 6 RYAN BAILEY
- 7 SCOTT BOWMAN
- 8 SCOTT LANPHIER
- 9 SHANNON BENSAL
- 10 STEPHEN CADY
- 11 STEVE ANDERSON
- 12 STEVEN BLOCKER
- 13 STEVEN MEEHAN
- 14 STORM TREANOR
- 15 SUSIE SURPRENANT
- 16 TERESA HAMILTON
- 17 TERRY THOMPSON
- 18 THOMAS PASQUARELLI
- 19 TIM MIRABILE
- 20 TRISH HANSEN
- 21 VICTOR JONES
- 22 VINCENT OUIMETTE
- 23 WENDY JACOBSON
- 24 WILLIAM MICHAEL MASTERTON
- 25

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 2 (The meeting commenced at 12:02 p.m.)
 3 **CHAIR DOYNOW:** -- to SEMAC and a nice
 4 cold windy day out there. Just remember it is
 5 difficult to tell who is speaking. So if you are
 6 going to talk, please state your name for the
 7 transcriptionist. And also, when you're done let us
 8 know that you're finished speaking. It will work
 9 quite well with med standards and hopefully it will
 10 work well with us.
 11 Hoping our next meeting will be in
 12 person. I was hoping this one was going to be but
 13 obviously that -- that did not happen. Also, Val, if
 14 you can move Lou to the panelists, he's not there, he
 15 just send me a text about it. Okay. Let's move on.
 16 Can we have a roll call please, Val?
 17 **MS. OZGA:** Yes. Good afternoon,
 18 everyone. Okay. Dr. Alexandrou. Dr. Alexandrou?
 19 **MR. ALEXANDROU:** Yes, I'm here. I'm
 20 sorry.
 21 **MS. OZGA:** Okay, that's fine. Dr.
 22 Bart?
 23 **MR. BART:** Bart here. I'm here.
 24 **MS. OZGA:** Okay. Thank you.
 25 **MR. BART:** Got it.

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 2 **MS. OZGA:** Dr. Olsson.
 3 **MR. OLSSON:** Olsson here.
 4 **MS. OZGA:** Dr. Pickett. Dr. Talbott.
 5 **MR. TALBOTT:** Here.
 6 **MS. OZGA:** Just wanted to make note.
 7 Welcome Dr. Talbott to SEMAC. He was just currently
 8 vetted, so we're happy for him to be able to join us
 9 today.
 10 **MR. TALBOTT:** Thank you, Val.
 11 **MS. OZGA:** Dr. Walters.
 12 **MR. WALTERS:** Walters here.
 13 **MS. OZGA:** Dr. Wicelinski?
 14 **MR. WICELINSKI:** Wicelinski here.
 15 **MS. OZGA:** Okay. Non-voting members.
 16 Oren Barzilay.
 17 **MR. BARZILAY:** Barzilay here.
 18 **MS. OZGA:** Aiden O'Connor. Mark
 19 Phillippy.
 20 **MR. PHILIPPY:** Mark Phillippy present.
 21 **MS. OZGA:** Maryanne Portoro.
 22 **MS. PORTORO:** Maryanne Portoro
 23 present.
 24 **MS. OZGA:** Dr. Rabrich.
 25 **MR. MCEVOY:** He is present, but he

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 2 **MS. OZGA:** Dr. Berkowitz?
 3 **MR. BERKOWITZ:** Berkowitz present.
 4 **MS. OZGA:** Dr. Cherisse Berry
 5 (phonetic spelling). I believe she said she was not
 6 going to be able to attend today. Dr. Bombard
 7 Tiffany (phonetic spelling). Dr. Cooper. Dr.
 8 Cushman.
 9 **MR. CUSHMAN:** Cushman here.
 10 **MS. OZGA:** Dr. Dailey?
 11 **MR. DAILEY:** Dailey here.
 12 **MS. OZGA:** Dr. Detraglia?
 13 **MR. DETRAGLIA:** Detraglia here.
 14 **MS. OZGA:** Dr. Doynow?
 15 **CHAIR DOYNOW:** Here.
 16 **MS. OZGA:** Dr. Gomez. Dr. Kugler.
 17 **MR. KUGLER:** Dr. Kugler is here.
 18 **MS. OZGA:** Dr. Lynch.
 19 **MR. LYNCH:** Lynch is here.
 20 **MS. OZGA:** Dr. Markowitz.
 21 **MR. MARKOWITZ:** Markowitz is here.
 22 **MS. OZGA:** Dr. Maynard. Dr. Marshall.
 23 **MR. MARSHALL:** Dr. Marshall here.
 24 **MS. OZGA:** Dr. Murphy.
 25 **MS. MURPHY:** Dr. Murphy here.

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 2 needs to be moved into the panelist.
 3 **MS. OZGA:** Okay. I'll take care of
 4 that. Mike McEvoy?
 5 **MR. MCEVOY:** I am here as well,
 6 McEvoy.
 7 **MS. OZGA:** Steven Kroll?
 8 **MR. KROLL:** Steven Kroll is present.
 9 **MS. OZGA:** And Jonathan Washko. Is
 10 Jonathan on? Okay. Let me see how many we got.
 11 One, two, three -- we have met quorum and Dr. Doynow,
 12 you can continue.
 13 **CHAIR DOYNOW:** Okay. Thank you, Val.
 14 Welcome Dr. Talbott. Thank you for joining us.
 15 **MR. TALBOTT:** You're welcome.
 16 **CHAIR DOYNOW:** Can we have approval of
 17 the October minutes. Anybody want to make a motion
 18 to that?
 19 **MR. ALEXANDROU:** I make a motion to
 20 proof.
 21 **MR. MCEVOY:** McEvoy second.
 22 **CHAIR DOYNOW:** So -- okay. Dr.
 23 Alexandrou and Dr. McEvoy. Is there anyone who
 24 objects or abstains. I mean, we don't want to go
 25 through the whole list. Hearing nothing, then it's

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 2 unanimously approved. Okay. Moving on. Ryan, would
 3 you like to give the bureau report. Ryan, are you
 4 there?
 5 **MR. GREENBERG:** How about now?
 6 **CHAIR DOYNOW:** Okay.
 7 **MR. GREENBERG:** Double mute.
 8 **CHAIR DOYNOW:** Not a problem.
 9 **MR. GREENBERG:** Sorry everybody.
 10 Thanks for joining. And thanks for being
 11 accommodating of the last-minute time changes on
 12 everything that's going on. Going to try and keep it
 13 to a brief for Bureau Report on what's going on,
 14 obviously, a lot going on and the Department of
 15 Health right now as we continue down the next wave of
 16 this pandemic.
 17 And from an operational point of view,
 18 we are still deployed around the state. So most of
 19 our staff is deployed in some sort of COVID activity
 20 related to things. The most recent right now is the
 21 -- we have two deployments going on, actually three.
 22 So we have one that supports the vaccine sites,
 23 there's about fifteen vaccine sites out there.
 24 And then we have a state mobilization
 25 and a federal mobilization to support load balancing,

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 2 backup number one, and patient movement for hospital
 3 capacity that are going on. So we have forty-two
 4 ambulances in the state right now predominantly
 5 serving the Albany, Syracuse, and western part of the
 6 seat and they are spread out.
 7 We've also moved some resources up
 8 into the Potsdam area to serve the North Country.
 9 And the other resources are moved on the day to day
 10 most -- the biggest move to that we have is that we
 11 are now moving several units down into Hudson Valley
 12 area to support that side. And we have ten units
 13 that are in New York City.
 14 So spread out across the state, those
 15 resources are -- go out through the search operation
 16 center. And their dispatch do that and/or
 17 communications with the local county emergency E.M.S.
 18 coordinators or emergency management when there's
 19 other priorities or other needs that are there.
 20 So if any of your areas do need
 21 assistance, you're seeing backup in your E.R.s and
 22 you think that additional resources to help move
 23 patients would help, please by all means, feel free
 24 to reach out. The other thing is the surge
 25 operations center, which also falls under the Bureau

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 2 of E.M.S. is under the direction of Deputy Director
 3 ... I believe last count we had done just under about
 4 three hundred care coordination or patient placements
 5 moving around the state.
 6 So hospitals who need to find
 7 placement for patients there, because they're
 8 boarding in the E.R., or other problems that are
 9 happening, that would happen through that
 10 communication or through surge operation center. So a
 11 lot going on from -- from those components.
 12 Some quick updates, in the operation
 13 side of things, again, the bulk of our staff are
 14 currently deployed. And so that is what's happening
 15 on the operation side. We do continue, obviously on
 16 the investigation side and the other components of
 17 that. In addition, on the E.M.S. for children side,
 18 the survey starts, so E.M.S. for children survey
 19 starts -- begins on January 5th, and only takes about
 20 five to ten minutes to complete.
 21 If you can encourage your agencies to
 22 please complete it, again, it opens on January 5th,
 23 and I believe -- I believe there'll be a brief
 24 presentation by Amy on that one, like literally ...
 25 And then our E.M.S. for children's meeting -- council

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 2 meeting is next week on Tuesday, January 11th.
 3 That'll be held at one o'clock and it's virtually for
 4 anybody who would like to attend.
 5 And the data and -- data and
 6 informatics side, thanks to the hundreds of agencies
 7 who have enrolled in the C.M.E. program and started
 8 to document electronically. I have a picture from
 9 when I first started as the director of where we
 10 were, and it was basically like, half the state was
 11 electronic, half the state wasn't.
 12 We've really managed to turn the
 13 entire state or predominantly the entire state
 14 electronic and for the areas that aren't they're
 15 still charting on paper, the paper portal has given
 16 us more real live time data than we've ever had
 17 before where normally it would take upwards of a year
 18 to get into a system.
 19 So that's been really exciting on that
 20 part. And just a reminder, you know, on this
 21 program, those agencies who want in the C.M.E.
 22 program who are still on paper, please reach out to
 23 Deputy Chief Brody, if you're into -- you can
 24 understand kind of how to get to electronic to in
 25 order to stay in the system. We do offer a free

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 2 platform at the state.
 3 We're learning more and more about the
 4 platform every day and -- and working to improve it.
 5 Vital signs, so really excited that we're able to
 6 have vital signs, very successful. We had about five
 7 hundred and thirty people in person. We normally
 8 have about twelve hundred.
 9 But our goal for this year was to stay
 10 about at that fifty percent mark. And ... we can do
 11 spacing and everything else. And then we -- for the
 12 first time this year, we had a virtual component.
 13 And we had about three -- just under three hundred
 14 people on the virtual component, so really happy,
 15 really successful on that one. Excited with it and
 16 Saratoga turned out to be a great place to have it.
 17 Next year, we'll be hybrid as well.
 18 Will be October 26, to the 30th and it'll be in
 19 Albany. So for those of you who can join will be in
 20 Albany next year. For those of you who are
 21 downstate, just reminder, Albany is only two hours
 22 and fifteen minutes away from the city as when I
 23 asked most of my friends are like, well, it's like
 24 four or five hours up, isn't it? So it's not.
 25 Corporate presenters is now open. So

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 2 please submit your presentations for your corporate
 3 presenters, if you -- any of you would love to have
 4 more physicians presenting, we have some great
 5 physician speakers in the last one. And I would love
 6 to see more of that. And then stay tuned for more
 7 stuff coming out from the E.M.S. Council Awards for
 8 the awards next year.
 9 This year's Memorial, the E.M.S.
 10 Memorial will be on May 17th, 2022. And there are
 11 nine ... that will be going on to the memorial this
 12 year, so May 17th, 2022. And we'll be talking a
 13 little bit about the expansion of that wall as well.
 14 I think a little -- either a little
 15 later in this meeting, if not at the SEMSCO meeting
 16 as we are out of space on our current wall. And we
 17 have a couple of things that are on there that we'll
 18 be discussing with the SEMSCO and I believe later in
 19 this meeting as well, we'll talk about that one based
 20 on time.
 21 Last but not least, I wanted to share
 22 with everybody here a little bit of statistics and
 23 some numbers. You know, as we look at this pandemic,
 24 and we look at a number of things going on, we've
 25 seen E.M.S. providers working in -- in different

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 2 environments. We were calling in the med standards
 3 meeting the non-traditional environments, and maybe
 4 that's not the best term, we're going to find a
 5 better term for that.
 6 But we have through executive orders,
 7 they've been working in non-traditional environments,
 8 they have been working in different places. And it's
 9 been very, you know, interesting to see the different
 10 hospitals and you see Albany med posting and
 11 different hospitals around that have taken advantage
 12 of -- of this opportunity that normally isn't there.
 13 And so, you know, within the
 14 Department of Health and the Bureau of E.M.S., we've
 15 been also working on a scope of practice documents
 16 with ... everybody from med standards, I'm giving
 17 some input on that one, to be able to help people in
 18 these different when they work in different
 19 environments, or they're working in a, you know,
 20 hospital home program or fill in the blank, whatever
 21 these other programs might be.
 22 And so we're really excited to see
 23 what E.M.S. providers are doing and the different
 24 ways that they're going to be paramedicine possible
 25 at home, working in E.R. And we understand it's a

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 2 controversial topic. It's a controversial topic,
 3 because the counselor say we don't have enough
 4 providers in the state to work in a facility or to
 5 work in a E.M.S. agency.
 6 How do we take more providers and put
 7 them into -- into these non-traditional environments.
 8 And so when we look at that, when we look at the non-
 9 traditional environments, we also have to think about
 10 the entire E.M.S. population or E.M.S. pool and
 11 certified providers. One of the things we're doing
 12 is trying to certify more providers.
 13 So in January in the next week or so
 14 you'll hear about a pilot program that we're doing
 15 where we're going to try and train an extra three
 16 hundred providers and an academy style class
 17 throughout the state, so we're going to run probably
 18 close to between twenty and twenty-four programs.
 19 And actually half of those programs
 20 will be for anybody who wants to any citizen who
 21 wants to become an E.M.T., and do it completely for
 22 free. And the other half of the program is to train
 23 between three and four hundred National Guard members
 24 to become E.M.T.s. So we're excited because those
 25 National Guard members, again, you know, one weekend,

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 2 a month, two weeks a year also be able to take this
 3 and use it both as a guard, but also outside of guard
 4 and add more providers into the field.
 5 So thank you to all the co-sponsors
 6 who were, you know, helping us with this one, it's a
 7 big lift. We're going to do all the training and
 8 six-week gap. And the six weeks will be from the
 9 last week of January, for the most part, to the
 10 second week in March. And again, the goal is to
 11 train about six hundred providers, half of which will
 12 be civilians, half of which are National Guard
 13 members.
 14 The National Guard members will
 15 actually also be used to help out in hospitals and
 16 nursing homes and different component like that. The
 17 civilians predominantly for -- for E.M.S. hopefully
 18 people who want to take on the E.M.S. as a career.
 19 But some of the data that I also want
 20 to share with you is where we are today in number of
 21 providers that we have, and number of providers who
 22 are practicing. And the way that we looked at this
 23 was how many providers actually show up on a P.C.R.
 24 and so we went in and Texas did a report on this.
 25 We saw the report and said, wow,

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 2 that's really interesting. Let's -- let's do it we
 3 can find out when something similar. And so we went
 4 into report and we looked at how many certified
 5 providers we have, or how many providers show up on
 6 at least one P.C.R. in the given years.
 7 So we don't know how much they
 8 provided -- how much care they provided, but they
 9 provided care on a P.C.R. And so when we looked at
 10 2018 -- sorry, when we looked at 2019, we were at
 11 about eighty thousand providers who are certified.
 12 Some of those are duplicates, because if you hold the
 13 C.F.R. and as an E.M.T., or paramedic, we do see
 14 that.
 15 But there were about eighty thousand
 16 providers, we take out the -- the C.F.R.s. and we
 17 only had about thirty-six thousand provider, so we're
 18 actually on a P.C.R. So in 2019, out of eighty
 19 thousand providers were only about thirty-six
 20 thousand that were on a P.C.R.
 21 Fast forward to 2021 were just under
 22 seventy thousand, we're down to about sixty-seven
 23 thousand providers who are certified, take out those
 24 C.F.R.s. And the reason we take those out is because
 25 they don't always turn on P.C.R. they may be, you

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 2 know, working on a first response agency, not
 3 everybody is accounted for.
 4 So again, take out those C.F.R.s out
 5 of the sixty-seven thousand and take out C.F.R.s
 6 we're down to about sixty thousand. And thirty
 7 thousand of those were on a P.C.R. So that means
 8 that, you know, pretty much about half of our E.M.S.
 9 -- certified E.M.S. providers aren't providing care
 10 in the E.M.S. agency or on a P.C.R.
 11 And so the question is, where are
 12 they? And we don't have that answer right now. But
 13 I -- you know, bring that here to this committee,
 14 I'll bring that to the SEMSCO as well to start asking
 15 that question.
 16 And then also to start asking the
 17 question of the controversial question of working in
 18 what we're calling at least today non-traditional
 19 environments, is it -- is it a good thing? Can we
 20 take that other fifty percent, those thirty thousand
 21 providers who aren't working on ambulance for
 22 whatever reason, it might be.
 23 And are they, you know, something more
 24 in the healthcare environment that can help us in our
 25 ecosystem, that can help us you know, in maybe E.M.S.

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 2 offload times or other, you know, physicians that
 3 maybe is not an ambulance, but still benefits the
 4 system that can help us with community paramedicine
 5 or something else.
 6 So I just wanted to, you know, kind of
 7 leave with that thought and let people think about
 8 that, you know, a little bit. And like I said,
 9 please, you know, stay tuned for the classes that are
 10 coming up around the state. Please encourage, you
 11 know, people in your agency who have the ability to
 12 take a full-time E.M.T. class for four or five weeks,
 13 Monday through Friday often to become a certified
 14 provider, excellent opportunity.
 15 And this pilot class is a little bit
 16 different than our normal training model because we
 17 will pay for everything. We're paying for textbooks.
 18 We're paying for the online fees. We're paying for
 19 the course itself. Equipment it's a hundred percent
 20 paid for through this pilot program.
 21 So that's all I got. Happy to take
 22 any comments or questions and really appreciate your
 23 great support. Thanks for everything you're doing
 24 during the pandemic. If you have any more questions
 25 about the deployments that are happening throughout

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 2 the state, and some more that are coming in, please
 3 feel free to reach out to me offline.
 4 **MR. MARSHALL:** I have a question for
 5 Ryan.
 6 **MR. GREENBERG:** Hi.
 7 **MR. MARSHALL:** Hi. This is Dr.
 8 Marshall. So really appreciate all the work that
 9 department has been doing during the pandemic, but
 10 whatever happened to the State Emergency Management
 11 Office and those resources years ago, they were doing
 12 a lot of this preparation.
 13 **MR. GREENBERG:** You mean the Office of
 14 Emergency Management within digital?
 15 **MR. MARSHALL:** Yeah.
 16 **MR. GREENBERG:** We do a lot of
 17 planning with them. So I mean, I think just impart
 18 with the pandemic, everybody is, you know, take on
 19 more additional roles, but I mean, my -- my
 20 counterpart in the Office of Emergency Management, I
 21 am literally on the phone calls with almost daily and
 22 regular emails throughout the day in order to
 23 facilitate the ... deployment and all those things
 24 that come along with it.
 25 But the -- you know, a lot of planning

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 2 didn't feel that it was needed, but we want it there
 3 in the event that it was needed. And you know, up
 4 until I think, you know, a couple of weeks ago,
 5 there's the feeling on the Department of Health and
 6 the bureau was that it -- that it wasn't necessarily
 7 needed.
 8 We are giving strong consideration to
 9 it now and what they, you know, if an extension will
 10 be put in there and how long that extension would be.
 11 So there is strong consideration going into that
 12 right now. And I think you'll know more probably
 13 within next week or so. By the way, I still think
 14 ...
 15 **MR. ALEXANDROU:** No, she really did,
 16 but thanks.
 17 **MR. GREENBERG:** ...
 18 **MR. ALEXANDROU:** No, honestly it
 19 wasn't. But there was a lot of discussion around the
 20 region in with our E.M.T., so thanks.
 21 **MR. GREENBERG:** We -- we understand
 22 the importance. And I think, you know, I think the -
 23 - the part that we're also evaluating too in it and
 24 it is it would lead to a five-year certification for
 25 a lot of providers, and what's the impact of that and

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 2 documents and things like that, that's still being
 3 done by the -- by O.E.M., by the state O.E.M. So if
 4 there is other things specific, I'm happy to answer
 5 but you know, I think there's still a lot of work
 6 they're doing, but just everybody's pulled in
 7 multiple different directions.
 8 **MR. MARSHALL:** Okay, thank you.
 9 **MR. GREENBERG:** Absolutely.
 10 **CHAIR DOYNOW:** Thank you, Ryan.
 11 Anybody else have questions? Dr. Alexandrou?
 12 **MR. ALEXANDROU:** Yeah. Hi, Ryan.
 13 Thanks for all the information. I do have a
 14 question. With the recent surge, is there any
 15 consideration of bringing back the executive order
 16 for extending the E.M.T. certification and helped
 17 improve with the certification process throughout the
 18 state?
 19 **MR. GREENBERG:** The chief sponsor
 20 never put you up to that question.
 21 **MR. ALEXANDROU:** No. But there are a
 22 lot of people who were asking me about that. And
 23 this is the right time, I guess.
 24 **MR. GREENBERG:** Yeah. So you know, to
 25 be honest, when we put it in in the beginning, we

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 2 is that, you know, the pathway that we want to take
 3 and balance that with what's going on right now and
 4 trying to keep people safe and providing care and
 5 time and everything else, so absolutely being
 6 consistent.
 7 But and -- and thank you for bringing
 8 it up, I appreciate it. And if anybody else has any
 9 comments, thoughts or feedback or opinions on this,
 10 you know, is really needed in your region, I'd be
 11 glad to hear it, whether it be in this format or --
 12 you know, via an email.
 13 **CHAIR DOYNOW:** Thank you, Ryan.
 14 Anybody else have any questions for Ryan. Okay.
 15 Nothing heard. Let's move on into subcommittee's,
 16 Education. Dr. McEvoy, do you have anything to
 17 report?
 18 **MR. MCEVOY:** No, we -- we did not
 19 meet, we've been bantering around some goals and
 20 objectives for the committee on boardable and we also
 21 distributed some nice holiday reading, which I think
 22 I copied this committee on as well with the new
 23 federal educational standards that were released.
 24 But at this point, we're postponing
 25 that to talk about later in the year.

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 2 **CHAIR DOYNOW:** Okay. Thank you.
 3 Let's move on to med standards. I know Dr. Marshall
 4 has a lot to bring forth to the committee.
 5 **MR. MARSHALL:** Yes, lucky me. So if
 6 Amy could pull up the motions, that would be great.
 7 But I can tell you that -- actually the first one is
 8 about the E.M.S. viral pandemic triage protocol,
 9 which medical standards made some changes to and
 10 voted on ... SEMAC as a second in motion.
 11 And well, hopefully Amy can bring that
 12 up.
 13 **MS. EISENHAUER:** Dr. Marshall, I sent
 14 them to Val and Jacob is going to get presenter so
 15 she can pull them up.
 16 **MR. MARSHALL:** Okay, perfect.
 17 **MS. OZGA:** ...
 18 **MR. MARSHALL:** So we had a lot of
 19 discussion, there were originally two changes. One
 20 was inserting a statement that the protocol is not
 21 valid until activated by -- as needed by the region
 22 appropriate REMAC and would remain in effect for
 23 fourteen days unless renewed in which case it would
 24 just expire.
 25 We had some discussion on that in

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 2 terms of the timeframe and fourteen versus thirty
 3 days and the committee voted on fourteen days. The
 4 second one was at the end of the protocol an option
 5 if a patient doesn't have secondary underlying
 6 conditions or doesn't have ... can contact medical
 7 control for possible non-transport and treatment and
 8 place orders.
 9 We made a change to that so it would
 10 say contact medical control or follow regional policy
 11 for possible non-transport and treat in place orders.
 12 So if we can pull up that revised protocol so people
 13 can see it.
 14 **MS. OZGA:** Hang on a second, guys,
 15 something happened to my computer where I can't --
 16 okay, hold on a second. I think I got it now. Okay.
 17 Can everybody see that?
 18 **MS. EISENHAUER:** Hey, Val.
 19 **MS. OZGA:** Yes.
 20 **MS. EISENHAUER:** Ryan had -- Ryan had
 21 sent the E.M.S. viral pandemic triage protocol, the
 22 update. With those updates and it is in boardable as
 23 the last document with P.D.F. after it if you need to
 24 share that as well.
 25 **MS. OZGA:** Okay.

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 2 **CHAIR DOYNOW:** Would you like this
 3 proposed motion put up or do you want the -- the
 4 modified protocol put up first?
 5 **MR. MARSHALL:** So let's put up the
 6 modified protocol if we can.
 7 **MS. OZGA:** So that's the document from
 8 Ryan, correct?
 9 **MR. MARSHALL:** Yeah.
 10 **MR. GREENBERG:** Would be the P.D.F. in
 11 your -- I put the P.D.F. in your email.
 12 **MS. OZGA:** Okay. Hold on one second.
 13 **MR. MCEVOY:** This is McEvoy here. I
 14 would also note that SEMAC does not have access to
 15 the medical standards folder, so we can't see it.
 16 It's not in the SEMAC folder.
 17 **MR. GREENBERG:** Amy, can you go ahead
 18 and put that in the SEMAC folder as well, please?
 19 **MS. EISENHAUER:** I did put it in, it's
 20 all the way at the bottom. So maybe refresh the
 21 screen. I'm in the -- I'm in the meeting and if you
 22 go into the meeting itself, all the documents for
 23 this meeting are in there. And then at the bottom,
 24 it'll say E.M.S. viral pandemic triage protocol, and
 25 then there's a redesign.

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 2 I put it in around one o'clock. So if
 3 you opened it before, then you might just need to
 4 refresh.
 5 **MR. MCEVOY:** I see it now, thank you.
 6 **MS. OZGA:** I'm so sorry guys, I'm
 7 having a lot of issues with my computer right now.
 8 I'm not sure why. Okay. All right. Amy, you said
 9 you put it in the SEMAC folder, correct?
 10 **MS. EISENHAUER:** Yes.
 11 **MS. OZGA:** Okay.
 12 **MR. PHILLIPPY:** This is Mark
 13 Phillippy. I just noticed a little bit of a glitch
 14 here that might be contributing to this. If you go
 15 to the documents and there are things there that are
 16 not in the meeting tab. I think it's just a glitch
 17 in boardable. So I think what -- Amy if I get you
 18 correctly, you're in the meetings tab. And --
 19 **MS. EISENHAUER:** Yeah, just like that,
 20 I'll just show you.
 21 **MR. PHILLIPPY:** Yeah, there we go.
 22 **CHAIR DOYNOW:** There we go.
 23 **MS. EISENHAUER:** Okay.
 24 **MS. OZGA:** Is this what you need?
 25 **MR. MARSHALL:** Yes.

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 2 **MS. OZGA:** Okay.
 3 **MR. MARSHALL:** Enlarge it a little
 4 bit, please. We can start at the top and scroll
 5 down.
 6 **MS. OZGA:** How's that?
 7 **MR. MARSHALL:** Little more. Little
 8 more, there you go.
 9 **MS. OZGA:** Okay.
 10 **MR. MARSHALL:** Thank you.
 11 **MS. OZGA:** You're welcome.
 12 **MR. MARSHALL:** So you'll see at the
 13 top under the title, the title was changed to add
 14 adult because if you recall when we put this protocol
 15 in place the primary patients that we were concerned
 16 with were adult patients who are the ones most
 17 affected my COVID. We did have a lot of discussion
 18 about pediatric pandemic triage protocols and
 19 E.M.S.C. we'll be taking a look at that at their next
 20 meeting.
 21 So this was made specific for adults
 22 with the understanding that our current pediatric
 23 protocols would allow for appropriate triage
 24 treatment and transport to an appropriate facility.
 25 The text in blue is what was added. This protocol is

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 2 **MR. MARSHALL:** Good question. That
 3 did not come up, but that's something we should
 4 definitely think about. If it is the ceiling then
 5 the region would have to renew it every fourteen
 6 days, I believe. If it is the floor, then region
 7 could implement it or longer period of time if they
 8 so choose.
 9 That would be my interpretation and so
 10 others may have a different interpretation.
 11 **MR. OLSSON:** Dr. Olsson. The way I
 12 read it is that we can't change the fourteen days,
 13 because that's how it's written. So we would just
 14 have to reissue it for another fourteen days. As it
 15 says it will expire unless renewed.
 16 **MR. MARSHALL:** Yes.
 17 **MR. OLSSON:** That's it.
 18 **MR. MARSHALL:** Any other comments? I
 19 mean, we did have a lot of discussion on the fourteen
 20 days versus thirty days and you know, timeframes for
 21 different regions may be different in terms of
 22 response and -- and pandemic effects. But the
 23 committee voted for the fourteen days. As Dr. Olsson
 24 explained, it will expire unless renewed.
 25 So it's not -- it's not onerous for a

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 2 not valid until activated by the appropriate REMAC
 3 and will remain in effect for fourteen days at which
 4 time will expire unless renewed.
 5 And we did have discussion about, you
 6 know, there are some regions where the REMAC has a an
 7 executive committee that makes decisions between
 8 REMAC meetings and that would be appropriate for --
 9 for that executive committee to make that decision.
 10 And then there are regions that have a regional
 11 medical director was empowered to act between REMAC
 12 meetings.
 13 And we felt that this language would
 14 cover both of those eventualities. Can you scroll
 15 down a little bit? Yes.
 16 **MR. DAILEY:** Lou, I'm sorry, it's my
 17 fault. So I still have the significant amount of
 18 issues operationalized in fourteen days, but -- but
 19 the other question that comes in here is, is the
 20 fourteen days the ceiling or the floor? So if REMAC
 21 wants to make it thirty days, can they do that?
 22 Or do they have to only make it less
 23 so they couldn't make it twelve days and that
 24 expired? How are we going to interpret that for
 25 purposes of this moving forward?

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 2 region to renew it. Can be done by the executive
 3 committee or the regional medical director.
 4 **MR. PHILLIPPY:** Dr. Marshall.
 5 **MR. MARSHALL:** Yes.
 6 **MR. PHILLIPPY:** Just -- Mark Phillippy
 7 here. Just a quick comment on box for patient
 8 assessment. There is an asterisk there that referred
 9 to B.L.S. protocols for pediatric vital signs. And I
 10 know there was extensive discussion at med standards
 11 about making this adult specific, should we remove
 12 that bullet point?
 13 **MR. MARSHALL:** I can't see it on the
 14 screen. So maybe when we get down to that box, we
 15 can --
 16 **MR. PHILIPPY:** Sorry, didn't mean --
 17 **MR. MARSHALL:** No, that's fine.
 18 That's fine. So the next change was, you notice box
 19 two, which should actually read, done appropriate
 20 P.P.E. before initiating close contact with the
 21 patient. And then the next -- what's next is I
 22 spelled it wrong. Sorry about that. Then third box
 23 is the -- identifying which patients meet those
 24 criteria.
 25 And then in box four we took out

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 2 temperature ... one. And we left and refer to B.L.S.
 3 protocols for pediatric vital signs. And I would --
 4 I would recommend that we take that out as -- as Mark
 5 mentioned, since we titled this adult, and then allow
 6 E.M.S.C. to come back with a corresponding protocol
 7 for pediatric patients.
 8 And then --
 9 **MR. OLSSON:** Dr. Olsson.
 10 **MR. MARSHALL:** Uh-huh.
 11 **MR. OLSSON:** Just -- just a quick --
 12 personally, I would leave that in there as a reminder
 13 or just another stimulus for somebody to look at the
 14 pediatric vital signs. It's my opinion.
 15 **MR. MARSHALL:** Thank you. Anybody
 16 else? Okay. If you scroll down a little more to the
 17 last box. Here, we changed it to contact medical
 18 control or follow regional policy for possible non-
 19 transport, treat and place orders. So those were the
 20 recommended changes, and they come forward as a
 21 second motion.
 22 I'm wondering if the -- the pediatric
 23 Asterix had been taken out from a previous version,
 24 because the one that we worked on earlier today did
 25 not have that.

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 2 **MR. DAILEY:** So I would suggest that
 3 that it should say refer to pediatric protocol rather
 4 than refer to B.L.S. protocol for pediatric vital
 5 signs because you want them to look at the one that
 6 E.M.S.C. is going to assess that. We do have a
 7 statutory problem that E.M.S.C. actually cannot
 8 generate protocols. They have to come through this
 9 committee.
 10 So we're not going to be able to do
 11 anything with the pediatric side of this until the
 12 April meeting, and I would still argue that fourteen
 13 days is not something that works operationally. And
 14 that that should be decided on a regional basis or we
 15 should allow regional versions of this rather than
 16 this single statewide version, which the City of New
 17 York has already issued.
 18 **MR. MARSHALL:** So the motion that has
 19 been brought -- brought forward for medical standards
 20 is that we change the name to adult viral pandemic
 21 triage protocol, remove the P.P.E. box to the second
 22 box, remove temperature from box four. And add the
 23 language at the bottom for possible non-transport and
 24 treatment.
 25 That's the -- that's the motion that's

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 2 being brought forward. There have been some
 3 suggested changes. And I guess we need our
 4 parliamentarian to tell us if those need to -- I
 5 guess they would need to be motions.
 6 **CHAIR DOYNOW:** Dr. Cooper has his hand
 7 up.
 8 **MR. LANGSAM:** Yes, yes, you I'll need
 9 motions -- formal motions to change that.
 10 **CHAIR DOYNOW:** Dr. Cooper, you got
 11 your hand up there.
 12 **MR. COOPER:** Thank you. With respect
 13 to the pediatric version of the protocol, which
 14 E.M.S.C. will address next week, with the permission
 15 of Ryan Greenberg and the department legal gurus, I
 16 do imagine that the protocol could be developed
 17 pretty quickly.
 18 I don't imagine that there'd be any
 19 barrier on an emergency basis to the department
 20 identifying some mechanism together with Dr. Doynow
 21 and the leadership of the -- of the SEMAC to approve
 22 the protocol on an interim basis until -- until the
 23 SEMAC can meet again later in the year.
 24 I think this is important that we have
 25 this flexibility because we all recognize that we're

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 2 in the middle of a -- of a huge surge in terms of
 3 Omicron variant of the ... agents and you know, we
 4 really -- I cannot put up the pediatric protocol
 5 implementation at least on an interim basis. And so
 6 we have to be done pretty quickly.
 7 So I'm going to specifically in the
 8 ... right now, and the department staff to help make
 9 that happen. Thank you.
 10 **MR. LANGSAM:** If I can just comment
 11 with all due respect to Dr. Cooper and I agree with
 12 everything that he's saying. I do not believe that
 13 the bylaws allow or create an executive committee to
 14 do what you're asking. So I think you need another
 15 mechanism. Or one mechanism might be to approve
 16 something right this minute temporary base -- on a
 17 temporary basis.
 18 And just say that the group will
 19 accept whatever the -- the -- the E.M.S.C. comes up
 20 with, at least until the next meeting, that will do
 21 it and give you to do right away. But I don't think
 22 you can get an office set up a terrible precedent,
 23 you're basically giving away the power of the SEMAC
 24 essentially and, you know that in New York City, we
 25 do have an executive ... and the bylaws.

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 2 But without that, technically, it's
 3 not legal as far as I can tell.
 4 **MR. COOPER:** Well, Dr. Langsam, there
 5 are other officials in the health department, namely
 6 a commissioner who's in a position to, you know, to
 7 get something like this out. And as I recall, the
 8 original viral protocol in the middle of the first
 9 wave of COVID was not issued with immediate SEMAC
 10 approval.
 11 So whatever mechanism was operative
 12 then I imagined can be -- can be used now. What I
 13 don't think it would be appropriate would be to rush
 14 something to in the next -- in the next five minutes
 15 without -- without almost having had a chance to look
 16 it over and think at least a little before we just go
 17 ahead and lodge it.
 18 So I will give ... Dr. Doynow and the
 19 department staff to identify a way that this can be
 20 handled. Thank you.
 21 **MR. LANGSAM:** Again, there is -- there
 22 is a Department of Bureau E.M.S. wants to do what
 23 they did last time whether it was legal or not they
 24 certainly can do it. I'm not just going to advise
 25 the SEMAC that is not a legal thing to do. Again,

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 2 I'm not telling the Bureau of E.M.S. what to do.
 3 They did it last time and nobody --
 4 well, actually a lot of people question what they
 5 did, and they want to do it again, go right ahead.
 6 **MR. GREENBERG:** Dr. Langsam, and let
 7 me --
 8 **MR. COOPER:** I think legal
 9 determinations are up to the department, not up to
 10 us. Thank you.
 11 **MR. GREENBERG:** Dr. Cooper and Dr.
 12 Langsam, so there wasn't a separate executive order
 13 last time that is not in place at this time so that
 14 would not be an option to this time. And the one
 15 thing that may be an option is to possibly hold an
 16 emergency meeting.
 17 So after your meeting to hold
 18 emergency meeting, however, the issue with holding an
 19 emergency meeting is, I believe, the ability to hold
 20 a virtual meeting -- a virtual council meeting
 21 expires on the 15th of January. And so I don't know
 22 that that would be able to happen in that time
 23 period.
 24 So Dr. Cooper, I don't -- I don't know
 25 and that it would kind of you know, going back to

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 2 this one, you know, within the patient assessment, do
 3 we leave for, you know, at the recommendation of this
 4 council, do you put something in here that includes
 5 pediatrics, including the line that was there related
 6 to, you know, pediatric vital signs?
 7 Or is it not a protocol that is used
 8 for pediatrics, and then we try and hold, possibly an
 9 emergency session. However, the challenges that can
 10 come with that if there is no executive order to
 11 extend ...
 12 **MR. LANGSAM:** The other thing is --
 13 the other possibility is that SEMAC right now vote
 14 provisionally to approve what E.M.C.C.C. does for the
 15 period between now and the next meeting, whatever
 16 that would occur. And if the government does come up
 17 with the executive order, then we can have a virtual
 18 meeting.
 19 I -- I also am not aware that she's
 20 planning on doing it, but maybe people will lobby her
 21 that she should do it as they did it last time. But
 22 I think you could do it now, you could vote now to
 23 authorize E.M.S.C. that SEMAC approves in advance of
 24 course, I trust Dr. Cooper to do the right thing,
 25 because that's what E.M.S.C. is.

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 2 And it'll expire by the next meeting.
 3 If, for some reason, we just decide that what they
 4 did was the wrong thing. Anyway, that's just my
 5 legal issues. That's not saying whether it's good
 6 thing or not.
 7 **MS. BOMBARD:** So guys, I'm not sure
 8 why we're worrying about this as much as we are.
 9 We're talking about protocol that allows us to leave
 10 people in place, right. And I'm not sure how many of
 11 these children that the parents call E.M.S. for
 12 should be left in place to begin with, especially
 13 without consulting medical control.
 14 So I think we have all the time in the
 15 world to do this. I don't see a giant crisis of
 16 lines and lines of E.M.S. crews being tied up on
 17 pediatric calls that are not appropriate for
 18 transport. Unless you're seeing this where you are,
 19 I am not seeing a lot of inappropriate 911 calls for
 20 pediatric patients, period.
 21 So why don't we just wait until the
 22 next med standards meeting and attack it then as a
 23 group. I don't see a time problem here.
 24 **MR. COOPER:** Dr. Bombard, I -- I do
 25 think some of the city facilities are pretty

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 2 overwhelmed with kids coming in with fever and no
 3 other symptoms. And -- you know, that would be the
 4 main issue. We don't want kids with -- with low
 5 grade fevers and no other symptoms, you know, coming
 6 in, you know, because it ties up the emergency
 7 departments.
 8 And even if they don't have COVID it
 9 would expose them to other kids who may have it in
 10 and our ... department ninety-five plus percent of
 11 the kid, anybody symptomatic or not are testing
 12 positive to COVID. So you know, and of course, our
 13 volumes are way up. But I think that's the issue at
 14 least in the downstate -- in the downstate areas, so
 15 I'm not sure that it would be prudent -- you know, to
 16 wait.
 17 I still think that -- that finding
 18 some way that E.M.S.C. can -- can you know, review
 19 this and get back to you and get it approved on an
 20 interim basis or shortly thereafter I think that
 21 that's probably the best ... to take.
 22 **MR. BART:** This is Joe Bart. I have
 23 few comments here. I think we -- we can all agree
 24 we've spent a lot of time on this previously, and
 25 then again today through committees. I want to just

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 2 of time on this, but I was a huge proponent when it
 3 started with all the unknowns here. But without any
 4 teeth at the end of it whatsoever, I'm not even sure
 5 I'm in favor of keeping this protocol live at all.
 6 So I'm kind of inches away from creating a motion
 7 that says that we just abandon this protocol
 8 entirely.
 9 Because it seems like we're already
 10 figuring this out through processes that we've
 11 developed over the past twelve months, or frankly,
 12 that we have an irregular protocol now with online
 13 and offline medical direction.
 14 **MR. OLSSON:** So Olsson's, quick
 15 comment. The pediatric vital signs, unless we're
 16 going to incorporate those pediatric vital signs into
 17 this adult triage are still referring the provider to
 18 a separate document. So this document with whatever
 19 wordsmithing of that one statement you want to make
 20 is still done.
 21 And then whatever comes out of
 22 E.M.S.C. is still an additional reference. So I
 23 think we can move forward.
 24 **CHAIR DOYNOW:** So this Don, can I --
 25 can I make a suggestion here. Let's -- let's remove

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 2 back us up to the idea of what was the intent of this
 3 in the first place. And the intent of this was
 4 because we had a whole lot of unknown when the
 5 pandemic started, we had unknown P.B.E. we had
 6 unknown presentation of illness.
 7 We had unknown amount of people that
 8 were going to maybe be a burden to the E.M.S. system
 9 or have to be displaced from anywhere but the
 10 emergency department. A lot of those problems have
 11 just been figured out. Some of them have not, in
 12 fact, many of them have not.
 13 But as I read the protocol now, it
 14 essentially says, if you've got any emergency medical
 15 complaint whatsoever, follow your protocol. If you
 16 have none of those contact online medical direction
 17 for decision. That to me doesn't even have any teeth
 18 to it.
 19 So it's not as if we're dissolving
 20 something here that's an offline protocol that
 21 suggested E.M.S., aside from calling online medical
 22 direction is going to have any authority to make
 23 decisions on factoring people away from ...
 24 department or refusing their transport.
 25 So I understand we spent a whole lot

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 2 the referred to B.L.S. protocols for pediatric vital
 3 signs. This essentially is an adult protocol. And
 4 the other is perhaps we can have E.M.S.C. come up
 5 with their protocol, have it emailed out to every one
 6 of the committee members.
 7 We can then look at it, vote on it on
 8 a temporary basis until the next meeting. That can
 9 perhaps be put on to a public document from the
 10 health department, so it is out there, what the vote
 11 was. And that probably is the easiest way to do
 12 this. Ryan, can we do that?
 13 **MR. GREENBERG:** I apologize, Don. Can
 14 you repeat what you -- the process you're on?
 15 **CHAIR DOYNOW:** Dr. Cooper, once they
 16 come up with their protocol, it gets emailed to every
 17 SEMAC member. We vote on all ... accept it or not.
 18 And it'll be temporarily accepted until the next
 19 meeting in which case we can reevaluate it that way
 20 it gets out there quickly.
 21 **MR. GREENBERG:** Yeah, I don't believe
 22 that would be an option. Again, the option could be
 23 to hold an emergency council meeting and have both
 24 the ... med standard SEMAC and SEMSCO for the
 25 specific, you know, for one item essentially meetings

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 2 and you would come together have that one meeting,
 3 vote on it and then move it through.
 4 But without that process and based on
 5 -- you know, the current executive orders and things
 6 that that's the only way if the pediatric would be
 7 able to go ...
 8 **CHAIR DOYNOW:** Okay. Yeah, that would
 9 be ...
 10 **MR. LANGSAM:** ... are not permitted
 11 under -- under our current rules.
 12 **CHAIR DOYNOW:** Well, then I -- I have
 13 a feeling that that is not going to occur, so I think
 14 it's either going to be it's going to wait next
 15 meeting or it's going to be what Dr. ... which is we
 16 give them temporary authority to come up with a
 17 protocol SEMSCO also agree to do that and then we
 18 will reevaluate it the next SEMAC meeting. All
 19 right. It seems to be the only way we --
 20 **MR. WALTERS:** Dr. Doynow, it's Dr.
 21 Walters.
 22 **MR. BART:** Now, we're creating wall
 23 breaks within wall breaks right now. Like I mean
 24 this is it -- it start to be comedic about it. But
 25 is this protocol really that thing that we really

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 2 need to dig in so deeply to find the cracks in the
 3 system to get it out there. I mean, unless there is
 4 -- unless there is an act of motion out there right
 5 now I want a motion to table this.
 6 **CHAIR DOYNOW:** Okay. Well, there is a
 7 motion to accept this on there's no motion for
 8 pediatrics.
 9 **MR. BART:** All right. Then I like to
 10 call the question.
 11 **CHAIR DOYNOW:** Does anybody want to
 12 make a motion for the pediatric?
 13 **MR. LANGSAM:** He called the question.
 14 He called the question which means you stop talking.
 15 It needs a second and it needs a two thirds votes.
 16 **MR. MCEVOY:** I'll second all the
 17 question, McEvoy.
 18 **CHAIR DOYNOW:** Can we have Dr.
 19 Marshall repeat what the actual motion is that we're
 20 voting on?
 21 **MR. MARSHALL:** Now the -- ... you went
 22 blank.
 23 **CHAIR DOYNOW:** We can't hear you.
 24 **MR. MARSHALL:** I'm sorry. I'm sorry,
 25 med -- calling the question of which now there is a

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 2 motion and a second on the floor. If it passes on a
 3 two third vote means you immediately go to vote on
 4 the motion without any further discussion. That's
 5 the only thing you can do right now is vote on
 6 calling the question.
 7 Which they -- call the question means
 8 everybody should shut up. We don't want to hear
 9 anymore and we go directly to vote on the motion
 10 that's currently in place. So that's what calling
 11 the question means.
 12 **CHAIR DOYNOW:** So the motion is -- is
 13 what Dr. Marshall needs to put up to the group again
 14 and we've talked about this about a half an hour ago,
 15 what actually is the motion we're voting?
 16 **MR. LANGSAM:** We're not voting on that
 17 right now. We're voting on whether we should stop
 18 talking then I'll put it up.
 19 **CHAIR DOYNOW:** Okay.
 20 **MR. LANGSAM:** That was made just a
 21 minute ago, let's stop talking.
 22 **CHAIR DOYNOW:** Okay. I guess I
 23 understood that. So let's end up having a vote as to
 24 what to stop talking. Valerie, if you would.
 25 **MS. OZGA:** Okay.

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 2 **MR. LANGSAM:** Two thirds voting.
 3 **MS. OZGA:** Two thirds vote. Okay.
 4 Dr. Alexandrou?
 5 **MR. ALEXANDROU:** I abstain. I'm not
 6 really sure what we're voting on.
 7 **MR. MARSHALL:** We're -- we're voting
 8 on whether or not to call the -- call the question
 9 means that discussion stops, and we vote on the
 10 motion. And we have to vote on whether or not to
 11 call the question. If you vote in the affirmative to
 12 call the question and as Dr. Langsam said, you go to
 13 the vote.
 14 If you vote in the negative to call
 15 the question, then you can continue discussion on the
 16 motion.
 17 **MR. ALEXANDROU:** I think it sounds a
 18 little bit more clarified. Okay. So I'm in the
 19 affirmative. Yes.
 20 **MS. OZGA:** Okay. Yes. Dr. Bart?
 21 **MR. BART:** Bart, yes.
 22 **MS. OZGA:** Dr. Berkowitz?
 23 **MR. BERKOWITZ:** Berkowitz, yes.
 24 **MS. OZGA:** Dr. Bombard?
 25 **MS. BOMBARD:** Dr. Bombard, yes, stop

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 2 talking.
 3 **MS. OZGA:** Dr. Cooper?
 4 **MR. COOPER:** Was that Kugler or
 5 Cooper?
 6 **MS. OZGA:** Cooper.
 7 **MR. COOPER:** Me. Arthur, yes.
 8 **MS. OZGA:** Dr. Cushman.
 9 **MR. CUSHMAN:** Cushman, yes.
 10 **MS. OZGA:** Dr. Dailey?
 11 **MR. DAILEY:** Dailey, yes.
 12 **MS. OZGA:** Dr. Detraglia?
 13 **MR. DETRAGLIA:** Detraglia, yes.
 14 **MS. OZGA:** Dr. Doynow?
 15 **CHAIR DOYNOW:** Yes.
 16 **MS. OZGA:** Was Dr. Gomez on, did he --
 17 did he get on at all? Okay. Dr. Kugler?
 18 **MR. KUGLER:** Kugler, yes.
 19 **MS. OZGA:** Dr. Lynch?
 20 **MR. LYNCH:** Lynch, yes.
 21 **MS. OZGA:** Dr. Markowitz?
 22 **MR. MARKOWITZ:** Markowitz, yes.
 23 **MS. OZGA:** Dr. Maynard. Dr. Maynard
 24 joined us today? Dr. Marshall?
 25 **MR. MARSHALL:** Dr. Marshall, yes.

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 2 **MS. OZGA:** Dr. Murphy?
 3 **MS. MURPHY:** Murphy, yes.
 4 **MS. OZGA:** Dr. Olsson?
 5 **MR. OLSSON:** Olsson, yes.
 6 **MS. OZGA:** Dr. Talbott?
 7 **MR. TALBOTT:** Talbott, yes.
 8 **MS. OZGA:** Dr. Walters?
 9 **MR. WALTERS:** Walters, yes.
 10 **MS. OZGA:** And Dr. Wicelinski?
 11 **MR. WICELENSKI:** Yes, Wicelinski, yes.
 12 **MS. OZGA:** We have eighteen in the
 13 affirmative. With -- Dr. Langsam, you said it had to
 14 be two thirds, correct?
 15 **CHAIR DOYNOW:** Yes, that's what he
 16 said.
 17 **MS. OZGA:** Okay. And that's the
 18 voting members that who was present today, is that
 19 correct Dr. Langsam? Where did my parliamentarian
 20 go?
 21 **MR. LANGSAM:** I'm sorry. What was the
 22 question, I apologize.
 23 **MS. OZGA:** Okay. So we have eighteen
 24 in the affirmative. And you said we needed to have
 25 two thirds. So is it two thirds of the voting

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 2 members who are present today?
 3 **MR. LANGSAM:** No, two thirds of -- of
 4 the -- the people are present today that comes to the
 5 quorum.
 6 **MS. OZGA:** Okay. So then motion
 7 passes to call the question.
 8 **CHAIR DOYNOW:** Okay. Now, can we go
 9 back to the original motion, Dr. Marshall?
 10 **MR. MARSHALL:** Yes.
 11 **MS. OZGA:** Okay. Let me bring him in
 12 ... give me one moment.
 13 **MR. LANGSAM:** No, in the middle of a
 14 meeting with the State I can't do this.
 15 **MS. OZGA:** Okay. I believe this is
 16 the motion if you could just confirm it that would be
 17 great.
 18 **MS. EISENHAUER:** Now the first three
 19 motions are in relation to this document.
 20 **MS. OZGA:** Okay. So do I bring one
 21 motion up at a time?
 22 **MR. GREENBERG:** Well, no because I
 23 think -- and Dr. Marshall, correct me if I'm wrong
 24 ... correct?
 25 **MR. MARSHALL:** Yes.

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 2 **MS. OZGA:** Okay. I did not hear what
 3 was ... and my apologies, he was going in and out.
 4 **MR. MARSHALL:** Can you bring up motion
 5 two and three just so we can take a look at them?
 6 **MS. OZGA:** Yeah.
 7 **MR. MARSHALL:** Just motion one is --
 8 is what was being drawn.
 9 **MS. OZGA:** Okay. Motion two.
 10 **MR. MARSHALL:** Forward.
 11 **MS. OZGA:** Here is motion two.
 12 **MR. MARSHALL:** Motion two was
 13 defeated.
 14 **MR. MARSHALL:** Motion three.
 15 **MS. OZGA:** Motion three.
 16 **MR. MARSHALL:** Motion three is
 17 actually included in motion one I think because we
 18 brought forward the final document.
 19 **MR. :** So the vote would be on the
 20 amended document that were shown, correct?
 21 **MR. MARSHALL:** Correct.
 22 **CHAIR DOYNOW:** Would include motion
 23 one and motion three.
 24 **MS. OZGA:** Do I need to bring the
 25 document back up?

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 2 **MR. LANGSAM:** Yeah, you can bring the
 3 document back up. Thank you.
 4 **MS. OZGA:** Any other questions or
 5 should I go to the roll call vote?
 6 **MR. MARSHALL:** We don't see the
 7 document.
 8 **MS. OZGA:** You don't?
 9 **MR. MARSHALL:** So you're on -- you're
 10 on motion three, that's okay.
 11 **MS. OZGA:** Hold on one moment. Do you
 12 see it now?
 13 **MR. MARSHALL:** We see it now.
 14 **MS. OZGA:** Okay. Sorry about that
 15 guys.
 16 **MR. MARSHALL:** So the motion is, add
 17 the language in blue at the top, rearrange the boxes
 18 and so box number two as approved by medical standard
 19 was done appropriate P.P.E. that would have to be
 20 adjusted. Well actually, it's in the second
 21 sentence. And E.R. was removed from box four, and
 22 the ability to contact medical control or follow
 23 regional policy for non-transport and treatment in
 24 place.
 25 (Off the record, 1:01 p.m.)

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 2 (The proceeding commenced)
 3 **MS. OZGA:** All right. Any other
 4 questions, shall I continue my roll call?
 5 **THE CHAIR:** Yes, no further
 6 discussion, right, Dr. Langsam?
 7 **MR. LANGSAM:** That's correct and not
 8 want to discuss it all now.
 9 **MS. OZGA:** Okay. I will do roll call.
 10 Okay. Dr. Alexandrou?
 11 **MR. ALEXANDROU:** Yes.
 12 **MS. OZGA:** Dr. Bart?
 13 **MR. BART:** Bart, no.
 14 **MS. OZGA:** Dr. Berkowitz?
 15 **MR. BERKOWITZ:** Yes.
 16 **MS. OZGA:** Dr. Bombard Tiffany?
 17 **MS. TIFFANY:** Bombard, yes.
 18 **MS. OZGA:** Dr. Cooper?
 19 **MR. COOPER:** Dr. Cooper, yes.
 20 **MS. OZGA:** Dr. Cushman?
 21 **MR. CUSHMAN:** Cushman, no.
 22 **MS. OZGA:** Dr. Dailey?
 23 **MR. DAILEY:** Dailey, no.
 24 **MS. OZGA:** Dr. Detraglia?
 25 **MR. DETRAGLIA:** Detraglia, yes.

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 2 **MS. OZGA:** Dr. Doynow?
 3 **THE CHAIR:** Yes.
 4 **MS. OZGA:** Dr. David Kugler?
 5 **MR. KUGLER:** Kugler, yes.
 6 **MS. OZGA:** Dr. Lynch?
 7 **MR. LYNCH:** Lynch, no.
 8 **MS. OZGA:** Dr. Markowitz?
 9 **MR. MARKOWITZ:** Markowitz, yes.
 10 **MS. OZGA:** Dr. Marshall?
 11 **MR. MARSHALL:** Dr. Marshall, yes.
 12 **MS. OZGA:** Dr. Murphy?
 13 **MS. MURPHY:** Dr. Murphy, no.
 14 **MS. OZGA:** Dr. Olsson?
 15 **MR. OLSSON:** Olsson, yes.
 16 **MS. OZGA:** Dr. Talbott?
 17 **MR. TALBOTT:** No.
 18 **MS. OZGA:** I'm sorry. Dr. Talbott,
 19 was that no?
 20 **MR. TALBOTT:** Correct. It was no.
 21 **MS. OZGA:** Okay. Thank you. Dr.
 22 Walters?
 23 **MR. WALTERS:** Walters, yes.
 24 **MS. OZGA:** And Dr. Wicelinski?
 25 **MR. WICELINSKI:** Wicelinski, no.

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 2 **MS. OZGA:** I'm just double checking,
 3 hold on. Okay. We have a eleven in the affirmative
 4 and six -- six noes. Dr. Langsam, does that need to
 5 be two thirds to pass?
 6 **MR. LANGSAM:** No, it doesn't need two
 7 thirds but it needs to be majority of the -- all the
 8 voting members not just those who are present. I
 9 don't know how much voting members you have.
 10 **MS. OZGA:** So out of the twenty-three.
 11 **MR. LANGSAM:** So majority of twenty-
 12 three is -- half of twenty-three plus one.
 13 **MS. OZGA:** Hold on. All right. So we
 14 only have eleven. So I would say this does not pass.
 15 **THE CHAIR:** Are they all ...
 16 **MR. LANGSAM:** It misses it by one
 17 vote. Okay. ... back to med standards next time,
 18 wherever the old protocol still ... and is still out
 19 there but it has not been rescinded. So the old
 20 protocol is not modified. It's still in ...
 21 **MR. MARSHALL:** Shall I continue, Dr.
 22 Doynow?
 23 **MS. OZGA:** Yes.
 24 **THE CHAIR:** Yes.
 25 **MR. MARSHALL:** The next motion comes

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 2 medical standards is motion to approve. The
 3 pediatric dose optimization for seizures and E.M.F.
 4 study. This is the studies brought forward by
 5 University of Buffalo and ... Buffalo who have been
 6 selected to participate in a phase three multicenter
 7 trial midazolam dosing procedures in pediatric
 8 patients in a pre-hospital setting.
 9 It randomizes twenty participating
 10 agencies to switch from conventional weight based
 11 dosing to standardized age based dosing and that
 12 switch will occur at the same time for every agency
 13 and be done over a four year enrollment period, and
 14 the period of the study is for five years.
 15 The goal of this study is to show that
 16 using weigh based age appropriate dosages for
 17 midazolam, it will be associated with a lower
 18 frequency of active seizures upon ... arrival.
 19 That comes forward as a second in
 20 motion and Dr. ... if he's on and help answering the
 21 questions, if you may have questions. Hearing none,
 22 Dr. Doynow, would you like to --
 23 **THE CHAIR:** Sure.
 24 **MR. MARSHALL:** -- call for a vote.
 25 It's a motion number four, I believe, yeah.

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 2 **THE CHAIR:** Val, if we have ...
 3 **MR. DAILEY:** Actually, my apologies.
 4 I was trying to get off mute, Don. I just wanted to
 5 comment briefly that this is an excellent opportunity
 6 for the folks in Buffalo to assist with the lexicon
 7 of pediatric research. I'm excited this is being
 8 done in New York and I'm glad we can be supportive of
 9 it. Thank you.
 10 **THE CHAIR:** Thanks, Mike ...
 11 **MS. OZGA:** Dr. Doynow, I couldn't hear
 12 you. Do you want me to do the roll call?
 13 **THE CHAIR:** Yes, please.
 14 **MS. OZGA:** Okay. Dr. Alexandrou?
 15 **MR. ALEXANDROU:** Yes.
 16 **MS. OZGA:** Dr. Bart?
 17 **MR. BART:** Yes.
 18 **MS. OZGA:** Dr. Berkowitz?
 19 **MR. BERKOWITZ:** Yes.
 20 **MS. OZGA:** Dr. Bombard?
 21 **MS. TIFFANY:** Bombard, yes.
 22 **MS. OZGA:** Dr. Cooper?
 23 **MR. COOPER:** Cooper, yes.
 24 **MS. OZGA:** Dr. Cushman?
 25 **MR. CUSHMAN:** Cushman, yes.

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 2 **MS. OZGA:** Dr. Dailey?
 3 **MR. DAILEY:** Yes.
 4 **MS. OZGA:** Dr. Detraglia?
 5 **MR. DETRAGLIA:** Detraglia, yes.
 6 **MS. OZGA:** Dr. Doynow?
 7 **THE CHAIR:** Yes.
 8 **MS. OZGA:** Dr. David Kugler?
 9 **MR. KUGLER:** Dr. Kugler, yes.
 10 **MS. OZGA:** Dr. Lynch?
 11 **MR. LYNCH:** Lynch, yes.
 12 **MS. OZGA:** Dr. Markowitz?
 13 **MR. MARKOWITZ:** Markowitz, yes.
 14 **MS. OZGA:** Dr. Lewis Marshall?
 15 **MR. MARSHALL:** Marshall, yes.
 16 **MS. OZGA:** Dr. Murphy?
 17 **MS. MURPHY:** Murphy, yes.
 18 **MS. OZGA:** Dr. Olsson?
 19 **MR. OLSSON:** Olsson, yes.
 20 **MS. OZGA:** Dr. Talbott?
 21 **MR. TALBOTT:** Talbott, yes.
 22 **MS. OZGA:** Dr. Walters?
 23 **MR. WALTERS:** Walters, yes.
 24 **MS. OZGA:** Walters was yes. Dr.
 25 Wicelinski?

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 2 **MR. WICELINSKI:** Yes, Wicelinski.
 3 **MS. OZGA:** Well, Dr. Wicelinski, that
 4 was yes?
 5 **MR. WICELINSKI:** Yes.
 6 **MS. OZGA:** Okay. Thank you so much.
 7 Motion passes.
 8 **MR. MARSHALL:** Thank you. Can you
 9 bring up the next motion? The next motion is to
 10 improve E.M.S. treatment of acute opioid withdrawal.
 11 This was brought forward by the collaborative, I
 12 believe, and it allows for patients who are in acute
 13 withdrawal to receive the option of getting
 14 buprenorphine that would be prescribed by a physician
 15 who was specifically trained to and approve for this
 16 medication.
 17 And also, there's called Matters M-A-
 18 T-T-E-R-S Medical Direction. And, Dr. -- the
 19 collaborative will write that out in the document and
 20 as well as defining what P.C.M.C. was, which is
 21 actually pointing to the motion being removed to
 22 medical control facility.
 23 And then, I got to also add the cows
 24 ... criteria. Some people are using this protocol or
 25 have those criteria in front of them and --

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 2 **MR. DAILEY:** Dr. Marshall, the changes
 3 have been made to that document, it's been uploaded
 4 to Boardable with -- with those, cows will be an
 5 appendix within the protocols as our other scores
 6 have been.
 7 **MR. MARSHALL:** Okay.
 8 **MR. DAILEY:** We'll also encourage the
 9 use of MDCalc through our educational interventions.
 10 **MR. MCEVOY:** Could those -- that
 11 document be uploaded into the SEMAC Boardable? It's
 12 not visible to us.
 13 **MR. DAILEY:** I can't upload it there,
 14 I'm like -- I unfortunately don't have access to the
 15 SEMAC Boardable only to this -- to the med standards
 16 one.
 17 **MS. EISENHAUER:** What folder did you
 18 put it in, Dr. Dailey?
 19 **MR. DAILEY:** It's in the med standards
 20 protocol -- med standards folder for today's meeting.
 21 **MS. EISENHAUER:** Okay. I will go
 22 look. Dr Dailey, Dr. Dailey, I don't see it in the
 23 other documents. Can you email it to me and then I
 24 can share it?
 25 **MR. DAILEY:** Certainly can.

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 2 **MS. EISENHAUER:** Thanks.
 3 **MR. LANGSAM:** Marshall, do you have
 4 any elevator music to put in the background?
 5 **MR. MARSHALL:** Yeah, I know, right?
 6 **MR. DAILEY:** Without due deference to
 7 Dr. Langsam and the way this needs to proceed, can we
 8 move onto the next item while we wait for Boardable
 9 and email to do their thing?
 10 **MR. LANGSAM:** Certainly can. There's
 11 nothing wrong with doing that.
 12 **MR. MARSHALL:** So while we're waiting
 13 for that, the next two items on the agenda were
 14 advisories from ... One has to do with E.M.S.
 15 Geriatric TeleConsult Algorithm and that would allow
 16 or -- sorry.
 17 For teleconsult for geriatric patients
 18 and guidance by the physician, they have a specific
 19 facility algorithm for Geriatric TeleConsult.
 20 Dr. Cushman, did you want to address
 21 anything? So this was -- this comes as a seconded
 22 motion. Both of these were reviewed and the motion
 23 was to move both of these to SEMAC.
 24 And so, there was no --there's a very
 25 little discussion on protocol versus regional

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 2 advisory. And the endpoint was that this was a
 3 regional advisory and it comes forward as a seconded
 4 motion as -- as a regional advisory for SEMAC
 5 discussion and vote.
 6 **MR. MCEVOY:** McEvoy here. This is a
 7 similar issue. Again, we have no eyes on this.
 8 **MR. MARSHALL:** Can you get into the
 9 med standards Boardable?
 10 **MR. MCEVOY:** Negative.
 11 **MR. MARSHALL:** All right.
 12 **MR. DAILEY:** So if I can actually open
 13 some of the background on this. So the Geriatric
 14 TeleConsult Algorithm and advisory for alternative
 15 transportation.
 16 Both of these were procedures that
 17 were originally developed to address local
 18 conditions. If I may, elegantly ... Monroe
 19 Livingston, regional E.M.S. on a council and I have
 20 absolutely no idea how these were not brought to the
 21 SEMAC and the SEMSCO as examples of best practices.
 22 Rather, MILREMS ... was asked to
 23 remove these from operation pending this meeting.
 24 These are both exactly how regions should function,
 25 demonstrate excellence in E.M.S. And I would argue

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 2 that both of these particularly in these trying
 3 times, difficult to access health care and crises and
 4 behavioral health are exquisite demonstrations of
 5 teamwork within healthcare and within behavioral
 6 health.
 7 And we should immediately not only
 8 past these but encourage similar collaborations to
 9 occur in other regions and find out exactly why these
 10 were not allowed to move forward because there's
 11 nothing within Article 30 that should restrict such
 12 regional approach to appropriate care.
 13 **MR. KUGLER:** Question for the Chair.
 14 This is Dr. Kugler.
 15 **THE CHAIR:** Go ahead.
 16 **MR. KUGLER:** So along the lines of Dr.
 17 Dailey's very eloquently stated discussion just now,
 18 I would ask that if we are to start passing a
 19 regional -- approving regional policies at the SEMAC
 20 and SEMSCO levels, where the Article 30 does allow
 21 for the regions to create policies and procedures
 22 that are specific to their region.
 23 I think we're sort of trending on a
 24 very fine line, where now the state is overtaking the
 25 regional authority, which is allowed to that. I

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 2 think that we should acknowledge the great work that
 3 MILREMS is done and give Dr. Cushman and his team
 4 kudos and move on.
 5 We do not need to approve this because
 6 this is a regionally approved policy that the state
 7 has no bearing on.
 8 **THE CHAIR:** Thank you. Any other
 9 discussion?
 10 **MR. WALTERS:** I have a question for
 11 Dr. Cushman.
 12 **MR. CUSHMAN:** What?
 13 **MR. WALTERS:** Dr. Cushman, I saw a --
 14 I guess, as I'm looking at this, basically, this
 15 algorithm is just essentially inclusion and exclusion
 16 criteria to either transport via standard protocols
 17 or to engage a geriatrician or to do a teleconsult
 18 with a geriatrician to evaluate these patients, where
 19 they are during the height of a pandemic and the
 20 Department of Health told you, no?
 21 **MR. CUSHMAN:** Cushman, sum and
 22 substances, that's -- that's accurate. So Advisory
 23 2113 was developed in concert with geriatricians from
 24 both of our health systems. That was borne out
 25 initially because of very large numbers of

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 2 asymptomatic COVID positive patients that were being
 3 transported out of sniffs in-house, without actually
 4 getting their docs involved.
 5 And so we started having conversations
 6 that ultimately led to Advisory 2113 supported by
 7 both Rochester Regional Health as well as UR
 8 Medicine, both of their geriatrics groups and so
 9 forth, to really provide Geriatric TeleConsult, does
 10 he notice within the algorithm in no way whatsoever
 11 does it say that we will refuse a patient's
 12 transport.
 13 It was to engage someone that is much
 14 better qualified to determine the best disposition
 15 for the patient in the specific facilities. And you
 16 notice that it was very facility specific, because
 17 those are specifically facilities that are overseen
 18 by those two geriatric groups.
 19 It is not inclusive of all sniffs in-
 20 house within the Rochester region because of that --
 21 that simple fact. That advisory was issued on
 22 September 29th of 2021. That was issued based upon
 23 my understanding of Article 30.
 24 And -- and really, kind of
 25 specifically, Section 3003-4, which allows the REMAC

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 2 to develop those policies, procedures and triage
 3 treatment transport protocols consistent with the
 4 SEMAC. I felt -- REMAC felt, we did a purpose at the
 5 time that that was consistent with existing policy
 6 and practice.
 7 I received a call from -- from the
 8 director and deputy director on October 21st
 9 indicating that there were some complaints received
 10 regarding that, which I have not had any
 11 substantiation to rather, they were patient care
 12 concerns or what have you to run for a quality
 13 improvement process and was directed to rescind that
 14 policy immediately, it was done the following day.
 15 Through that conversation, I was told
 16 that this is a protocol and had to be rescinded
 17 because it was not reviewed and approved by the
 18 SEMAC. Doesn't mean cluttering everyone's inboxes,
 19 as well as, using up your fine time today regarding
 20 these two regional advisories regarding both
 21 engagement of geriatric medical control, if you will,
 22 as well as transporting our patients to a behavioral
 23 health access and crisis center, which I won't get
 24 into that but if folks want background on that, as
 25 well, I'm happy to provide that.

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 2 So here -- here and we live and I
 3 appreciate the wisdom of the SEMAC in the end. Our
 4 goal was simply to provide the best possible care to
 5 our patients regardless of -- of where they are.
 6 **THE CHAIR:** So yeah, Doctor, I agree
 7 with you when -- when you're reading this Section
 8 3004 ... what the concern was, but now, it's in front
 9 of SEMAC, my suggestion is we bring it up to a vote
 10 and move it forward because it does appear to be
 11 appropriate ...
 12 **MR. CUSHMAN:** Cushman to the chair.
 13 Again, my only concern with bringing it to a vote is
 14 does a vote confer that that is the expected practice
 15 for the advisory or not. Else, my great friends in
 16 New York City just -- just did something that I,
 17 absolutely, we should be doing.
 18 But that would mean that every single
 19 thing has to come before this body and I think that's
 20 ultimately the question that the bureau in our
 21 regions all grapple with.
 22 And so I just -- I just -- I
 23 appreciate the support but at the same time I'm
 24 concerned about the precedent that something like
 25 that sets.

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 2 **MR. DAILEY:** I would argue --
 3 **THE CHAIR:** ...
 4 **MR. DAILEY:** -- actually, we brought
 5 this here for discussion. But I think what we do is
 6 we endorse the efforts that you're making and that
 7 ultimately should be our mission here today and the
 8 motion that we bring forward should be to endorse
 9 regional efforts to expand teleconsult as appropriate
 10 and work towards alternative destinations when
 11 possible.
 12 **MR. LANGSAM:** You can make that as a
 13 substitute motion get a second if you vote on that,
 14 it happens and that's the end of it.
 15 **THE CHAIR:** Would you like to make
 16 that motion?
 17 **MR. DAILEY:** Certainly. Certainly,
 18 Dr. Doynow. I vote -- we do not vote to approve
 19 these advisories but to endorse them and that we
 20 support regional teleconsult and alternative
 21 transportation initiatives to assist the E.M.S.
 22 system.
 23 **MR. PHILIPPY:** Mark Philippy, I
 24 second.
 25 **MR. OLSSON:** Olsson, third. Do we

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 2 need to be specific as opposed to we're going to
 3 endorse regional policies that come to this body
 4 without limiting ourselves to telemedicine and
 5 everything else? Just by -- I don't know.
 6 **MR. LYNCH:** It's -- it's Lynch. Do we
 7 need to have any action on regional policies? I
 8 mean, I guess, I'm -- I'm not really sure if they're
 9 -- if there's something that we're -- that we have to
 10 do right now because of this or we say thank you and
 11 move on.
 12 **MR. PHILIPPY:** Dr. Lynch, it's Mark
 13 Philippy --
 14 **MR. WALTERS:** It's Walters.
 15 **MR. PHILIPPY:** Walters, I'm sorry.
 16 **THE CHAIR:** Dr. Mark, and then, Dr.
 17 Walters. Go ahead.
 18 **MR. PHILIPPY:** Thanks, Dr. Doynow. I
 19 think the issue with it, Dr. Lynch, is is something
 20 we talked about briefly at med standards, is that
 21 there is some confusion at some level of state
 22 government has the understanding of what is the
 23 policy or procedure and what is a protocol.
 24 And when we started throwing the word
 25 protocol then people start looking for a certain

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 2 format and -- and certain ways things are done. It
 3 was good at it that standards that the New York City
 4 procedure or policy and physician did not appear in a
 5 protocol or algorithm, boxes and arrows kind of
 6 format. Therefore, perhaps, that's how they get
 7 around it.
 8 It's calling an apple an orange ... I
 9 don't particularly care. I think what we're looking
 10 to do here is at some point, maybe not today, but at
 11 some point, decide what the heck is a policy, with an
 12 X procedure and what's X protocol.
 13 For the time being it lifted moment,
 14 we've got two things before the body and I suggest
 15 that supporting the concepts that are in this goes a
 16 long way toward at least alleviating the issue
 17 temporarily until we can get a chance to sit down and
 18 make those decisions in writing. That's my point.
 19 **MR. GREENBERG:** Dr. Doynow, ...
 20 Bombard and Jeremy thanks for providing their
 21 background on where this all came from. Two, and
 22 when that did come up and the issue came up, it was,
 23 you know, brought forward to division of legal ...
 24 which is where they came back feeling this was a
 25 protocol, which by their ... approval by med

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 2 standard, SEMAC ...
 3 I think, you know, I think what really
 4 helps in clarity and we had the conversation on the
 5 earlier meeting today is helping me, either having
 6 this group or med standards, whichever the Chair
 7 feels is appropriate to do it, further -- not even
 8 further, you know, to put ... on paper, what is a
 9 policy versus what is a protocol in order to allow
 10 the regions to have the regional policy.
 11 And to know where that line crosses
 12 for when something falls into a medical treatment and
 13 protocol versus a regional policy. And then
 14 everybody I think is on the same page statewide
 15 opposed to, you know, because some doing this one
 16 way, some doing something else. And I believe that
 17 is what Chairman Philippy was talking -- had
 18 mentioned before.
 19 So, you know, when you talk about
 20 whether it be this and how he choose to do that, but
 21 also the long term in getting to the point to where
 22 regions are doing what they need to with -- with the
 23 policies as they should, first when they need to
 24 know, okay, this passes that line, it needs to go up
 25 for the protocol.

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 2 But yes, when that -- when the
 3 incident did occur, it was brought up, you know, to
 4 the leadership and the division of legal affairs,
 5 which is where that conversation happens and where we
 6 are today.
 7 **THE CHAIR:** Thank you, Ryan. Dr.
 8 Bart, do you have comments as well?
 9 **MR. BART:** I did not, ... that's all I
 10 got.
 11 **MR. WALTERS:** It was Walters. I think
 12 I did.
 13 **MR. BART:** We always confusing me and
 14 Walters ... anymore.
 15 **MR. WALTERS:** Western accent.
 16 **MR. BART:** Because we were sound like
 17 we're from Canada?
 18 **THE CHAIR:** Dr. Walter?
 19 **MR. WALTERS:** My -- yes. So I guess,
 20 my comment is, I -- listen, I'm fine with endorsing
 21 this, you know, alleviates the issue in the short
 22 term, then fine, we can do that but I guess I'm just
 23 echoing some of the other sentiments here when I -- I
 24 look at this and I say every -- every region or most
 25 regions, I don't know if everyone does, but I'm going

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 2 can't even -- when they're too busy to have two days
 3 of SEMAC and SEMSCO meetings but yeah, we can
 4 prohibit a region from trying to provide high quality
 5 care to the highest risk population during a
 6 pandemic.
 7 I just, am not even sure what we're
 8 doing, if that's our stand at the D.O.H. hearing.
 9 **THE CHAIR:** Thank you.
 10 **MR. LANGSAM:** Can I make a suggestion
 11 because we're going to be here all day long?
 12 **THE CHAIR:** Yes, Dr. Langsam, please.
 13 **MR. LANGSAM:** We possibly have a
 14 motion that says, I'm not going to make motions. Do
 15 we have a motion that saying, one, without
 16 establishing a precedent SEMAC has no objection to
 17 these two advisories ... and then just go on.
 18 **THE CHAIR:** I one hundred percent
 19 agree with you. Would somebody like to make that
 20 motion?
 21 **MR. DAILEY:** Also I'll make that.
 22 **THE CHAIR:** Do we have a second?
 23 **MR. MARSHALL:** Marshall, second.
 24 **THE CHAIR:** Okay. Is there any
 25 discussion before we vote ...

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 2 to presume every region has some type of, you know,
 3 refusal of care type policy, which has similar type
 4 criteria, sometimes vital sign criteria or injury
 5 criteria similar to this.
 6 So when you get transported or in this
 7 case, whether or not you get, you know, sign off, but
 8 you are eligible for a teleconsult, you know,
 9 evaluation. And so I just think this is, again, a
 10 slippery slope to endorse or to be approved "a
 11 regional policy", and again, I just want to come back
 12 to the fact I think it's shameful for the Department
 13 of Health in the middle of a pandemic to have chosen
 14 the highest risk people, the geriatric population to
 15 hospitals and more people and potentially COVID, as
 16 Dr. Cushman pointed out.
 17 I think for a bunch of attorneys for
 18 the states to weigh in on this, who are not medical
 19 experts, who misinterpret this as a protocol. And
 20 for the bureau to be complicit in that, I think, is
 21 just -- I think we need to call a spade a spade and
 22 say that it's shameful and should never have happened
 23 and should not happen again.
 24 I mean, if this is really what the
 25 Department of Health is spending their time on, we

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 2 **MR. WALTERS:** We are -- are we in
 3 agreement that if we -- if we -- if we approve this
 4 motion that was just made, we're basically saying we
 5 do not feel that this is a protocol but we are
 6 endorsing this as well. Is that correct?
 7 **MR. LANGSAM:** We're just saying we
 8 have no problem with it, go ahead and do it. And we
 9 don't want to discuss it anymore. That's really what
 10 it's all about.
 11 And at some later point, people get
 12 together and decide what's the protocol, what's an
 13 advisory. But I think you want to get this off the
 14 floor going and people don't want to commit
 15 themselves to any rules right now.
 16 So let's just say without, it's very
 17 important, without establishing a precedent, the
 18 REMAC has no objection to these two advisories, just
 19 endorse, just says go out and do what you want.
 20 **MR. LYNCH:** It's Lynch. I still don't
 21 understand why we have to do this.
 22 **THE CHAIR:** I think if we don't do it,
 23 it's not going to move on because the D.O.H. has
 24 decided that ... I mean, we can only get this point
 25 out, but I don't know where we'll get other than

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 2 sending it back to D.O.H. ... be all the way.
 3 **MR. LYNCH:** Has the D.O.H. made it
 4 clear what we -- what we -- what needs to come out of
 5 this group in order for it to be allowed to carry on?
 6 Does it -- is it endorsement enough? Does it need
 7 anything?
 8 **THE CHAIR:** Ryan, do you want to
 9 explain that to us?
 10 **MR. GREENBERG:** Yeah, the D.O.H.
 11 opinion on this one was that it was a protocol. I
 12 think maybe when we talked about that maybe the vote
 13 is, you know ... protocol. We'd move that forward.
 14 **MR. LYNCH:** Well, the -- if the D.O.H.
 15 feels that it's a protocol and has officially weighed
 16 on it. If we endorse it as not a protocol, does that
 17 even make a difference in the -- in the Department's
 18 eyes?
 19 **MR. GREENBERG:** I believe it would in
 20 regards to it being reviewed by this committee.
 21 **MR. RABRICH:** Dr. Doynow, can I make a
 22 comment as well? It's Rabrich.
 23 **THE CHAIR:** Go ahead.
 24 **MR. RABRICH:** Yeah. So I mean, do we
 25 not have -- I mean, I can't make a motion either but

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 2 perhaps the motion is that the SEMAC affirms the
 3 authority of REMACS under Article 30 to make advisory
 4 statements and that the current ones being considered
 5 meet that criteria and are not considered a protocol.
 6 **MR. KROLL:** Now, if you said that
 7 slower, maybe someone, you know, can type that too.
 8 **MR. RABRICH:** Yeah, someone else would
 9 have done a non-voting member of this committee. So
 10 I think someone else would have to make that motion
 11 but --
 12 **THE CHAIR:** Well, I think we already
 13 have --
 14 **MR. :** Rabrich, speak for me, please.
 15 **MR. RABRICH:** Okay. So the SEMAC
 16 affirms the authority --
 17 **THE CHAIR:** Hold on.
 18 **MR. RABRICH:** Sure.
 19 **THE CHAIR:** Before we get there, Val,
 20 are you ready to -- to type that way, Jeff, you don't
 21 have to second ...
 22 **MS. OZGA:** I will do my best but
 23 please talk slowly.
 24 **MR. RABRICH:** Sure. That the SEMAC
 25 affirms the authority of REMAC to issue advisories --

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 2 **MS. OZGA:** Hold on. Okay.
 3 **MR. RABRICH:** -- to issue advisories
 4 under Article 30 and that the above advisories, so
 5 you could just copy it. It's 21-13 and 21-14, meet
 6 the criteria of advisories and are not considered
 7 protocols.
 8 **MR. DAILEY:** Jeff.
 9 **MR. RABRICH:** Yes.
 10 **MR. DAILEY:** If I can make a
 11 suggestion.
 12 **MR. RABRICH:** Please.
 13 **MR. DAILEY:** I think the language that
 14 we actually want to use is that Regional Emergency
 15 Medical Advisory Committees shall develop policies,
 16 procedures and triage treatment and transportation
 17 protocols, which are consistent with the standards of
 18 the State Emergency Medical Advisory Committee, which
 19 address specific local conditions.
 20 Regional Emergency Medical Advisory
 21 Committees may also approve physicians to provide
 22 online medical control, coordinate the development of
 23 regional medical control systems and participate in
 24 quality improvement activities, addressing system
 25 wide concerns.

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 2 **MR. RABRICH:** I see Article 30.
 3 **MR. DAILEY:** That's three thousand ...
 4 slow clap, slow clap.
 5 **THE CHAIR:** Guys, if I could just take
 6 control here for a second. I appreciate what Jeff
 7 has. There is a motion that and second on the floor
 8 already prior to this that needs to be rescinded. I
 9 will however, Dr. Langsam thinks we need to remove it
 10 if we're going to move on to this one.
 11 **MR. KROLL:** All right. This one, I
 12 would offer as a substitute motion but I don't know
 13 how we do that.
 14 **THE CHAIR:** Dr. Langsam, can you
 15 assist us with this?
 16 **MR. LANGSAM:** Okay. Substitute motion
 17 you just vote this as a substitute motion, if it's
 18 approved, it's done.
 19 **THE CHAIR:** Do we have a second ...
 20 **MR. DAILEY:** So I'm going to make the
 21 motion that, firstly, the motion on the floor I
 22 believe was mine. I'm going to remove it. The
 23 motion I'm going to make is that the SEMAC endorse
 24 three thousand and four A and that these advisories
 25 issued by the MILREMS qualify as such.

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 2 **MR. BART:** That's essentially what it
 3 says in Article 30.
 4 **MS. OZGA:** So am I removing what Dr.
 5 Rabrich said and put them down with Dr. Dailey said?
 6 **THE CHAIR:** Dr. Dailey, are you are
 7 changing that -- you're actually making a motion. So
 8 how do you ...
 9 **MR. DAILEY:** I saw Dr. Langsam getting
 10 upset with me but I will leave the motion as the
 11 SEMAC endorses Article 30, 3004-A and says that the
 12 MILREMS advisories qualify as such.
 13 **MR. LANGSAM:** And I'm not going to get
 14 upset with you because that's a perfectly good
 15 motion. And you just need a second that says the
 16 same thing, Dr. Rabrich says but that's fine.
 17 **MR. DAILEY:** Yeah, you were more
 18 eloquent.
 19 **MR. LANGSAM:** And that's fine.
 20 **MR. DAILEY:** Like always.
 21 **MR. KUGLER:** This is Dr. Kugler. I
 22 would like to second that motion.
 23 **THE CHAIR:** Okay.
 24 **MS. OZGA:** Can I have Dr. Dailey --
 25 can I have Dr. Dailey repeat that one more time so I

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 2 can pin all the verbiage correct?
 3 **MR. DAILEY:** SEMAC endorses Article
 4 30, Section 3004-A and states that the MILREMS
 5 advisories qualify as such.
 6 **MS. OZGA:** I get it.
 7 **MR. DAILEY:** Yes, ma'am.
 8 **MR. LANGSAM:** You need a second --
 9 **MS. OZGA:** Okay.
 10 **MR. LANGSAM:** -- you need a second and
 11 this has been offered as a sec -- as a substitute
 12 motion. So when this passes, which I hope it will,
 13 we're done.
 14 **MR. KUGLER:** This is Dr. Kugler. I'd
 15 have to reaffirm my second ...
 16 **THE CHAIR:** Excellent. Valerie, can
 17 we have a vote, please?
 18 **MS. OZGA:** Yes, it will be my honor to
 19 do a roll call. Okay. Dr. Alexandrou?
 20 **MR. ALEXANDROU:** Yes.
 21 **MR. COOPER:** Wait, wait, are we
 22 allowing Ms. ...
 23 **UNIDENTIFIED SPEAKER:** Once we start a
 24 roll call ...
 25 **MR. COOPER:** I think we are beyond

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 2 that. Dr. Doynow, are we allowing ... of the motion?
 3 **THE CHAIR:** Dr. Langsam, I think we
 4 started the roll call, again, we stop for discussion.
 5 **MR. LANGSAM:** You actually should have
 6 asked for discussion before we started the vote. I
 7 was afraid I would be lynched if I interrupted you.
 8 So yeah, Dr. Cooper is correct, you can have a
 9 discussion and let's start the vote again.
 10 **THE CHAIR:** All right. Dr. Cooper ...
 11 **MR. COOPER:** With all due respect, I
 12 think it is presumptuous about the SEMAC to say that
 13 we endorse what the people of the State of New York
 14 have put in the law as our -- as our specific
 15 authority.
 16 Dr. Dailey is on the right track in --
 17 in suggesting that because we have the authority to
 18 develop policies and procedures consistent with those
 19 of the SEMAC and address specific local condition,
 20 you know, that that these policies that MILREMS would
 21 develop probably need that that test.
 22 So I personally do not believe that
 23 these motion are statutory and, furthermore, I
 24 believe it's out of order. Thank you.
 25 **THE CHAIR:** Any other discussion before

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 2 we vote? Okay. Well, then, I will call a roll call
 3 vote, please.
 4 **MS. OZGA:** Okay. I will start over.
 5 Dr. Alexandrou?
 6 **MR. ALEXANDROU:** Yes.
 7 **MS. OZGA:** Dr. Bart?
 8 **MR. BART:** Yes.
 9 **MS. OZGA:** Dr. Berkowitz?
 10 **MR. BERKOWITZ:** Yes.
 11 **MS. OZGA:** Dr. Bombard?
 12 **MS. TIFFANY:** Yes.
 13 **MS. OZGA:** Dr. Cooper?
 14 **MR. COOPER:** No, for the reasons I
 15 stated.
 16 **MS. OZGA:** Dr. Cushman?
 17 **MR. CUSHMAN:** Cushman, yes, and thank
 18 you.
 19 **MS. OZGA:** Dr. Dailey?
 20 **MR. DAILEY:** Yes.
 21 **MS. OZGA:** Dr. Detraglia?
 22 **MR. DETRAGLIA:** Detraglia, yes.
 23 **MS. OZGA:** Dr. Doynow?
 24 **THE CHAIR:** Yes.
 25 **MS. OZGA:** Dr. Kugler?

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 2 **MR. KUGLER:** Dr. Kugler, yes.
 3 **MS. OZGA:** Dr. Lynch?
 4 **MR. LYNCH:** Lynch, yes.
 5 **MS. OZGA:** Dr. Markowitz?
 6 **MR. MARKOWITZ:** Markowitz, yes.
 7 **MS. OZGA:** Dr. Marshall?
 8 **MR. MARSHALL:** Marshall, yes.
 9 **MS. OZGA:** Dr. Murphy?
 10 **MS. MURPHY:** Murphy, yes.
 11 **MS. OZGA:** Dr. Olsson?
 12 **MR. OLSSON:** Olsson, yes.
 13 **MS. OZGA:** Dr. Talbott?
 14 **MR. TALBOTT:** Yes.
 15 **MS. OZGA:** Dr. Walters?
 16 **MR. WALTERS:** Walters, yes.
 17 **MS. OZGA:** And Dr. Wicelinski?
 18 **MR. WICELINSKI:** Wicelinski, yes.
 19 **MS. OZGA:** Motion passes.
 20 **THE CHAIR:** Thank you, Val. Dr.
 21 Marshall, what else do you have?
 22 **MR. MARSHALL:** I got plenty more.
 23 **THE CHAIR:** Okay.
 24 **MR. MARSHALL:** Not to worry, I haven't
 25 run out of motions yet. But the next one is also

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 2 from MILREMS and this is care guidelines for a
 3 persistent ... and a hospital algorithm for ...
 4 Evidence is showing that patients who
 5 are in persistent -- persistent ... may benefit from
 6 ECMO and by taking them to a facility that has that
 7 capability.
 8 There has been some increased
 9 functional in tax survival, one reported up to forty-
 10 eight percent. The reason this is coming to SEMAC is
 11 because in the protocol that they develop two things
 12 have happened, one is, they stop epinephrine and
 13 after the third dose, then, the second is the limit
 14 amiodarone to three hundred milligrams.
 15 Other than that, there was no change
 16 in the ... protocol. And this is being brought
 17 forward as a second motion.
 18 **THE CHAIR:** Okay. Do we have any --
 19 any discussion? Lewis, do you want to bring it up
 20 for a vote?
 21 **MR. MARSHALL:** Yes, it was seconded,
 22 so we just need a roll call though.
 23 **THE CHAIR:** Val, please.
 24 **MS. OZGA:** All right. Dr. Alexandrou?
 25 **MR. ALEXANDROU:** Yes.

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 2 **MS. OZGA:** Dr. Bart?
 3 **MR. BART:** Yes.
 4 **MS. OZGA:** Dr. Berkowitz?
 5 **MR. BERKOWITZ:** Yes.
 6 **MS. OZGA:** Dr. Bombard?
 7 **MS. TIFFANY:** Yes.
 8 **MS. OZGA:** Dr. Cooper?
 9 **MR. COOPER:** Yes.
 10 **MS. OZGA:** Dr. Cushman?
 11 **MR. CUSHMAN:** Cushman, yes.
 12 **MS. OZGA:** Dr. Dailey?
 13 **MR. DAILEY:** Dailey, yes.
 14 **MS. OZGA:** Dr. Detraglia?
 15 **MR. DETRAGLIA:** Detraglia, yes.
 16 **MS. OZGA:** Dr. Doynow?
 17 **THE CHAIR:** Yes.
 18 **MS. OZGA:** Dr. Kugler?
 19 **MR. KUGLER:** Dr. Kugler, yes.
 20 **MS. OZGA:** Dr. Lynch?
 21 **MR. LYNCH:** Lynch, yes.
 22 **MS. OZGA:** Dr. Markowitz?
 23 **MR. MARKOWITZ:** Markowitz, yes.
 24 **MS. OZGA:** Dr. Marshall?
 25 **MR. MARSHALL:** Marshall, yes.

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 2 **MS. OZGA:** Dr. Murphy?
 3 **MS. MURPHY:** Murphy, yes.
 4 **MS. OZGA:** Dr. Olsson?
 5 **MR. OLSSON:** Olsson, yes.
 6 **MS. OZGA:** Dr. Talbott?
 7 **MR. TALBOTT:** Talbott, yes.
 8 **MS. OZGA:** Dr. Walters?
 9 **MR. WALTERS:** Walters, yes.
 10 **MS. OZGA:** Dr. Wicelinski?
 11 **MR. WICELINSKI:** Wicelinski, yes.
 12 **MS. OZGA:** Motion passes.
 13 **THE CHAIR:** Thank you. Dr. Marshall.
 14 **MR. DAILEY:** Can you bring it on -- I
 15 think it's actually important for us to follow-up on
 16 that one with -- with a reminder that if any other
 17 REMAC were to have resources similar to these and
 18 want to implement this policy, that is the same as
 19 the policy and MILREMS, that they'd be allowed to do
 20 so.
 21 **THE CHAIR:** So Mike, I'm not sure are
 22 you -- are you trying to make a motion that we adopt
 23 that or do you --
 24 **MR. DAILEY:** No, that's -- that's not
 25 a motion on -- that's just a reminder to the group.

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 2 **THE CHAIR:** Okay.
 3 **MR. DAILEY:** We've passed that as
 4 policy, therefore, if this were to be adopted by
 5 policy in Erie County, for example, they would be
 6 able to implement the same thing.
 7 **THE CHAIR:** It sounds quite
 8 reasonable. Dr. Marshall, back to you.
 9 **MR. MARSHALL:** Yeah, can you bring up
 10 motion eight, which I hope is the last one. The next
 11 one has to do with the automated compression devices.
 12 So MILREMS is implementing protocol in their region
 13 which will allow for the use compressive devices in a
 14 pre-hospital setting for those patients who would
 15 benefit and this goes along with the previous one
 16 that we just approved for persistent ... protocol.
 17 There are multiple devices that that
 18 exists in the marketplace. Their protocol
 19 specifically mentions LUCAS device and that's because
 20 all the agencies that are participating in this use
 21 the same device in the region. And we did have some
 22 discussion about endorsing specific products, but
 23 this motion comes forward as an approved secondary
 24 second -- secondary motion.
 25 **MR. CUSHMAN:** Dr. Marshall, Dr.

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 2 Cushman, if I may.
 3 **MR. MARSHALL:** Yes.
 4 **MR. CUSHMAN:** Given the action of the
 5 SEMAC related to my -- my other advisories earlier,
 6 it would seem to me that approval of -- of this
 7 guidance is superfluous by the -- by the SEMAC,
 8 again, anything, -- anything we create is -- is more
 9 than welcome to be plagiarized excessively.
 10 But it's really a training and use
 11 guidance, which would be reinforced by the earlier
 12 motion by the SEMAC, I welcome alternative
 13 interpretations of that but.
 14 **MR. MARSHALL:** I don't think that's an
 15 unreasonable interpretation. But as a seconded
 16 motion, Dr. Langsam, would be our --
 17 **MR. LANGSAM:** Once again -- once
 18 again, if someone wants to, they can make the
 19 identical motion you made before and vote on that one
 20 to substitute for this motion. No one wants to do
 21 that, then you're stuck with this, because this is a
 22 motion on the floor.
 23 So if you want to do exactly the same
 24 thing you did before, that would be fine. I would
 25 certainly be in the spirit of what you approved a

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 2 moment ago. I would agree that that is probably the
 3 reasonable thing to do but someone has to do it.
 4 Otherwise, you're forced to vote on this.
 5 **MR. KUGLER:** I would make that motion,
 6 Dr. Kugler.
 7 **THE CHAIR:** All right. Dr. Kugler
 8 made a motion and Dr. Murphy seconded. Is that
 9 correct?
 10 **MR. KUGLER:** Yes.
 11 **THE CHAIR:** All right. So we'll need
 12 that motion typed up ... if we can and we'll --
 13 **MR. DAILEY:** Pull up the other one.
 14 **THE CHAIR:** Yeah, pulled the other
 15 one.
 16 **MS. OZGA:** Okay. So is the -- the
 17 same verbiage as the last one, correct?
 18 **THE CHAIR:** Correct.
 19 **MR. KUGLER:** That's the advisory
 20 motion.
 21 **MS. OZGA:** Okay. All right. Hold on
 22 one moment and I will get it up there.
 23 **THE CHAIR:** Okay.
 24 **MR. KUGLER:** It said the SEMAC
 25 endorses section Article 30, 3004-A, adopt the

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 2 MILREMS advisories qualify as such, as a substitute
 3 in motion.
 4 **MS. OZGA:** Okay. Can everybody see
 5 that?
 6 **THE CHAIR:** Yes, it looks fine.
 7 **MR. KUGLER:** Yes.
 8 **THE CHAIR:** Any discussion before we
 9 vote on this? Okay. Val, hopefully one last roll
 10 call vote here.
 11 **MS. OZGA:** For this meeting anyway.
 12 We still have one more meeting to go. Okay. Dr.
 13 Alexandrou?
 14 **MR. ALEXANDROU:** Yes.
 15 **MS. OZGA:** Dr. Bart?
 16 **MR. BART:** Yes.
 17 **MS. OZGA:** Dr. Berkowitz?
 18 **MR. BERKOWITZ:** Yes.
 19 **MS. OZGA:** Dr. Bombard?
 20 **MS. TIFFANY:** Bombard, yes.
 21 **MS. OZGA:** Dr. Cooper?
 22 **MR. COOPER:** No, for the reasons I
 23 stated previously, thank you.
 24 **MS. OZGA:** Dr. Cushman?
 25 **MR. CUSHMAN:** Cushman, yes.

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 2 **MS. OZGA:** Dr. Dailey?
 3 **MR. DAILEY:** Dailey, yes.
 4 **MS. OZGA:** Dr. Detraglia?
 5 **MR. DETRAGLIA:** Detraglia, yes.
 6 **MS. OZGA:** Dr. Doynow?
 7 **THE CHAIR:** Yes.
 8 **MS. OZGA:** Dr. Kugler?
 9 **MR. KUGLER:** Dr. Kugler, yes.
 10 **MS. OZGA:** Dr. Lynch?
 11 **MR. LYNCH:** Lynch, yes.
 12 **MS. OZGA:** Dr. Markowitz?
 13 **MR. MARKOWITZ:** Markowitz, yes.
 14 **MS. OZGA:** Dr. Marshall?
 15 **MR. MARSHALL:** Marshall, yes.
 16 **MS. OZGA:** Dr. Murphy?
 17 **MS. MURPHY:** Murphy, yes.
 18 **MS. OZGA:** Dr. Olsson?
 19 **MR. OLSSON:** Olsson, yes.
 20 **MS. OZGA:** Dr. Talbott?
 21 **MR. TALBOTT:** Talbott, yes.
 22 **MS. OZGA:** Yes.
 23 **MS. OZGA:** Dr. Walters?
 24 **MR. WALTERS:** Walters, yes.
 25 **MS. OZGA:** And Dr. Wicelinski?

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 2 **MR. WICELINSKI:** Wicelinski, yes.
 3 **MS. OZGA:** Motion passes.
 4 **THE CHAIR:** Thank you, everybody. The
 5 other things were discussion items, scope of practice
 6 document, which is in the Boardable teleconsult
 7 document draft which is also in Boardable and our
 8 most updated, which confirms that pre-hospital
 9 providers can accept.
 10 **MR. LANGSAM:** Dr. Marshall ... skip
 11 the opioid one, you will get to come back to it until
 12 you got it, it was on Boardable, the motion, I think
 13 you said that you're going to go out of order.
 14 **MR. MARSHALL:** Okay.
 15 **MR. LANGSAM:** That's the acute --
 16 treatment of acute opioid withdrawal.
 17 **MR. MARSHALL:** Okay.
 18 **MR. LANGSAM:** And without that ...
 19 sorry to bother you.
 20 **MR. MARSHALL:** No, no problem.
 21 Valerie, that would be the second -- second motion,
 22 no, the fourth motion.
 23 **MS. EISENHAUER:** And for everyone's
 24 reference, this is Amy, it is in this meetings
 25 documents at the very bottom.

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 2 **MR. MARSHALL:** That's the updated one.
 3 **MS. EISENHAUER:** Yes.
 4 **MS. OZGA:** Shall we give the members a
 5 few minutes to look at that or bring it up on the
 6 screen?
 7 **MR. MARSHALL:** If you can bring it up
 8 quick, that would be fine.
 9 **MS. OZGA:** Okay.
 10 **MR. MARSHALL:** And we could --
 11 **MS. OZGA:** Give me one moment.
 12 **MR. MARSHALL:** Since we already had
 13 some discussion on it, I think we can move pretty
 14 quickly to a vote.
 15 **MS. OZGA:** Amy, did you say it was in
 16 SEMAC?
 17 **MS. EISENHAUER:** It's at the bottom,
 18 it's E.M.S. treatment of acute opioid withdrawal
 19 amendment doc. It's the last one.
 20 **THE CHAIR:** It is there.
 21 **MS. OZGA:** Okay. I have to refresh my
 22 page. There we go, okay. Okay. Can everybody see
 23 that?
 24 **MR. MARSHALL:** Yes. Can you enlarge a
 25 little bit, but yeah, we can see it. And then the

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 2 changes are there highlighted in yellow. Those are
 3 the ones that were agreed to at medical standards.
 4 **MR. WICELINSKI:** Dr. Marshall, this is
 5 Rob Wicelinski. How would one qualify as matters
 6 physician? I only ask because I'm also boarded in
 7 addiction medicine, so.
 8 **MR. MARSHALL:** That is beyond my
 9 wheelhouse. Perhaps Dr. Dailey knows.
 10 **MR. DAILEY:** No, I'm actually going to
 11 make sure that Dr. Wicelinski and Dr. Lynch have a
 12 conversation as soon as this meeting is over.
 13 **MR. DAILEY:** Sounds good to me.
 14 **MR. WICELINSKI:** Yeah, I'll -- Mike,
 15 if you can connect us, that'd be great. Love to talk
 16 with you about it.
 17 **MR. DAILEY:** I'll just give you my
 18 email in the group chat.
 19 **MR. WICELINSKI:** Perfect, thanks.
 20 **MR. MARSHALL:** So this comes forward
 21 as a seconded motion. Is there any discussion? Dr.
 22 Doynow, would you like to have a roll call vote?
 23 **THE CHAIR:** Yes. Let's have our roll
 24 call vote, Val.
 25 **MS. OZGA:** Okay. Dr. Alexandrou?

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 2 **MR. ALEXANDROU:** Yes.
 3 **MS. OZGA:** Dr. Bart?
 4 **MR. BART:** Yes.
 5 **MS. OZGA:** Dr. Berkowitz?
 6 **MR. BERKOWITZ:** Yes.
 7 **MS. OZGA:** Dr. Bombard? Is Dr.
 8 Bombard still off?
 9 **MS. TIFFANY:** Bombard, yes.
 10 **MS. OZGA:** Dr. Cooper?
 11 **MR. COOPER:** Cooper, yes.
 12 **MS. OZGA:** Dr. Cushman?
 13 **MR. CUSHMAN:** Cushman, yes.
 14 **MS. TIFFANY:** Bombard, yes.
 15 **MS. OZGA:** Dr. Dailey?
 16 **MR. DAILEY:** Dailey, yes.
 17 **MS. OZGA:** Yes, Dr. Bombard, I got
 18 your vote.
 19 **MS. TIFFANY:** Thank you.
 20 **MS. OZGA:** Dr. Detraglia?
 21 **MR. DETRAGLIA:** Detraglia, yes.
 22 **MS. OZGA:** Dr. Doynow?
 23 **THE CHAIR:** Yes.
 24 **MS. OZGA:** Dr. Kugler?
 25 **MR. KUGLER:** Dr. Kugler, yes.

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 2 **MS. OZGA:** Dr. Lynch?
 3 **MR. LYNCH:** Sorry, Lynch, yes, I was
 4 too excited emailing Dr. Wicelinski.
 5 **MS. OZGA:** Dr. Markowitz?
 6 **MR. MARKOWITZ:** Markowitz, yes.
 7 **MS. OZGA:** Dr. Marshall?
 8 **MR. MARSHALL:** Marshall, yes.
 9 **MS. OZGA:** Dr. Murphy?
 10 **MS. MURPHY:** Murphy, yes.
 11 **MS. OZGA:** Dr. Olsson?
 12 **MR. OLSSON:** Olsson, yes.
 13 **MS. OZGA:** Dr. Talbott? Dr. Talbott?
 14 Dr. Walters?
 15 **MR. WALTERS:** Walters, yes.
 16 **MS. OZGA:** And Dr. Wicelinski?
 17 **MR. WICELINSKI:** Wicelinski, yes.
 18 **MS. OZGA:** All right. Going back.
 19 Dr. Talbott, are you still on? Okay. Motion still
 20 passes.
 21 **MR. MARSHALL:** Thank you. And thank
 22 you for all your participation then. I need to
 23 inform you, but I have no further motions for this
 24 meeting. But I will bring some to the next one.
 25 **THE CHAIR:** Thank you, Dr. Marshall,

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 2 we appreciate everything. We're running a little
 3 over here. Let's try and move it along quickly here
 4 if we can. E.M.S.C., Dr. Cooper, do you have
 5 anything to mention? I know you have your meeting
 6 coming up next week.
 7 **MR. COOPER:** I'll comment briefly on
 8 two things, Dr. Doynow. And thank you for the
 9 opportunity to advise our SEMAC colleagues. First,
 10 as we continue to work on a pediatric agitation
 11 protocol update, I expect that we're going to have
 12 something that's close to final and our upcoming
 13 meeting.
 14 We also continue to work on the issue
 15 of early identification of success in the field and,
 16 of course, so that ties in some level to our new
 17 assignment I got today to work on the pandemic triage
 18 protocol.
 19 In the interest of time, I'll stop
 20 there. I think those are the major issues that are
 21 before, any ... she feel is important enough to
 22 comment on ... Thank you.
 23 **THE CHAIR:** Thank you, Dr. Cooper.
 24 Amy, do you have any comments?
 25 **MS. EISENHAUER:** Thank you, Dr.

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 2 Cooper. I do have a presentation but I can pretty
 3 much sum up everything. Like Ryan had said in the
 4 beginning, in the bureau report, every year there's
 5 an E.M.S. for children, E.M.S. agency survey and it
 6 starts tomorrow. I email every agency in the State.
 7 And I believe all of you and the
 8 E.M.S. coordinators and the program agencies will
 9 also get an email just for situational awareness for
 10 agencies to complete the survey, last year, we had a
 11 twenty-five percent response rate, which was expected
 12 to some extent just due to the pandemic and
 13 everything that was going on.
 14 And so this survey covers performance
 15 measure number two and performance measure number
 16 three. And so number two is the Pediatric Emergency
 17 Care Coordinator program. And then, number three is
 18 using skills scenarios during training for all
 19 agencies.
 20 So that survey assesses those things,
 21 ask general questions and it helps me and also the
 22 federal E.M.S.C. program, kind of gauge what kind of
 23 tools and education E.M.S. providers need to best
 24 treat pediatric patients.
 25 So if you have agencies, if you can

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 2 follow-up with them and let them know that the survey
 3 will be coming their way and if they don't get it,
 4 please email me and I'll be happy to resend it and
 5 that's everything.
 6 **THE CHAIR:** Thank you, Amy, I
 7 appreciate that. All right. Moving onto some old
 8 business. Good news, just to mention to every
 9 members of the SEMAC to recall, we were tasked with
 10 sending a letter to the commissioner to meet with her
 11 and our Philippy and I will be meeting with her in
 12 January.
 13 We're trying to set up a date. She
 14 was very receptive. I think that's great that we
 15 ended up, having such a quick response. If anyone
 16 has any specific issues they would like to bring up,
 17 please email me and I'll be more than happy to bring
 18 those to the meeting.
 19 Moving to new business, there's a few
 20 issues here. I don't know if we have too many
 21 comments. First responder PCR/documentation is on
 22 the list.
 23 **MS. OZGA:** We can do it, right?
 24 **THE CHAIR:** Any comments on that?
 25 **MR. GREENBERG:** Valerie, I don't think

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 2 you're on mute. I think that was ...
 3 **THE CHAIR:** All right. If there's no
 4 comments on that, hospital overcrowding and the
 5 E.M.S. wait times. I know for my hospitals, it has
 6 been very difficult but we've been managing to work
 7 with E.M.S. to get them in as quickly as possible.
 8 Does anybody have any comments or any
 9 suggestions as how it's working at their particular
 10 shops in -- in getting folks in? Okay. I can see
 11 everybody wants to get through this meeting.
 12 Suffolk County, R.S.I. data, Dr.
 13 Winslow. Are you here to give us some information?
 14 I know it was sort of rushed through at the last
 15 meeting. Okay. Nothing heard there.
 16 The only last thing I'd like to bring
 17 up is I really appreciate Dr. Langsam help on every
 18 one of our meetings and I know sec -- part eight
 19 hundred doesn't have a specific place for a
 20 parliamentarian.
 21 However, as best as I read the
 22 regulations, I don't see anywhere where I can't share
 23 appointing a parliamentary advisor to the committee
 24 unless Dr. Langsam thinks I cannot do that, in which
 25 case I would like to officially do so, if you're

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 2 willing to accept that.
 3 **MR. LANGSAM:** You -- you can do that,
 4 okay, because a parliamentarian simply provides
 5 advice to the Chair. And I appreciate the thanks, I
 6 really do.
 7 But also when the bylaws eventually
 8 get done, remember this from the last meeting, it
 9 should go into the bylaws as well. But yes, you can
 10 do that.
 11 **THE CHAIR:** Well, thank you for
 12 accepting that position. Thank you for all your
 13 help.
 14 **MR. LANGSAM:** You're welcome.
 15 **MR. WINSLOW:** Hey, Dr. Doynow, it's
 16 Dr. Winslow from Suffolk County.
 17 **THE CHAIR:** Hello, Dr. Winslow, how
 18 are you?
 19 **MR. WINSLOW:** I was in the ... so they
 20 moved me into the meeting. Hello.
 21 **THE CHAIR:** Hello. Would you like to
 22 give your information to us?
 23 **MR. WINSLOW:** I had sent my slide
 24 presentation to Val. I wasn't sure if I was able to
 25 share that.

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 2 **MS. OZGA:** Yes, it did go through the
 3 A.D.C.C. process so you -- you can share it. Do you
 4 want me to share it or, Jacob, if you could give Dr.
 5 Winslow ... with the patient?
 6 **MR. WINSLOW:** I just shared my screen.
 7 Can people see that?
 8 **THE CHAIR:** Yes, it's there.
 9 **MR. WINSLOW:** Okay.
 10 **MS. OZGA:** Yes.
 11 **MR. WINSLOW:** Okay. I'll go very
 12 quickly. I did want to review our data, it was a ten
 13 year anniversary of us having a rapid sequence
 14 intubation in Suffolk County.
 15 We represent a large system ... we
 16 have a hundred and eight different E.M.S. agencies
 17 and represent a population of over five thousand
 18 E.M.S. providers of which about a hundred and fifty
 19 ... are R.S.I. medics.
 20 This is a copy of the protocol. It's
 21 slightly different from the collaborative but that
 22 will be my last slide. So instead of wasting
 23 everyone's time reading through the protocol, I'll
 24 just go with the data that I was asked to present.
 25 This began as a ... in 2011 for three

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 2 agencies. It involved three agency medical directors
 3 and fire paramedics. We went through the initial
 4 credentialing ... as certain medications and
 5 equipment. We undergo further education and training
 6 on the procedure.
 7 It began as a two A.L.S. provider
 8 skill with one hour psych medic ... and then one ...
 9 A.L.S. provider for assistance. Now, it is standing
 10 orders for a solitary R.S.I. paramedic as the sole
 11 provider.
 12 What began as just ... and
 13 succinylcholine as the only medications, now we have
 14 added ketamine and ... as alternate medication
 15 choices and we've added fentanyl as pretreatment
 16 consideration in selected patients such as head
 17 injury and stroke.
 18 We also added -- I'm sorry ... fifteen
 19 liter per minute ... We also have added over the
 20 years the use of an automated transport ventilator if
 21 the agency so chooses to purchase trained and
 22 equipped and authorized its use.
 23 Currently, the number of providers and
 24 agencies participating in R.S.I. in Suffolk has
 25 grown. We have twenty-six E.M.S. agencies, one

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 2 hundred and fifty ... R.S.I. paramedics.
 3 So the R.S.I. agencies are approved by
 4 the Suffolk County REMAC. The application is brought
 5 before the R.S.I. subcommittee which is made up of
 6 members of the REMAC and some are agency medical
 7 directors of R.S.I. agencies, some are R.S.I.
 8 credential paramedics with experience, some are
 9 R.S.I. educators.
 10 E.M.S. agencies are required to have
 11 proper training education for its providers and to
 12 have the proper equipment, including video
 13 laryngoscope and Supraglottic airways. Over the
 14 years we found that adding video laryngoscope became
 15 -- increase in the success rate of endotracheal
 16 passage, and now, it is required by several agencies
 17 at the agency level as a first pass.
 18 Many agencies also require the use of
 19 ... so the E.M.S. -- sorry, the E.M.T. paramedics can
 20 then apply after having a minimum of three years of
 21 quality field medical care in the 911 system as a
 22 medic and having ten successful documented field
 23 endotracheal tubes to become an R.S.I. trained
 24 paramedic.
 25 R.S.I. paramedic credentialing

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 2 requires annual skills verification with a high
 3 fidelity management and successful performance of the
 4 R.S.I. procedure in person with standardized patient
 5 scenarios. Notes of a written exam that is
 6 periodically reviewed and updated, it does have an
 7 online version that was added during COVID.
 8 What we like is it involves the agency
 9 medical director, the agency medical director can
 10 perform the skills pre-credentialing and -- and
 11 provide the skilled credentialing for their
 12 paramedics at the agency level.
 13 Also as a secondary level of oversight
 14 and the regional E.M.S. system medical director in
 15 the Suffolk County chief of E.M.S. education and
 16 training, that's Mike Matheson and I serve as the
 17 medical director. We're also involved heavily in the
 18 training and credentialing, but then ... the process.
 19 The R.S.I. subcommittee currently
 20 serves as an ad hoc committee of our REMAC and has
 21 both position in paramedic members. It involves also
 22 Stony Brook University Hospital E.M.S. Medical
 23 Director, Dr. Marshall, Trevor Marshall, and the
 24 paramedic supervisor, John Edward, for Stony Brook
 25 E.M.S.

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 2 We kind of think it's a best practice
 3 and then we've linked ground and aviation under the
 4 same umbrella, use the same protocol, have the same -
 5 - same credentialing, the same equipment. It also
 6 makes it great for a handoff in the field if a
 7 patient has to be transferred from a field agent -- a
 8 field provider to an aviation provider.
 9 So we've done more than five hundred
 10 total performances of R.S.I. over the ten years,
 11 averaging eighty to ninety cases per year on average.
 12 This was actually written for the November meeting
 13 and so we had fifty-five already up until November of
 14 2021.
 15 And we closed out the year with a
 16 total of seventy-eight, even during COVID. In 2021,
 17 there were ninety cases, sixty-eight by ground and
 18 twenty-two by aviation. There are eighty-two
 19 successful endotracheal placements, seven
 20 supraglottic airway placements, and one patient was
 21 an unsuccessful procedure out of the total number.
 22 This actually happened to be a patient
 23 that had a complete airway obstruction by impacted
 24 turkey over the Thanksgiving holiday. The patient
 25 wasn't able to be intubated in the E.R. by multiple

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 2 physician attempts as well.
 3 Overall success rate of the advanced
 4 care and placement in 2020 therefore is ninety-nine
 5 percent, eighty-nine out of ninety procedures with
 6 one failure. The overall success rate of
 7 endotracheal tube placement was ninety-one percent,
 8 that is eighty-two out of ninety total procedures.
 9 For more data metrics, sixty percent
 10 of the time the sedation choice agent was accommodate
 11 to forty percent of the time it was ketamine. Ninety
 12 percent of the time the paralytic choice agent was
 13 succinylcholine and ten percent was ...
 14 The quality improvement process is a
 15 five step process. It's evolved over many
 16 generations -- many different ... generations that
 17 we've had over the years. What we like is that it
 18 involves the agency level first.
 19 The first is, of course ...
 20 notification in Suffolk County Medical controls so
 21 that the call can be flagged in the system. Step
 22 two, an audit form is signed by the physician at the
 23 receiving hospital to verify the only placement.
 24 This R.S.I. audit form -- formally
 25 documents the advanced airway placement confirmation

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 2 Steps four and five are more formal
 3 peer review. Step four is done at the agency level
 4 and step five is done by the R.S.I. subcommittee
 5 where every single P.C.R. is reviewed.
 6 We have noticed that ninety percent of
 7 the time there are three clinical scenarios for six -
 8 - for the use of R.S.I. One is for the head injury
 9 or multi system injury trauma patient with a decrease
 10 in mental status and clenched jaw.
 11 Two is the impending respiratory
 12 failure patient, many are elderly with either C.H.F.
 13 or C.O.P.D. and the third is the altered mental
 14 status with ... from either stroke, overdose or
 15 sepsis.
 16 Pediatric R.S.I. is exceptionally
 17 rare. In our ten years, we've only had two incidents
 18 of use of pediatric R.S.I. We defined pediatrics in
 19 our county as less than fifteen years of age or
 20 thirty-six-kilogram weight of the patient.
 21 Currently Suffolk County REMAC has
 22 approved pediatric R.S.I. only as a medical control
 23 option. The medics in the field feel that having
 24 online medical control physician presence to assist
 25 with medication choices, dosage and to be there

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 2 as well as offers the ability for the physician in
 3 the E.R. to do real in time any re-education,
 4 comments on the care of the patient and to be able to
 5 allow for that teachable moment at the bedside.
 6 This a copy of the audit form
 7 documenting pre and post end-tidal CO2 and end-tidal
 8 CO2 documenting the indication for the procedure
 9 mounds and lemons ... the medications given and some
 10 patient characteristics, age, weight, etcetera.
 11 Step three, the R.S.I. medic then
 12 calls our agency medical director within twenty-four
 13 to forty-eight hours, this is another key component
 14 to the success of the program.
 15 If that case was a success, this is a
 16 great moment to not only applaud the medic for the
 17 good job well done, but it's also a great case to
 18 discuss what was the medication he chose, how did
 19 your patient fare, is there anything that I can do as
 20 the agency medical director to follow up on the
 21 patient care.
 22 And if there was a problem, it's
 23 something that involves the agency medical director
 24 right off the bat so they can be involved in any kind
 25 of review of the case.

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 2 online in case there was an issue is a bit of a
 3 safety net that the medics enjoy.
 4 The agencies also, therefore, are not
 5 required to supply every agency ambulance with
 6 pediatric sized equipment must they wish to do so.
 7 R.S.I. paramedics are not obliged to try to perform a
 8 pediatric R.S.I. on a pediatric patient unless the
 9 R.S.I. medic feels comfortable with the situation.
 10 As compared to the New York State
 11 Collaborative Protocol, this is kind of a slide that
 12 I think I will leave on the screen for a few moments
 13 because I think it's pertinent to the SEMAC.
 14 We currently do not require a G.C.S.
 15 less than eight to perform the R.S.I. I did an audit
 16 of the last twenty-five successful R.S.I.
 17 performances in Suffolk County and noted that eleven
 18 out of twenty-five at a G.C.S. greater than eighty,
 19 which is forty-four percent.
 20 Suffolk County allows for two attempts
 21 of endotracheal placement by the R.S.I. paramedic
 22 before clearly stating that the medic must place a
 23 supraglottic airway.
 24 The collaborative language is a little
 25 different here. They allow for three attempts and

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 2 they say consider insertion of an alternate airway
 3 device. They are different, Suffolk County does not
 4 have a second rescue assist with laryngeal
 5 manipulation.
 6 The R.S.I. medics in our area have ...
 7 not helpful, and many of our E.M.S. agencies use
 8 video laryngoscopy, practically eighty percent of the
 9 time and, therefore, it would not actually be
 10 helpful.
 11 We also have the fourth differences,
 12 we supply fentanyl, two micrograms per kilogram as a
 13 priests -- as a pretreatment sedation dose,
 14 especially in cases of increased intracranial
 15 pressure or stroke, this was brought forth by a
 16 neurologist.
 17 That's all I have. That is our
 18 experience in Suffolk County R.S.I. program. It's
 19 been in place for ten years. It represents the
 20 ability for ground and aviation E.M.S. units alike to
 21 work together and also represents a very robust
 22 quality of ... peer review process that I think
 23 represents the best practice in medicine. That's all
 24 I have, thank you.
 25 **THE CHAIR:** Thank you, Dr. Winslow,

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 2 for the very nice presentation. Does anybody have
 3 any comments or questions for Dr. Winslow?
 4 **MR. WINSLOW:** If any would like it
 5 emailed to them directly, please send me an email. I
 6 had sent it to the majority of the November SEMAC
 7 attendance, but if anyone is missing out, please send
 8 me an email, I'll put my email up in chat.
 9 **THE CHAIR:** Thank you.
 10 **MR. MARSHALL:** Thank you. It's great
 11 study.
 12 **MR. GREENBERG:** And Dr. Winslow, it
 13 should be obviously on Boardable but ... be up on our
 14 website under the documents for this meeting as well.
 15 **THE CHAIR:** Thank you.
 16 **MR. WINSLOW:** I'm trying to un-share
 17 my screen, one moment.
 18 **MR. MCEVOY:** Dr. Chairman, Mike
 19 McEvoy, I have one more item.
 20 **THE CHAIR:** Go ahead, Dr. McEvoy.
 21 **MR. MCEVOY:** I know that we killed a
 22 lot of met standards and wasted about an hour of time
 23 here as well with the viral pandemic protocol but
 24 we're now left with one that I think this body
 25 considers ineffective.

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 2 Is there any -- does anyone have any
 3 idea as to what we should do with the one that's left
 4 remaining, kill pad, leave it.
 5 **MR. BART:** I was just going to thank
 6 you, Mike, for bringing that. I was going to bring
 7 up -- that last item was going to be that exact same
 8 thing. So thank you, Dr. McEvoy, for bringing that
 9 up.
 10 I think we -- we voted down some
 11 changes there to improve on a document that is
 12 probably not functional right now. So to leave the
 13 old documents in place right now, to be the remaining
 14 protocol doesn't seem to make a lot of sense. I
 15 don't think that was the spirit of that discussion
 16 and it was not what I intended as well.
 17 So as far as the intent of what the --
 18 the old protocols at the range, I think a final
 19 remaining item there would be to create some, you
 20 know, language saying that we want to either
 21 permanently suspended or just get rid of it entirely,
 22 or leave it up to the regions.
 23 And I'd like some -- maybe some
 24 comments or from my colleagues that -- they think
 25 there might be still value to it if they feel like

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 2 there still is, but it's current census that out
 3 there doesn't -- doesn't make sense to us. So we
 4 need to do something with it before we let this
 5 meeting go.
 6 **MR. MARSHALL:** Hi, it's Dr. Marshall -
 7 -
 8 **THE CHAIR:** ... we have an interesting
 9 question. Sorry, go ahead.
 10 **MR. DAILEY:** Dr. Marshall and then Dr.
 11 Dailey.
 12 **MR. MARSHALL:** Yeah, so thank you for
 13 that. I think that with our plan to have a broader
 14 disaster protocol, I think leaving this there for
 15 regions to use would not be inappropriate, nor would
 16 deactivating it at a statewide level.
 17 But -- and my preference would be to
 18 just leave it and go with the broader disaster
 19 response protocols that we plan on developing,
 20 thanks.
 21 **THE CHAIR:** Dr. Dailey?
 22 **MR. DAILEY:** I think we have an
 23 interesting question before us too. The City of New
 24 York as a region has issued their own directive
 25 regarding this same situation.

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 2 So I think that leaves us in a
 3 position where it either -- well, first, we should
 4 probably deactivate this protocol. The second is
 5 whether or not that advisory the City issued is
 6 appropriate to stand, and if so, whether or not
 7 regions are free to issue their own in the model of
 8 New York City's.
 9 **MR. WASHKO:** I'd like to throw out
 10 real quick and bring to the group's attention that
 11 this does have potentially financial ramifications
 12 from an E.M.S. sustainability standpoint, given
 13 C.M.S. waivers in which reimbursement is available
 14 for treating place or not transport for COVID
 15 patients as long as there's a regional protocol in
 16 place in -- in, you know, in effect.
 17 So removing this option could have
 18 some potential financial implications to the region's
 19 just so everyone is aware of that.
 20 **THE CHAIR:** Thank you. ... on the
 21 issue?
 22 **MR. MCEVOY:** I do think that there --
 23 there should be some, you know, as Dr. Dailey points
 24 out, there should be some ability for regions to make
 25 their own selection here.

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 2 **THE CHAIR:** Mark Philippy, you also
 3 have a comment?
 4 **MR. PHILIPPY:** Thank you. Mark
 5 Philippy. I -- I struggle with this because I
 6 understand where Dr. Bart is coming from but at the
 7 same time, we're -- we're at a point of crisis
 8 throughout our system and I -- and I keep using that
 9 term, but I don't think it's any more applicable ever
 10 before then the time right now.
 11 We're -- we're looking at a ten,
 12 fifteen, twenty calls waiting for ambulances in a
 13 community the size of Rochester, Monroe County, where
 14 potentially a protocol like this, and I want to speak
 15 for Dr. Cushman, but I'm just using this as a -- as a
 16 -- for instance, potentially, some of those patients
 17 could be treated in place with a protocol like this.
 18 So, you know, I was very hopeful
 19 coming to this meeting today and with met standards
 20 earlier this morning that we would come away with
 21 some ideas of how we can mitigate the current
 22 situation, and how we could deal with both -- with --
 23 with all of the options that are available to us.
 24 Telehealth, treating place,
 25 alternative destination and what I -- what I hear is

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 2 that, well, we're going to -- we're going to work on
 3 that later, we're going to push that off to another
 4 meeting. We're going to work on that some other
 5 time.
 6 I'm sorry, doctors, but -- but my
 7 people are struggling right now just getting
 8 ambulances out the door. We're waiting in hospitals
 9 for hours on end, and I -- I'm looking to this body
 10 into you folks, as our -- our subject matter experts
 11 to help us with solutions. And -- and I'm -- I'm
 12 very frustrated, I don't know what else to do right
 13 now.
 14 So I'm sorry if there's a little bit
 15 of emotion in my voice, but -- but the fact that we
 16 keep pushing these -- kicking this can down the road,
 17 when -- when our system is -- is about ready to fall
 18 apart, and I don't think that's hyperbole, I -- I
 19 don't know what else to say.
 20 So I -- I thank you for bringing this
 21 up. I -- I hope that we can come to some decision
 22 about something that will help keep our system
 23 functioning.
 24 **MR. BART:** It just wasn't that
 25 protocol, Mark, and -- and I totally appreciate what

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 2 you're saying there. I'm not saying it has no value.
 3 I'm saying that protocol has been changed a bunch of
 4 times to where the value of the protocol was.
 5 If you didn't meet the inclusion
 6 criteria, E.M.S. didn't have to transport you, which
 7 involve our E.M.S. professionals doing an initiated
 8 code four refusal from their perspective, not the
 9 patient's perspective.
 10 In which we asked for the teeth of
 11 that protocol and ultimately we're told no, it was --
 12 it was changed to the bureau and actually the feeling
 13 of the states of the Department of Health that we
 14 couldn't issue such a protocol that allowed providers
 15 to initiate that refusal of care.
 16 So the cross section here where we
 17 have something that we -- we can't actually fix is
 18 not necessarily medical direction. I think the
 19 medical directors all appreciate the idea that we
 20 want to empower the system to utilize its -- its own
 21 resources, how it ... sees fit, and maybe not the
 22 person on the other end that says, I just want an
 23 ambulance to be transported.
 24 And these are the situations where we
 25 wanted to identify patients that were at lower risk

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 2 who were complaining of some viral illnesses that
 3 maybe wants to go to the hospital. But we're saying,
 4 listen, we're out of resources for you today so we
 5 can't do that.
 6 But the protocol that exists right
 7 now, doesn't and never have the teeth to say that, or
 8 to have something that inclusion criteria, that
 9 ultimate, the end says, we'll contact online medical
 10 direction, I was at any different than what we do
 11 every day.
 12 So if that's all it says right now
 13 that I don't think that protocol is useful. So to
 14 keep it alive or to make modifications to it is -- is
 15 just -- is just painting an old house, it might look
 16 fresh and might come with a new date on it but it
 17 still doesn't give you any more authority, or give
 18 any provider any more authority to do the job we
 19 wanted to do in the first place.
 20 So I'm not against the idea, I don't
 21 think anybody is, I'm against what that protocol is
 22 actually doing. Because I think it's functionless,
 23 it's the lame duck protocol here. And if it comes
 24 out positive beyond ... like that's what we want to
 25 do, I don't think we've made any market improvements

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 2 ambulances to be freely available afterwards when the
 3 call volume is very high and those resources are very
 4 needed. So, you know, here in New York, especially,
 5 we have forty-six hundred calls a day.
 6 So it really and we have a forty
 7 percent call out rate right now, a sick rate. So
 8 we're working our numbers with even with, you know,
 9 forty percent less of staff, where this protocol does
 10 assist us and allows us to make those decisions and
 11 doesn't overwhelm our telemetry either, because
 12 that's another issue.
 13 With so many calls, you know, we do
 14 overwhelm telemetry, perhaps in other regions that's
 15 not the case but here in New York, that is a -- that
 16 is a major issue, so I wanted to bring those points
 17 out because I agree that we should have something out
 18 there that helps guide us and allows us to make these
 19 decisions. That's my point.
 20 **THE CHAIR:** Thanks, Nick.
 21 **MR. MARSHALL:** Dr. Marshall.
 22 **THE CHAIR:** Dr. Marshall, you're next.
 23 **MR. MARSHALL:** Yeah, thanks. Yeah, I
 24 want to just follow up with what Nick said, I think
 25 that the old protocol did have some teeth because at

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 2 today.
 3 **THE CHAIR:** Thanks, Joe.
 4 **MR. ALEXANDROU:** Don, if I -- if I
 5 may, it's Nick Alexandrou. I just want to talk along
 6 that lines for a second because I think the protocol
 7 with the modifications allowed a lot of outs. And it
 8 also empowered the -- the providers in a way as well,
 9 they were allowed to R.M.A. patients or leave them at
 10 home.
 11 If the patient disagreed there was an
 12 ability to transport the patient, and calling
 13 telemetry did perhaps assist the -- the providers in
 14 making that -- making that decision when they're
 15 difficult patients or difficult decisions where it
 16 can become an argumentative kind of a situation.
 17 So there was the possibility, I mean,
 18 there was the option there of empowering the -- the
 19 providers and allowing for flexibility or online
 20 medical control or a physician on the other line to
 21 back up the situation where it might have been a
 22 difficult situation where patients may not want to go
 23 to the hospital, because -- just because the E.M.T.
 24 or paramedic tells them that they can't.
 25 And it also allows for those

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 2 the end, it says this patient meets criteria for non
 3 transport and or treatment in place and that gives
 4 you the authority on a reasonable basis to utilize
 5 that.
 6 And certainly a region could, you
 7 know, require their -- their teams to call medical
 8 control for that, but this policy the way it was
 9 originally written in March of 2020 allowed units to
 10 leave cases at home without calling medical
 11 appropriate patients, of course.
 12 They think that what the amendment or
 13 the adjustment was at medical standards and the
 14 discussion at least around this part was, you know,
 15 contact medical control or following regional policy
 16 and I think that that's where, you know, New York
 17 City comes in, because that's our regional policy in
 18 terms of -- of -- have been in place for non
 19 transport.
 20 So I -- I think it does have some
 21 teeth and may not have as much teeth as we want, but
 22 the way it currently exists, it -- it does have some
 23 teeth, and it does need to be revised, I -- I agree
 24 with that. But I think in place it has some value.
 25 Thanks.

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 2 **MR. GREENBERG:** I guess the question
 3 would come from the difference of opinions in the
 4 region is, you know, if you're leaving the current
 5 one in place do you just add the line in at the
 6 discretion, you know, make a modification to the
 7 current one at the discretion of the region to have
 8 in place.
 9 You don't make the other modifications
 10 and you only make the modification of whether or not
 11 the region chooses to have it on or off.
 12 **MR. ALEXANDROU:** I'm going to say
 13 something here as well, I'm sorry, it's Alexandrou
 14 again. But the -- the present protocol and triage --
 15 the present pandemic protocol has the error built
 16 into it and you're going to be transporting patients,
 17 perhaps with just a fever to the hospital and that's
 18 one of the things we try to avoid here.
 19 And the purpose of this triage was to
 20 be able to minimize transports to the hospital and
 21 overwhelmed both the ambulance services and the
 22 hospitals. So if we leave this in place the way it
 23 is, it doesn't serve a purpose, we're going to be
 24 still transporting those patients to the hospital.
 25 One of the issues, I think that, you

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 2 to bring it back up, yes.
 3 **MR. RABRICH:** Maybe we should have a
 4 motion to ... motion to reconsider. I think we're
 5 trying to let perfect be the enemy of good. I think
 6 we all acknowledge the problems, but we need
 7 something in the short term until we get to where we
 8 ultimately want to go.
 9 **THE CHAIR:** I would agree. I think we
 10 can get rid of it. All right. So we have a motion
 11 to bring it back up, did we have anybody to second
 12 it, Jeff, you can vote but I don't think you can make
 13 a motion. Is that correct?
 14 **MS. BOMBARD:** Bombard, I'll second.
 15 **THE CHAIR:** Someone else would have to
 16 make the motion, which Nick did, I believe.
 17 **MR. ALEXANDROU:** Yes.
 18 **THE CHAIR:** I -- I would hate to ... I
 19 would hate to make another roll call because that
 20 takes forever. So let's try this, does anybody ...
 21 from the vote to bring this back up?
 22 Okay. I hear nothing, so it's brought
 23 back up. Let's discuss it again. We only have
 24 twenty-six minutes to the next meeting.
 25 **MR. WALTERS:** Dr. Doynow, it's

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 2 know, helped to vote this down was the change to the
 3 adult protocol where we didn't have something for
 4 pediatrics and there was a lot of discussion on this.
 5 Perhaps in that criteria where we also have an age
 6 criteria of greater than sixty-five, we could have
 7 put something in there that said, less than -- less
 8 than fifteen for pediatrics.
 9 And then if you look at the hour to
 10 the right of that box, it does suggest call
 11 telemetry, or call medical control which the
 12 physician can assist in making that decision. And it
 13 would solve probably both of our problems, or address
 14 the issues at least to some degree until E.M.S.C. can
 15 get together and provide further assistance. That's
 16 all I have to say.
 17 **THE CHAIR:** Well, I'm not sure where
 18 to go with this at the moment. We voted down the new
 19 protocol, we had that standards discussion on it for
 20 quite some time. And somebody wants to bring it up
 21 again with some modification, I have no problem doing
 22 that.
 23 **MR. ALEXANDROU:** I think that we don't
 24 --
 25 **MR. MR. DOYNOW:** I think that motion

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 2 Walters.
 3 **THE CHAIR:** Go ahead.
 4 **MR. WALTERS:** So I -- I think one of
 5 the discussions -- we seem to get a little wrapped up
 6 around sending this to E.M.S.C. and -- and, I guess,
 7 when I look at -- at the, you know, the draft we're
 8 looking at or working off of really we weren't asking
 9 E.M.S.C. to come up with a -- many changes to the
 10 protocol and that really -- I think it was really
 11 centered around the -- the differences in pediatric
 12 vital signs, right.
 13 I -- I don't think there's anything
 14 else in there that really would change, the symptoms
 15 of this are the same, essentially, and -- and
 16 probably the high risk ... I mean, pregnancy doesn't
 17 apply to most of your pediatric patients.
 18 But -- but otherwise, your -- your
 19 other comorbidities and things that make them high
 20 risk are -- are probably in there. So if that's a
 21 sticking point, I guess, the question is, do we make
 22 this just adult or if we want to include pediatrics
 23 and -- and then have E.M.S.C. review and provide some
 24 input for consideration at the next meeting.
 25 Do we just go to saying, here are the

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 2 vital signs or abnormal pediatric vital signs
 3 appropriate, you know, based on their age or
 4 something, right, because even if E.M.S.C. comes back
 5 with vital sign abnormalities, they're going to have
 6 to be age specific, it's not going to be a one cut
 7 off of a certain number, right?
 8 Your respiratory rate could be very
 9 different for, you know, a one-year-old versus an
 10 eight-year-old, for example. And with that, I guess,
 11 the only other consideration I would say regarding
 12 pediatrics is, do you put, you know, a lower age on
 13 there is it, you know, less than a year less than six
 14 months, whatever we feel is appropriate.
 15 Maybe those things should be
 16 considered if the ticking point is adult versus
 17 pediatrics.
 18 **MR. ALEXANDROU:** Well, I'm going to
 19 come back and make my suggestion about putting in
 20 something for pediatrics. In the meantime, perhaps,
 21 when that box where it says greater than sixty-five
 22 we could put something that mimics pediatrics age of
 23 less than fifteen where that covers it for now and if
 24 there's any discrepancy or concerns, the box to the
 25 right of that says to reach out to online medic

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 2 control to make a decision.
 3 And the physician can assist with the
 4 vital signs and the condition of the patient and make
 5 a decision with the -- with the provider. And then
 6 that -- that would solve some of the problem right
 7 now in the immediate time and -- and then we can let
 8 E.M.S.C. reevaluate that or come up with something
 9 perhaps different.
 10 **THE CHAIR:** Val, can you put it back
 11 up so we can see those changes and then we can
 12 perhaps put that in there and vote?
 13 **MS. OZGA:** Yes, this was the version -
 14 -
 15 **THE CHAIR:** The last version that we
 16 had of the pandemic protocol, it got voted down.
 17 **MS. OZGA:** Okay. Just hold on.
 18 **THE CHAIR:** Those modifications that
 19 Dr. Walters, Dr. Alexandrou suggested.
 20 **MR. OLSSON:** This is Olsson. While
 21 she is doing that, two quick comments. First, right
 22 at the top E.M.S. adult viral pandemic triage.
 23 Number two, the inbox for refer to the B.L.S.
 24 protocols. It's already done, if you've got a kid
 25 you go to B.L.S. protocols or consult with medical

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 2 advice. I -- I don't see it needs anymore. Thank
 3 you.
 4 **THE CHAIR:** Thank you, Dr. Olsson.
 5 **MR. PHILIPPY:** Dr. Doynow, could I ask
 6 -- or Dr. Bart to -- if he could, maybe or one of the
 7 other physicians who voted against this in the first
 8 go around.
 9 What would you want to see added to
 10 this? What can we do to -- to make this more
 11 palatable for the -- or more effective, I -- guess
 12 that's where I'm also a little bit at a loss.
 13 **MR. CUSHMAN:** Mark, I'll -- I'll --
 14 I'll speak to my no vote. My -- my no vote is that
 15 this is just exemplary of a failed process, you know,
 16 we -- we -- we get these documents to review with
 17 very little time, there's no opportunity for really,
 18 I mean, you know, how long our region takes to that
 19 public comment, review, modify public comment again,
 20 and then, finally, approve a protocol.
 21 And there's a reason for that, it's
 22 because there are many -- many unintended
 23 consequences of -- of making well intentioned, but
 24 reactionary decisions to -- to try to make everybody
 25 happy without truly thinking them all through, a

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 2 pilot testing a protocol to make sure that how it is
 3 written is a -- is -- is interpreted by both B.L.S.
 4 and A.L.S. providers with the intent that it was
 5 created.
 6 You know, that -- that to me is --
 7 again, with -- without it saying that you can deny
 8 the patient being transported to a hospital, then
 9 it's no different than what our providers do every
 10 day is they use their clinical judgment based upon
 11 the presentation at the time to make a -- to make a
 12 clinical decision.
 13 **THE CHAIR:** It is back up here. So
 14 can we have those changes that you folks want to
 15 make?
 16 **MR. ALEXANDROU:** Well, I, you know, it
 17 all depends on every -- if everyone wants to add
 18 something for pediatrics and get this out sooner and
 19 probably, you know, fit a lot of our patients, we
 20 would have to take out adult on the top.
 21 **THE CHAIR:** Right.
 22 **MR. ALEXANDROU:** And then, down in the
 23 one, two, three, fourth box, where it says, age
 24 greater than sixty-five, I would just add age less
 25 than fifteen is another criteria for -- for

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 2 pediatrics, where now would be to the right -- it
 3 would go to the right in the -- in the box on the
 4 right where you would either follow your protocols or
 5 call online medical control and make that decision.
 6 Leave it to the region and it leaves
 7 it to the physician in difficult circumstances.
 8 **THE CHAIR:** Okay. That was --
 9 **MS. BOMBARD:** Bombard here. I would
 10 like to make a motion.
 11 **THE CHAIR:** Yes, who -- who is this?
 12 Tiff?
 13 **MS. BOMBARD:** It's Tiff.
 14 **THE CHAIR:** Okay.
 15 **MS. BOMBARD:** All right. I'd like to
 16 propose a motion making three changes to this
 17 protocol. One, we get rid of adult at the top. So
 18 delete adults -- adult for the viral pandemic
 19 protocol.
 20 Two, in box four the one that says
 21 patient assessment reveals any of the following after
 22 the asterisk, add for patients under fifteen years
 23 old.
 24 And the third change would be get rid
 25 of the last box, the one in red that says contact

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 2 medical control. The whole intent of this protocol
 3 was that we were giving our E.M.S. providers an
 4 avenue to not contact medical control.
 5 So when we're invoking this protocol
 6 that shouldn't be there, when we're not invoking this
 7 protocol that's implied. So let's get rid of that
 8 box. So that is my proposal.
 9 **MR. MARSHALL:** Marshall. I -- I agree
 10 with everything you said, except removing the last
 11 box, because I think the wording there allows a
 12 region to do that but it also allows a region who
 13 prefers to have them contact medical control to do
 14 that as well.
 15 **THE CHAIR:** I would -- I would agree
 16 with Dr. Marshall on that.
 17 **MR. MARSHALL:** I know it says it on
 18 the right and the boxes on the right, but I think
 19 that you still need that final -- you need something
 20 there to end the flow.
 21 **MR. BART:** Which is then be permitted
 22 to use language that says, if there's no indication
 23 to transport the above sections, the patient is not
 24 required medical condition and transport by ambulance
 25 because we tried to have that once before, and as a

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 2 statewide protocol that was vetoed, that to me has
 3 some teeth to it that a region can say out of that
 4 fits with by metric or not.
 5 Would that be part of the region non
 6 transport because if that's the case then it's a yes
 7 from me.
 8 **MR. MARSHALL:** That would be my
 9 interpretation and that wording that's there now,
 10 with following regional policy would give a region
 11 the capability of putting that in place, non
 12 transport or treat in place.
 13 **THE CHAIR:** Yeah. Or how about
 14 contact --
 15 **MR. DAILEY:** I think there's one more
 16 thing that we have not covered here, which is the
 17 fact that we asked for whether or not there was any
 18 data over this protocol that is currently been
 19 accessible to our E.M.S. providers for the last
 20 eighteen months.
 21 We need to make sure that before we
 22 approve this that there is a pathway that Deputy
 23 Chief Brody can put in place in order to assure that
 24 every utilization of this protocol can be reviewed to
 25 make sure that there are no misinterpretations and to

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 2 see what the consequences ultimately are so we can
 3 follow and see whether or not any of these patients
 4 are being touched twice in twenty-four hours and if
 5 so, what's happening?
 6 **MR. ALEXANDROU:** I'm going to suggest
 7 that that is a regional QA issue that needs to take -
 8 - take place and not at the state level, although
 9 that information can be shared but I think that's,
 10 you know, I don't want to prevent this protocol from
 11 going out because we can ensure that the data gets up
 12 to the state. It should at least be at the regional
 13 level.
 14 **MR. GREENBERG:** And -- and I can go
 15 one step further there and just say to -- to both Dr.
 16 Dailey, to ... that we're happy to work with, you
 17 know, how that can happen, you know, within E.P.C.R.
 18 platforms or not to document when this protocol is
 19 being used, or things like that, to the best of our
 20 abilities.
 21 So happy to -- I think it's a, you
 22 know, a good suggestion, it helps with, you know, and
 23 then the regions can do the -- the quality on it, but
 24 at least it would help to flag the charts for it.
 25 **MR. DAILEY:** If I may? So we did, and

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 2 we -- we followed ours. But we would like to make
 3 sure that indeed if we're going to promulgate a
 4 statewide protocol that there'd be a statewide
 5 quality initiative to make sure that this drastic
 6 change and additional emphasis doesn't incur
 7 additional harm to our patients.
 8 **MR. WINSLOW:** Dr. Doynow?
 9 **THE CHAIR:** Yes?
 10 **MR. WINSLOW:** Yeah, it's -- it's
 11 Winslow from Suffolk. One thing that we found in our
 12 region was that many a time they weren't filing a
 13 P.C.R. without disposition code of no transport by
 14 protocol. And they were just R.M.A.ing everybody and
 15 that required in our region, the R.M.A. to go through
 16 medical control.
 17 So it kind of screwed up the whole
 18 process of allowing them to, you know, transport. We
 19 kind of like there being a medical control option for
 20 the provider to be able to then double check with the
 21 medical control, either consultant paramedic or
 22 physician, whether the protocol will be in use.
 23 And also to assist with the fact that
 24 now the paramedic isn't start telling a patient who
 25 may be argumentative on the scene of why they're not

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 2 running out of time. So --
 3 **MR. WALLERS:** I -- I think the issue,
 4 Dr. Doynow, though, is -- is that, you know, most
 5 regional policies for non transport are -- are some
 6 type of refusal of transport, they're not an E.M.S.
 7 driven.
 8 No, this patient does not meet
 9 transport criteria because of the healthcare crisis
 10 that we're in. I -- I -- I honestly, I -- I agree
 11 with what Dr. Bart is saying and I think what -- what
 12 Dr. Bombard is saying also, this bottom box needs to
 13 be changed. It needs to say, you don't meet
 14 criteria, you don't go to the hospital.
 15 And -- and -- and we can even put in
 16 language like New York City did in theirs, something
 17 that says that there's a discrepancy, you know,
 18 contact med control or something like that. I mean,
 19 we can put in some wording like that, but -- but
 20 essentially this -- I don't think our regional
 21 policies for non transport are the same as what we're
 22 trying to do here, I think they're different.
 23 Dr. Bart, as you're shaking your head,
 24 are you agreeing?
 25 **MR. BART:** Yeah, I do agree that

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 2 going to the -- to the hospital.
 3 So -- so in our region, particularly,
 4 we found it to be a quality improvement issue that we
 5 feel in our region if we were going to bring this
 6 back our medical control would be a big piece of it.
 7 **MS. BOMBARD:** I don't think we took
 8 medical control out of this though, that's the box to
 9 the right, right? Consult with medical control for
 10 any difficult or unclear situations.
 11 **MR. WINSLOW:** That's true.
 12 **MS. BOMBARD:** Again, if we're revoking
 13 this protocol, the whole idea is to empower people to
 14 leave patients in place. If we don't need to do that
 15 because our volumes are down or because we need to
 16 have better oversight of our providers or for
 17 whatever reason, then we don't need the protocol at
 18 all at that time, right?
 19 You know, the whole reason for this
 20 protocol is to get rid of to -- to be able to take
 21 the medical control part away, if needed.
 22 **THE CHAIR:** Well, it says you don't
 23 have to contact medial local control. It just says
 24 or follow regional policy. So it leaves it open. I
 25 mean I hate to stop the discussion but we're really

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 2 that's the reason why this got procedurally voted
 3 down, I think, in the first place. It wasn't about
 4 the edits of this document. It's about the action
 5 items that this document would say.
 6 And this is not a refusal of medical
 7 assessments, this is not an R.M.A. typically, in
 8 which you involve medical direction to say, listen,
 9 this guy doesn't want to go to the hospital, you
 10 know, what -- what can we do about it?
 11 Oh, yeah, that's A.M.A., or that seems
 12 appropriate. This is us saying, you can go to the
 13 hospital if you want to, we're just not taking you in
 14 an ambulance and that's going to be possibly against
 15 what the patient is already requesting us to do.
 16 And as an exceptional protocol during
 17 a pandemic or something that needs an exceptional
 18 pathway. That's what this protocol needs to say, and
 19 if it doesn't say that, that's kind of why I said I
 20 didn't need it, or don't want it.
 21 So if -- if it's going to remain same
 22 like this, it's still getting a no vote in my
 23 opinion.
 24 **MR. MARSHALL:** One -- one more comment
 25 -- one more comment, please. So in the March 2020

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 2 version, that last box says this patient meets
 3 criteria for non transport and -- or treatment in
 4 place, and then it tells you to leave the patient
 5 there and provide them with information from follow
 6 up.
 7 That's what we had originally, but
 8 people didn't like that, I guess, because they didn't
 9 want to leave people at home.
 10 **MR. BART:** We -- we liked it, Mark
 11 asked me a few minutes ago, like what -- what would
 12 make you say that you like this protocol, and that
 13 for me moves the needle --
 14 **MR. MARSHALL:** It was changed. So
 15 that's what we had originally, but it was changed.
 16 **MR. BART:** Changed by us.
 17 **MR. MARSHALL:** So we can put that back
 18 in the way it is and then move on from there.
 19 **MR. ALEXANDROU:** New York City
 20 protocol actually has that last bullet and it also
 21 that says, in difficult situations, if the patient
 22 can't be persuaded, transport them anyway.
 23 So you could put that in as some kind
 24 of another option if these things are very difficult,
 25 instead of wasting time on scene or arguing with the

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 2 So C.M.S.C. is meeting next week. Is
 3 there any reason med standards itself could be next
 4 week, and then we held an emergency SEMAC meeting,
 5 say in two weeks to -- to look at it's final versions
 6 of an adult and P.D.F. version of the protocol.
 7 That would be my suggestion. I'll
 8 leave it to you to decide if that's a good idea, Dr.
 9 Doynow. So that would be my suggestion, thank you.
 10 **THE CHAIR:** The problem, Mark, is then
 11 we have to get an quorum together, which may not
 12 occur and now, we need to get a SEMSCO quorum
 13 together to approve what we have. So there's a --
 14 there's a -- probably a problem and may not occur at
 15 all --
 16 **MR. COOPER:** Then, that will appear to
 17 preclude doing anything on the pediatric side, which
 18 I don't think it's a good idea.
 19 **THE CHAIR:** Well, again, unless we
 20 modify this, we -- we're stuck with the old protocol
 21 or we deactivate the old protocol. My suggestion is
 22 we modify this one to the point that it's reasonable,
 23 that includes the age that we talked about, and
 24 whatever statement everybody's comfortable with at
 25 the bottom.

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 2 patient or calling telemetry that may waste more
 3 time.
 4 You could just have that as in there
 5 that it's an option to transport the patient if they
 6 can't be persuaded.
 7 **MR. BART:** It seems like a reasonable
 8 compromise, Nick.
 9 **MS. BOMBARD:** And God, I would hope
 10 that's what we're doing anyway, but if we need to
 11 write that down for people, I guess, we need to write
 12 that down for people.
 13 **THE CHAIR:** So how do you guys want to
 14 put that --
 15 **MR. COOPER:** Yeah, I think it's --
 16 **THE CHAIR:** -- somebody would have
 17 make --
 18 **MR. COOPER:** Dr. Doynow, may I?
 19 **THE CHAIR:** Yeah, Dr. Cooper.
 20 **MR. COOPER:** Thank you. You -- you
 21 know, we are -- it appears to me that we're doing
 22 exactly what Jeremy Cushman was warning us about a
 23 few minutes ago or trying to develop this protocol in
 24 the last ten, fifteen minutes of our meeting with
 25 multiple different points of view being expressed.

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 2 If we can't do that and we can't make
 3 that, we have nine minutes until SEMSCO ... So if
 4 somebody wants to make a suggestion how to change
 5 that last box, I'm all for it.
 6 **MR. BART:** Do we have anybody that can
 7 modify the screen in front of us? It's kind of a
 8 working screen or we're doing this blindly.
 9 **THE CHAIR:** I believe that the health
 10 department has an open version of this and they can
 11 modify. Or Dr. Marshall, do you have an open version
 12 of it?
 13 **MR. MARSHALL:** Yes, hold on.
 14 **MR. BART:** No some ... looks like they
 15 can grab it.
 16 **MR. GREENBERG:** Yeah, the -- version
 17 on the screen is a PDF, but Dr. Marshall, let me --
 18 Peter, can I have -- hold on one sec. Dr. Marshall,
 19 I'm going to send this back to you.
 20 **MR. MARSHALL:** Okay.
 21 **MR. PHILIPPY:** Sorry to be the kid in
 22 the classroom raising his hands and everybody is
 23 trying to leave, just for what it's worth.
 24 **MR. BART:** You're ... we needed to do
 25 this.

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 2 **THE CHAIR:** It's okay, Mark, you're --
 3 you're the chair anyway. So the next meeting can't
 4 start without you.
 5 **MR. GREENBERG:** Dr. Marshall, it
 6 should be in your email.
 7 **MS. BOMBARD:** And besides this we've
 8 been working on this since what, eight o'clock this
 9 morning. I don't think we're actually doing this in
 10 ten minutes, we're doing it like ten hours.
 11 **MR. MARSHALL:** Which email did you
 12 send it to ...
 13 **MR. GREENBERG:** ...
 14 **MR. MARSHALL:** Two seconds. So do you
 15 want the language from the previous version?
 16 **MR. GREENBERG:** So I think what they
 17 were asking for is -- is that one in publisher to be
 18 put up so that you can make your -- so you can type
 19 as they're looking for it.
 20 **THE CHAIR:** So the most recent version
 21 that we can modify, the one that just up on the
 22 screen.
 23 **MR. GREENBERG:** So I just put the
 24 language we had come up with for the original draft
 25 that went to the Department before the temperatures

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 2 all changed into the chat. That was the language in
 3 the box at the bottom.
 4 **MR. MARSHALL:** I'm sharing my screen,
 5 this is publisher.
 6 **THE CHAIR:** We've got it.
 7 **MR. MARSHALL:** You see it?
 8 **THE CHAIR:** Yes, they're there.
 9 **MR. MARSHALL:** Adult is not on this
 10 version.
 11 **THE CHAIR:** Great. You need to put a
 12 team to that next -- second next step.
 13 **MR. MARSHALL:** Yes.
 14 **THE CHAIR:** Don't worry about that.
 15 **MR. MARSHALL:** I'll fix that later,
 16 yeah.
 17 **MR. ALEXANDROU:** The part about the --
 18 the gown has to be changed to appropriate P.P.E.
 19 **MR. MARSHALL:** So just change this
 20 whole thing to appropriate P.P.E.?
 21 **MR. ALEXANDROU:** I think that's how we
 22 had a -- the new one, yeah.
 23 **MR. DAILEY:** Yeah, it says don
 24 appropriate P.P.E.
 25 **THE CHAIR:** Yeah.

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 2 **MR. GREENBERG:** I guess don should be
 3 all caps.
 4 **MR. MARSHALL:** Okay.
 5 **MR. CUSHMAN:** When -- when I made that
 6 amendment, it was intentional for the underline bold
 7 capitalized that it simply say don appropriate P.P.E.
 8 before initiating close contact with the patient,
 9 period, end of story.
 10 **MR. MARSHALL:** Up here, you're talking
 11 about at the top?
 12 **MR. CUSHMAN:** That's correct altitude
 13 on it.
 14 **THE CHAIR:** All right. So just put it
 15 up at that upper one, don appropriate. Just put
 16 appropriate in there and get rid of the other one.
 17 I may need to move down to box number
 18 four with age variant sixty-five or less than fifteen
 19 if I recall our conversation.
 20 **MR. ALEXANDROU:** I suggest you make it
 21 a separate line so it stands out.
 22 **MR. MARSHALL:** What about down here at
 23 the asterisk putting -- wait.
 24 **MR. ALEXANDROU:** No, perhaps right
 25 under -- right -- yeah, right there.

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 2 **MR. MARSHALL:** Yeah?
 3 **MR. ALEXANDROU:** Yeah.
 4 **MR. MARSHALL:** Okay. And then, here,
 5 anything else up here?
 6 **MS. BOMBARD:** Yes, after the asterisk
 7 -- after the asterisk in that same box, yeah. Before
 8 refer, we're going to say for patients under fifteen
 9 years old.
 10 **MR. MARSHALL:** Can't spell.
 11 **MS. BOMBARD:** And just lowercase R for
 12 refer and then you're good.
 13 **MR. MARSHALL:** I going to have to move
 14 this --
 15 **MS. BOMBARD:** You may have to make
 16 that a less than sign instead of under to make it all
 17 fit.
 18 **MR. MARSHALL:** Yeah.
 19 **MS. BOMBARD:** You can probably get rid
 20 of for patients actually, if you just say less than
 21 sign at fifteen years old, you're good to go and you
 22 don't have to make it smaller so that old people
 23 can't read it like me.
 24 **MR. MARSHALL:** How's that?
 25 **MR. OLSSON:** You could -- you could

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 2 also eliminate for pediatric vital signs to refer to
 3 pediatric protocol, something like that.
 4 **MS. BOMBARD:** Well, I think the only
 5 thing we're referring to is vital signs. That's the
 6 only difference.
 7 **THE CHAIR:** Yeah.
 8 **MS. BOMBARD:** We don't need to make
 9 this too crazy.
 10 **MR. ALEXANDROU:** Last box.
 11 **MR. MARSHALL:** The last box would be
 12 the language from the other one in criteria failure.
 13 **MR. WALTERS:** I have a question about
 14 this age less than fifteen, right? Because
 15 everything if the age is less than fifteen you follow
 16 the arrow to the right, yes. And -- and this
 17 protocol doesn't apply, or are we just saying if the
 18 age is less than fifteen refer to B.L.S. protocol for
 19 pediatric vital signs?
 20 Because if -- if the intent is to
 21 apply it to pediatrics by using the pediatric vital
 22 signs of the B.L.S. protocol, then I -- I don't think
 23 we want that age less than fifteen bolded up above.
 24 I think we just make a -- I think we're saying
 25 something separate.

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 2 **MR. BART:** I think it's -- it was
 3 insinuating as Jeremy has said earlier that
 4 respirations, heart rate, blood pressure, these are
 5 the adult values. So refer to your -- your protocol
 6 for your pediatric values for the age.
 7 **MR. RABRICH:** Right, but Brian's point
 8 is in age greater than fifteen above should come out
 9 otherwise it will send you to the right.
 10 **MR. ALEXANDROU:** Or if you put an
 11 asterisk after the less than fifteen in the first
 12 column.
 13 **MR. BART:** You -- you need something
 14 indicates --
 15 **MS. BOMBARD:** Can we just give an
 16 event age less than fifteen entirely and then I think
 17 we're good?
 18 **MR. BART:** Yeah.
 19 **MR. ALEXANDROU:** Yeah.
 20 **MS. BOMBARD:** Take that back out --
 21 **MR. MARSHALL:** That one? This one in
 22 the box or the one down here?
 23 **MR. RABRICH:** The box, that one.
 24 **MS. BOMBARD:** The one in the box, just
 25 get rid of that and then I think we're back to --

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 2 **MR. RABRICH:** Now, we're good.
 3 **MS. BOMBARD:** Sorry about that.
 4 **MR. MARSHALL:** Okay. And so the
 5 language for the last box is patient meets criteria
 6 for non transport and/or treatment in place provide
 7 the patient with, but in the old one it says New York
 8 State COVID-19 hotline number and patient information
 9 handout.
 10 **MR. BART:** That sounds reasonable to
 11 me, and if you want to add that comment from New York
 12 City, if everybody likes it or doesn't like it, I'm
 13 just suggesting it. You could put, you know, if the
 14 patient can't be convinced to transport the patient.
 15 **MR. MARSHALL:** Or contact --
 16 **MR. BART:** I think we say if they
 17 can't be -- exactly. I think we say if they can't be
 18 convinced contact like med control for guidance.
 19 **MR. MARSHALL:** That's in the old one
 20 I'll put it in.
 21 **THE CHAIR:** That's it, that looks
 22 good. You just eventually have to take the PA and
 23 put it attached to the tent or down there.
 24 **MR. MARSHALL:** The what?
 25 **THE CHAIR:** The -- the patient got

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 2 sort of separated into two -- two words there.
 3 **MR. MARSHALL:** Okay.
 4 **THE CHAIR:** Not a big deal.
 5 **MR. MARSHALL:** No, we can just -- all
 6 right.
 7 **THE CHAIR:** Does everybody happy with
 8 this and willing to vote on it since we now have a
 9 motion on the floor?
 10 **MR. ALEXANDROU:** Just one last
 11 comment. Yeah, on that last statement that we put
 12 down there, are we still just saying, you know,
 13 instead of just transporting the patient, just call
 14 medical control?
 15 I mean, you know, if the patient wants
 16 to go, why don't we just take him, the majority will
 17 be triaged out here and you don't have to, you know,
 18 in a busy telemetry unit you won't have to go down
 19 that route and call telemetry overwhelming.
 20 **MR. RABRICH:** Nick, what if we play it
 21 and initiate transport or call medical control for
 22 guidance?
 23 **MR. ALEXANDROU:** That depends on all
 24 the other regions and how they feel with those
 25 telemetry areas, you know, --

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 2 **MR. RABRICH:** Yeah.
 3 **MR. ALEXANDROU:** -- during New York
 4 we're comfortable with that. We just say, you know,
 5 at this point we wasted enough time let's just go
 6 instead of spending perhaps in a busy telemetry unit,
 7 fifteen minutes on the phone trying to get the doctor
 8 discuss the case and then, you know, make a decision.
 9 **MR. BART:** Add the per regional
 10 guidance.
 11 **MR. RABRICH:** Yeah, let the regions
 12 decide.
 13 **MR. BART:** ... control per regional
 14 guidance.
 15 **MR. ALEXANDROU:** Well, how about per
 16 your regional guidance and local agency, because in
 17 some places you don't have that guidance in other
 18 places the agency making that decision.
 19 **MR. BART:** You're -- you're --
 20 **MR. MARSHALL:** Come on stop already --
 21 ... stop already.
 22 **MR. BART:** Comes up with their own,
 23 everybody else uses a region.
 24 **MR. ALEXANDROU:** It should be a
 25 region, whatever.

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 2 been reformatting --
 3 **MR. GREENBERG:** There you go.
 4 **MS. BOMBARD:** Awesome.
 5 **MR. GREENBERG:** Thank you.
 6 **MS. BOMBARD:** All right. I revised my
 7 motion that we accept the changes as we have just
 8 outlined.
 9 **THE CHAIR:** And I have a second on
 10 that revised motion, anybody?
 11 **MR. ALEXANDROU:** I am, I do.
 12 **THE CHAIR:** Who is that?
 13 **MR. ALEXANDROU:** Alexandrou.
 14 **THE CHAIR:** Okay. Well, we need one
 15 last roll call vote and then we can move on and end
 16 the meeting.
 17 **MR. GREENBERG:** Dr. Doynow, just -- I
 18 just want to confirm. So your -- this -- this would
 19 replace the current one that's in place, correct?
 20 **THE CHAIR:** That is correct.
 21 **MR. GREENBERG:** Thank you very much.
 22 **THE CHAIR:** Valerie, can we have roll
 23 call vote and then we can hopefully --
 24 **MS. OZGA:** Do you promise this is the
 25 last one?

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 2 **MR. MARSHALL:** Our regional guidance?
 3 **THE CHAIR:** Yeah, for regional
 4 guidance and let's be done already.
 5 **MR. MARSHALL:** That's it. My fingers
 6 are broken ... anymore.
 7 **MS. BOMBARD:** Can you ... place?
 8 **MR. MARSHALL:** No -- yes.
 9 **MS. BOMBARD:** I was an English major,
 10 it's my only --
 11 **MR. MARSHALL:** Okay. Okay.
 12 **MS. BOMBARD:** Like, okay.
 13 **MR. DAILEY:** That's all right, and I
 14 do formatting, it was soft return after the -- before
 15 the F.
 16 **MR. MARSHALL:** What?
 17 **MR. BART:** I agree.
 18 **MR. ALEXANDROU:** Put your -- put your
 19 cursor in front of the F and hit a soft return.
 20 **MR. DAILEY:** After packet in front of
 21 F, do a soft returns --
 22 **MR. GREENBERG:** Right there.
 23 **MR. DAILEY:** The next line.
 24 **MS. BOMBARD:** That is nicer.
 25 **MR. DAILEY:** I got it, I've -- I've

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 2 **THE CHAIR:** Yeah, I promise.
 3 **MS. OZGA:** Okay. I'm running out of -
 4 - running out of paper here. All right. Let's --
 5 let's get to this here. Dr. Alexandrou?
 6 **MR. ALEXANDROU:** Absolutely, yes.
 7 **MS. OZGA:** Dr. Bart?
 8 **MR. BART:** Yes.
 9 **MS. OZGA:** Dr. BERKOWITZ? Is Dr.
 10 Berkowitz still on? Dr. Bombard?
 11 **MS. BOMBARD:** Bombard, yes.
 12 **MS. OZGA:** Dr. Cooper?
 13 **MR. COOPER:** Abstain ... E.M.S.C.
 14 review. I think it'd be either yes or no or an
 15 abstention, unfortunately.
 16 **MS. OZGA:** Dr. Cushman?
 17 **MR. CUSHMAN:** I didn't say abstain.
 18 **MR. COOPER:** Okay. Sorry.
 19 **MS. OZGA:** Dr. Cushman?
 20 **MR. CUSHMAN:** Cushman will say yes,
 21 against my better judgment.
 22 **MS. OZGA:** Dr. Dailey?
 23 **MR. DAILEY:** Agree with Cushman, yes-
 24 ish.
 25 **MS. OZGA:** Yes or no. Dr. Detraglia?

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 2 **MR. DETRAGLIA:** Detraglia, yes.
 3 **MS. OZGA:** Dr. Doynow?
 4 **THE CHAIR:** Yes.
 5 **MS. OZGA:** Dr. Kugler?
 6 **MR. KUGLER:** Dr. Kugler said ... yes.
 7 **MS. OZGA:** Dr. Lynch? Dr. Lynch?
 8 Let's hope we still have quorum, guys. Dr.
 9 Markovitz?
 10 **MR. MARKOVITZ:** Markovitz, yes.
 11 **MS. OZGA:** Dr. Murphy -- I'm sorry.
 12 Dr. Marshall, first.
 13 **MR. MARSHALL:** Dr. Marshall, yes.
 14 **MS. OZGA:** Dr. Murphy? Is Dr. Murphy
 15 on?
 16 **MR. MARSHALL:** No, she put into the
 17 chat a little while ago that she had to step out.
 18 **MS. OZGA:** Okay. Dr. Olsson?
 19 **MR. OLSSON:** Olsson, yes.
 20 **MS. OZGA:** Dr. Talbott?
 21 **MR. TALBOTT:** Yes.
 22 **MS. OZGA:** Dr. Walters?
 23 **MR. WALTERS:** Walters, yes.
 24 **MS. OZGA:** Dr. Wicelinski -- Dr.
 25 Wicelinski? Okay. Let's see, one, two --

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 2 **THE CHAIR:** Hopefully we still have a
 3 ...
 4 **MR. LANGSAM:** Don't ask about a quorum
 5 because that requires a quorum call and I was -- ...
 6 you have a quorum unless someone challenge.
 7 **THE CHAIR:** That -- that sounds good
 8 to me.
 9 **MS. OZGA:** I have a quorum, and we
 10 have thirteen in the affirmative and one abstain.
 11 **THE CHAIR:** Okay.
 12 **MS. OZGA:** So those two passes.
 13 **THE CHAIR:** Excellent. Thank you,
 14 guys. What time is the pizza arriving ... All
 15 right. Let's close the meeting and move on to
 16 SEMSCO. Thank you, guys.
 17 **MR. MARSHALL:** Make a motion to
 18 adjourn.
 19 **THE CHAIR:** Yeah.
 20 Mr. : Move to adjourn.
 21 **MR. :** Second the motion. ...
 22 (Off the record, 3:08 p.m.)
 23 (The meeting concluded.)
 24
 25

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 2 STATE OF NEW YORK
 3 I, ANNETTE LAINSON, do hereby certify that the foregoing
 4 was reported by me, in the cause, at the time and place,
 5 as stated in the caption hereto, at Page hereof; that
 6 the foregoing typewritten transcription consisting of
 7 pages 1 through 158, is a true record of all proceedings
 8 had at the hearing.
 9 IN WITNESS WHEREOF, I have hereunto subscribed
 10 my name, this the 19th day of January, 2022.
 11 ANNETTE LAINSON

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