

9/18/2024 – SEMAC Meeting – Saratoga Springs, N.Y.
NEW YORK STATE
DEPARTMENT OF HEALTH
STATE EMERGENCY MEDICAL
ADVISORY COMMITTEE MEETING

DATE: September 18, 2024
TIME: 11:32 a.m. to 1:32 p.m.
CHAIR: Donald Doynow
LOCATION: Embassy Suites
86 Congress Street
Saratoga Springs, New York

1 9/18/2024 – SEMAC Meeting – Saratoga Springs, N.Y.
2 (The meeting commenced at 11:32 a.m.)
3 CHAIR DOYNOW: Everyone back after a
4 nice, pleasant summer. If we could stand for a
5 Pledge of Allegiance.
6 ALL: Pledge of allegiance to the flag
7 of the United States of America, to the republic for
8 which it stands, one nation under God, indivisible,
9 with liberty, and justice for all.
10 CHAIR DOYNOW: Okay, thank you. Just
11 a few announcements. First of all, I'd like to
12 welcome a number of new members, and I'm sure we're
13 going to have a quorum today. Dr. Shin, if you could
14 -- Dr. Shin?
15 DR. SHIN: Hi. Thanks for having me
16 here. I'm from the Finger Lakes region. Happy to be
17 part of the team.
18 CHAIR DOYNOW: Thanks, Dr. Shin. Dr.
19 Seth?
20 DR. SETH: Hi. Hi, Big Lake -- Big
21 Lake (unintelligible).
22 CHAIR DOYNOW: Dr. Hallinan?
23 DR. HALLINAN: Hi, Southern Tier.
24 CHAIR DOYNOW: And Dr. Dorsett, who
25 will become an official member tomorrow. She's here

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Page 3

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2 **APPEARANCES:**
3 ALBERT SIN
4 ALDAN O'CONNOR
5 BEN SENSENBACH
6 BRIAN CLEMENCY
7 BRIAN WALTERS
8 CARL GANDOLFO
9 DAVID KUGLER
10 DAVID VIOLANTE
11 DONALD HUDSON
12 DOUGLAS ISAACS
13 JASON RIEGERT
14 JASON WINSLOW
15 JEFFERY RABRICH
16 JEREMY CUSHMAN
17 JOHN WASHKO
18 JONATHAN BERKOWITZ
19 KATHLEEN HALLINAN
20 MAIA DORSETT
21 MICHAEL DAILEY
22 MICHAEL MCEVOY
23 NAVEEN SETH
24 PAMELA MURPHY
25 RYAN GREENBERG
STEVEN KROLL
THERESA ALLEN
TIFFANY BOMBARD

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2 at some place. And I'd really like to thank Dr.
3 Cushman. We will miss him. This is his last
4 meeting. He's been a rock for us, taking care of
5 collaborative protocols, always has good information
6 for the committee, steering the committee. Dr.
7 Cushman, thank you so much, and we're going to miss
8 you.
9 **DR. SENSENBACH:** So, I shouldn't stand
10 in striking distance, but I'm going to anyways.
11 Because as your --
12 **CHAIR DOYNOW:** Anybody looking for a
13 new program agency administrator?
14 **DR. SENSENBACH:** There's a lot of them
15 in the room upstairs that would love to work for you,
16 because it is absolutely the highlight of my career
17 so far. But this is from the members of the SEMSCO
18 here. And we would like to thank you for all of your
19 service. Dr. Cushman has been serving since 2009
20 with this group. Thank you, sir.
21 **DR. CUSHMAN:** Thank you, everybody.
22 **CHAIR DOYNOW:** Thank you again,
23 Jeremy. And we all have your number and if anybody
24 wants it, I'll give it out. So, you can give him a
25 call.

Page 2

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 2 **DR. MURPHY:** I --
 3 **CHAIR DOYNOW:** All right. If we can -
 4 -
 5 **DR. MURPHY:** I saw it on the bathroom
 6 wall.
 7 **CHAIR DOYNOW:** If we can have
 8 attendance?
 9 **SECRETARY ALLEN:** Sorry. Okay. Dr.
 10 Berkowitz?
 11 **DR. BERKOWITZ:** Here.
 12 **SECRETARY ALLEN:** Dr. Barry? Dr.
 13 Bombard?
 14 **DR. BOMBARD:** I'm here.
 15 **SECRETARY ALLEN:** Dr. Coates? Dr.
 16 Cooper?
 17 **DR. COOPER:** Here.
 18 **SECRETARY ALLEN:** Dr. Cushman?
 19 **DR. CUSHMAN:** Here. And thank you
 20 again.
 21 **SECRETARY ALLEN:** Dr. Dailey.
 22 **CHAIR DOYNOW:** He was here at some
 23 point.
 24 **SECRETARY ALLEN:** Dr. Doynow?
 25 **CHAIR DOYNOW:** Here.

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 2 **SECRETARY ALLEN:** Dr. Gomez? Dr.
 3 Isaacs?
 4 **DR. ISAACS:** Here.
 5 **SECRETARY ALLEN:** Dr. Kugler?
 6 **DR. KUGLER:** Here.
 7 **SECRETARY ALLEN:** Dr. Markowitz? Dr.
 8 Murphy?
 9 **DR. MURPHY:** Here.
 10 **SECRETARY ALLEN:** Dr. Olson? Dr.
 11 Rabrich?
 12 **DR. RABRICH:** Here.
 13 **SECRETARY ALLEN:** Dr. Seth?
 14 **DR. SETH:** Here.
 15 **SECRETARY ALLEN:** Dr. Shin?
 16 **DR. SHIN:** Here.
 17 **SECRETARY ALLEN:** Dr. Walters?
 18 **DR. WALTERS:** Here.
 19 **SECRETARY ALLEN:** Dr. Hallinan?
 20 **DR. HALLINAN:** Here.
 21 **SECRETARY ALLEN:** And Dr. Winslow?
 22 **DR. WINSLOW:** Here.
 23 **SECRETARY ALLEN:** Okay. Orin Barley?
 24 Aiden O'Connor?
 25 **DR. O'CONNOR:** Good morning.

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 2 **SECRETARY ALLEN:** Mark Philippi?
 3 Marianne Portoro? Mike McEvoy?
 4 **DR. MCEVOY:** Here.
 5 **SECRETARY ALLEN:** Steve Kroll?
 6 **MR. KROLL:** Present. Good morning.
 7 **SECRETARY ALLEN:** And John Washko.
 8 **MR. WASHKO:** Present.
 9 **SECRETARY ALLEN:** We have quorum.
 10 **CHAIR DOYNOW:** Excellent. Thank you.
 11 Can we have approval of the May minutes? Dr. Kugler.
 12 Anybody second? Dr. Bombard. Anybody against?
 13 Okay. Noted -- they have been approved. Brian, are
 14 you ready for your --
 15 **DR. GREENBERG:** You mind doing out of
 16 order though?
 17 **CHAIR DOYNOW:** What's that?
 18 **DR. GREENBERG:** Can we go out of
 19 order?
 20 **CHAIR DOYNOW:** Sure. No problem at
 21 all. Why don't we go to Don Hudson for education?
 22 **MR. HUDSON:** Thank you. Good
 23 afternoon -- well, good morning still everyone. So,
 24 training and education met, we had one virtual
 25 meeting during the summer break, if you will. We'll

Page 7

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 2 be meeting more often now that we're back in the
 3 swing of things.
 4 We do have one forwarded motion coming
 5 forth related to -- well just remind me, remind me,
 6 do that here or do we do that at SEMSCO.
 7 **CHAIR DOYNOW:** I believe that --
 8 SEMSCO.
 9 **MR. HUDSON:** SEMSCO? Okay. Just
 10 forgive my -- I just ate something. So, my blood is
 11 elsewhere. We -- we -- continuing open dialogue on
 12 conversations and open items from our previous
 13 agendas. There's some policy statements, which I'm
 14 sure the director will mention related to paramedic
 15 original practical skills exam that are released and
 16 some other guidance that should be coming out
 17 shortly.
 18 Other than that, happy to help. Hope
 19 I'm helping. Happy to answer questions and continue
 20 the work forward. Thank you.
 21 **CHAIR DOYNOW:** Thank you. Any
 22 questions? Okay. Dr. Rabrich, MED Standards.
 23 **DR. RABRICH:** All right. Thank you.
 24 Med Standards met this morning. We had a lively
 25 discussion on a number of items. Under old business,

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 2 we had a report on our clinical data integrity tag
 3 that's been established, and Dr. Dorsett is chairing
 4 that. So, I'd like to ask her to give a -- just a
 5 brief update on what that tag is working on.
 6 **DR. DORSETT:** So, the first purpose of
 7 it, the committee or the TAG meeting, was to define
 8 what the focus was. We decided that the focus was
 9 really on data quality which is the intent of data
 10 integrity. And data quality incorporates not just
 11 the quality of the documentation or where it goes,
 12 but data accessibility as well.
 13 We decided that the purpose is to make
 14 recommendations on how do we improve data quality
 15 really for all the stakeholders in E.M.S. data, not
 16 just those of us who work in pre-hospital care
 17 because there's lots of others who are using our data
 18 to improve care for patients, which is the big
 19 picture.
 20 We came up with a series of sort of
 21 five pillars about the purposes of how data is used
 22 that we're going to use as a basis of collecting
 23 survey to define the -- a survey to define the
 24 problem. So, the five pillars are patient care,
 25 quality improvement, research, public health, and

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 2 out to either of them, and they'll be meeting in the
 3 near future to -- to work through and share best
 4 practices for the regions.
 5 There was a seconded motion that came
 6 forward regarding the ranger austere guidelines
 7 protocols that was sent by Med standards to SEMAC as
 8 a seconded motion to approve those. So, I don't know
 9 if you want to have discussion on that.
 10 **CHAIR DOYNOW:** Yes, we can have
 11 discussion. Did you want to put them up?
 12 **SECRETARY ALLEN:** Yeah, I think.
 13 **CHAIR DOYNOW:** It's coming up.
 14 **DR. RABRICH:** So, this -- just to
 15 remind everyone, this is a protocol that does not
 16 apply to everyone. It's a specific group of people
 17 as stated in the protocols. The scope is for basic -
 18 - basically, yeah, certified first responder rangers
 19 to be used in an austere environment.
 20 There are issues with communications
 21 in parts of New York State where they're working and
 22 the ability to contact medical control. So, these
 23 protocols were specifically designed for Department
 24 of Environmental Conservation Forestry Protection
 25 Rangers with the appropriate training, not dissimilar

Page 11

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 2 reimbursement. And we've identified stakeholder
 3 groups in those five pillars. And we're in the
 4 process of developing a survey that looks at sort of
 5 the five dimensions of data quality because there's
 6 other areas that have already studied what are the
 7 contributors to data quality, which is completeness,
 8 accuracy, consistency, timeliness, and accessibility.
 9 So, that's what we're working on now
 10 because I think we got to define the problem before
 11 we come up with solutions to fix it.
 12 **DR. RABRICH:** Thank you. So, they
 13 will continue to -- to work and you may be seeing
 14 those surveys in the near future. So, there was also
 15 a discussion about starting a -- a blood integration
 16 working group collaborative. I believe it is now
 17 law, I believe it was just signed a little while ago,
 18 the blood legislation.
 19 So, as those regular regulations are
 20 implemented, there's a lot of issues around best
 21 practices regarding implementation and avoiding waste
 22 and all those. So, Dr. Isaacs and Dr. Dailey have
 23 been working on starting this group. And so, if you
 24 have an interest in blood implementation and working
 25 with them, I believe, you could -- you could reach

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 2 to other protocols we've approved for specific groups
 3 such as like rescue medics or tactical medics, that
 4 kind of -- of thing.
 5 **DR. GREENBERG:** So, just to touch if
 6 anyone does have additional questions on it. This is
 7 something that's been in the works for a little bit
 8 in -- with the Rangers and working with Dr. Dailey on
 9 this one, who, I don't know if he's in the room.
 10 **DR. RABRICH:** He's coming back, but I
 11 don't think he's here yet.
 12 **DR. GREENBERG:** Okay. To where, you
 13 know, similar to the F.D.N.Y. Haz-Tac units or things
 14 like that, very specialized units, these forest
 15 rangers go through some pretty specific training in
 16 a, you know, above and beyond some of the normal
 17 curriculum. And Dr. Dailey is working with them on
 18 that.
 19 And the goal would be for this
 20 particular protocol set to be really for them as they
 21 work in these very remote environments that they're
 22 in. And you know, sometimes have to spend even
 23 overnights with their patients before they can get
 24 them out. So, things that you might normally see at
 25 a higher level of certification for these particular

Page 12

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 2 individuals would be located at this level -- at the
 3 C.F.R. level.
 4 **CHAIR DOYNOW:** Thank you. So, that's
 5 what we'd be voting on. Does anybody have any
 6 questions? Okay. So, there's a motion to move the
 7 ranger austere guidelines forward to SEMSCO. We will
 8 need a roll call vote.
 9 **SECRETARY ALLEN:** Dr. Berkowitz?
 10 **DR. BERKOWITZ:** Berkowitz, yes.
 11 **SECRETARY ALLEN:** Dr. Bombard?
 12 **DR. BOMBARD:** Bombard, yes.
 13 **SECRETARY ALLEN:** Dr. Cooper?
 14 **DR. COOPER:** Yes.
 15 **SECRETARY ALLEN:** Dr. Cushman?
 16 **DR. CUSHMAN:** Cushman, yes.
 17 **SECRETARY ALLEN:** Dr. Doynow?
 18 **CHAIR DOYNOW:** Doynow, yes.
 19 **SECRETARY ALLEN:** Dr. Isaacs?
 20 **DR. ISAACS:** Isaacs, yes.
 21 **SECRETARY ALLEN:** Dr. Kugler?
 22 **DR. KUGLER:** Kugler, yes.
 23 **SECRETARY ALLEN:** Dr. Murphy?
 24 **DR. MURPHY:** Murphy, yes.
 25 **SECRETARY ALLEN:** Dr. Rabrich?

Page 13

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 2 **DR. RABRICH:** Rabrich, yes.
 3 **SECRETARY ALLEN:** Dr. Seth?
 4 **DR. SETH:** Yes.
 5 **SECRETARY ALLEN:** Dr. Shin?
 6 **DR. SHIN:** Shin, yes.
 7 **SECRETARY ALLEN:** Dr. Walters?
 8 **DR. WALTERS:** Yes.
 9 **SECRETARY ALLEN:** Dr. Hallinan?
 10 **DR. HALLINAN:** Yes.
 11 **SECRETARY ALLEN:** And Dr. Winslow?
 12 **DR. WINSLOW:** Yes.
 13 **SECRETARY ALLEN:** Motion passes.
 14 **CHAIR DOYNOW:** Okay, thank you.
 15 **DR. RABRICH:** Thank you.
 16 **CHAIR DOYNOW:** I appreciate it.
 17 **DR. RABRICH:** Yes. So, the
 18 collaborative protocols have been brought forth as a
 19 discussion item. We had some very good discussion at
 20 Med standards on this -- on these changes. There
 21 were some good feedback provided as well. We wanted
 22 to bring it to this body as well, so that additional
 23 feedback or commentary could be received with the
 24 idea of these being ready to be presented and voted
 25 on at the December meeting.

Page 14

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 2 So, I don't know if you want me to go
 3 through them or Dr. Cushman, if you want to run
 4 through the changes quickly, if it's -- I'm happy to
 5 do it, up to you.
 6 **DR. CUSHMAN:** Happy to briefly comment
 7 on them.
 8 **DR. RABRICH:** Thank you.
 9 **DR. CUSHMAN:** At all levels, adding
 10 ipratropium mixed with albuterol to the M.T. or
 11 higher under the agitated patient, both adolescent
 12 and adult to add under a med control option, the
 13 opportunity for Olanzapine now correctly spelled
 14 whoever texted that to Dr. Rabrich, thank you. I
 15 fixed it.
 16 To remove Haloperidol, given the less
 17 desirable side effect profile under cardiac for
 18 pediatric bradycardia, simply re-ordering the
 19 epinephrine and atropine to reflected in pediatric
 20 patients. Epinephrine is first, also adding some
 21 language regarding considering chest compressions
 22 from marked bradycardia. Also consistent with A.H.A.
 23 guidelines.
 24 Under difficulty breathing for acute
 25 pulmonary edema, correcting my inadvertent deletion

Page 15

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 2 of nitroglycerin as an option for the advanced
 3 E.M.T., my -- my apologies to the E.M.T., advanced
 4 E.M.T. colleagues in -- in the room.
 5 Adding palms and soles for the cold
 6 pack placement, also providing some consistency
 7 between our open fracture and amputation protocols to
 8 allow for the use of either oral or intravenous
 9 antibiotics if equipped and trained by personnel for
 10 -- for amputations.
 11 Under shock, specifically the trauma
 12 associated shock, and there may be some discussion
 13 later on in this, is just adding verbiage that
 14 reinforces that initiation of prehospital blood
 15 products are subject to REMAC endorsed blood product
 16 distribution plan and Department of Health's
 17 approval. So, it's very clear within those
 18 protocols. And if there's anything that we have to
 19 change in the coming weeks or months then, then we'll
 20 make those.
 21 And then probably the most substantive
 22 is under oxygen administration and airway management
 23 based upon the tremendous work and success of the
 24 Hudson Valley iGel project. To add under E.M.T. the
 25 placement of a supraglottic airway if equipped and

Page 16

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 2 trained in the adult cardiac arrest patient as
 3 regionally approved.
 4 And then revising under some of the
 5 key points, the providers may place an endotracheal
 6 tube or supraglottic airway if they utilize waveform
 7 capnography for initial and ongoing monitoring of
 8 airway patency. Those summarize --
 9 **DR. RABRICH:** Thank you.
 10 **DR. CUSHMAN:** I think --
 11 **DR. RABRICH:** Yes.
 12 **DR. CUSHMAN:** -- the majority of our
 13 discussion.
 14 **DR. RABRICH:** Very well done. Yes,
 15 that is a summary of the changes already
 16 incorporating some of the feedback that was provided
 17 at Med standards this morning. So, just wanted to --
 18 to open it up briefly if there's other comments or
 19 questions regarding these protocols. Again, we're
 20 going to vote on them at the next meeting.
 21 **CHAIR DOYNOW:** Any questions -- Dr.
 22 Cushman?
 23 **DR. CUSHMAN:** Dr. Cushman, I would
 24 just say between this meeting, next meeting, if maybe
 25 you, myself and Gina can sit and whoever else you

Page 17

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 2 think, just to see if there's any other smaller
 3 things on either side for adjustments. Thanks.
 4 **DR. RABRICH:** All right.
 5 **CHAIR DOYNOW:** Any questions? Okay,
 6 Dr. Rabrich?
 7 **DR. RABRICH:** Yes. It was discussed
 8 as well that the iGel demonstration project, which we
 9 will hear from again, but we heard an excellent
 10 summary of that study. At some point that project
 11 needs to end, and it needs to become put into a
 12 policy statement or some other form to allow it to
 13 continue. Otherwise, our colleagues from the Hudson
 14 Valley will be collecting data for the rest of their
 15 lives on this. Not that that's a bad thing, but --
 16 **SECRETARY ALLEN:** All in favor?
 17 **DR. RABRICH:** Yes. So, there was a
 18 suggestion that we make a motion that the iGel
 19 demonstration project be sunset at the time at which
 20 forthcoming policy statement from the bureau, other
 21 guidance is issued regarding the use of an iGel. Did
 22 I get that right? So, that would be -- that would be
 23 the motion as it even needs a second. It -- it's not
 24 a seconded motion.
 25 **DR. MURPHY:** Seconded.

Page 18

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 2 **DR. RABRICH:** All right. Discussion.
 3 **CHAIR DOYNOW:** And can we put that up?
 4 **DR. RABRICH:** I --
 5 **CHAIR DOYNOW:** I think -- Dr. Rabrich,
 6 I think I'll just need to restate it so we can --
 7 **DR. RABRICH:** Yes.
 8 **SECRETARY ALLEN:** Motion to sunset the
 9 iGel.
 10 **DR. RABRICH:** Motion to such sunset
 11 the iGel demonstration project at such time that a
 12 policy statement or their guidance is issued by the
 13 department regarding the use of the iGel or -- or
 14 other supraglottic airways.
 15 **CHAIR DOYNOW:** And I.T., if you could
 16 get the projector back on, it seems to be.
 17 **DR. RABRICH:** Yeah. Issued by the
 18 department, it can be whatever -- however they want
 19 to issue it.
 20 **CHAIR DOYNOW:** Maybe. And just --
 21 just a point of, but if it's going to end up in a
 22 protocol, isn't that part of it as well? Honest --
 23 honestly, if they're using the -- if the protocol
 24 updates as we just stated, put it in there -- she has
 25 it?

Page 19

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 2 **DR. RABRICH:** No, just placing in a
 3 protocol doesn't make it allowed for use in New York
 4 state necessarily at that level. In other words,
 5 there's something that's got to say that at the
 6 E.M.T. level, this can be done beyond just a protocol
 7 because it's not yet a national scope of practice
 8 document. Right?
 9 **CHAIR DOYNOW:** Any questions?
 10 **DR. RABRICH:** Yeah.
 11 **CHAIR DOYNOW:** Discussion?
 12 **DR. RABRICH:** Yeah. I think it's
 13 implies -- yeah, So, -- So, nothing would change
 14 until such time as that guidance. So, in other
 15 words, people can continue to use the iGel under the
 16 demonstration project until such time as further
 17 guidance is -- we're not stopping anything, we're
 18 just trying to codify it in a different way.
 19 **DR. GREENBERG:** And just a point of
 20 clarification, are agencies that are not in the
 21 program right now still able to -- well, I know there
 22 was some discussion on that as well.
 23 **DR. RABRICH:** Yeah. So, the answer is
 24 yes. They -- those agencies --
 25 **DR. GREENBERG:** Thank you.

Page 20

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 2 **DR. RABRICH:** -- can participate. All
 3 right. Any other discussion on this? Is this roll
 4 call?
 5 **CHAIR DOYNOW:** It would be a roll call
 6 if we have no discussion. Does anybody have any
 7 questions? Will you -- if a new agency wants to
 8 join, then they will follow the old policy --
 9 **DR. RABRICH:** The existing guidance,
 10 yes.
 11 **CHAIR DOYNOW:** -- and -- and continue
 12 sending data, unfortunately to you guys. All right.
 13 Okay, I guess, we have -- need a roll call vote.
 14 **SECRETARY ALLEN:** Dr. Berkowitz?
 15 **DR. BERKOWITZ:** Yes.
 16 **SECRETARY ALLEN:** Dr. Bombard?
 17 **DR. BOMBARD:** Yes.
 18 **SECRETARY ALLEN:** Dr. Cooper?
 19 **DR. COOPER:** Yes.
 20 **SECRETARY ALLEN:** Dr. Cushman?
 21 **DR. CUSHMAN:** Cushman, yes.
 22 **SECRETARY ALLEN:** Dr. Doynow?
 23 **CHAIR DOYNOW:** Yes.
 24 **SECRETARY ALLEN:** Dr. Isaacs?
 25 **DR. ISAACS:** Isaacs, yes.

Page 21

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 2 **SECRETARY ALLEN:** Dr. Kugler?
 3 **DR. KUGLER:** Yes.
 4 **SECRETARY ALLEN:** Dr. Murphy?
 5 **DR. MURPHY:** Murphy, yes.
 6 **SECRETARY ALLEN:** Dr. Rabrich?
 7 **DR. RABRICH:** Rabrich, yes.
 8 **SECRETARY ALLEN:** Dr. Seth?
 9 **DR. SETH:** Yes.
 10 **SECRETARY ALLEN:** Dr. Shin?
 11 **DR. SHIN:** Shin, yes.
 12 **SECRETARY ALLEN:** Dr. Walters?
 13 **DR. WALTERS:** Yes.
 14 **SECRETARY ALLEN:** Dr. Hallinan?
 15 **DR. HALLINAN:** Yes.
 16 **SECRETARY ALLEN:** And Dr. Winslow?
 17 **DR. WINSLOW:** Yes.
 18 **SECRETARY ALLEN:** Motion passes.
 19 **CHAIR DOYNOW:** Excellent. Thank you.
 20 Dr. Rabrich?
 21 **DR. RABRICH:** Yeah. There was a -- a
 22 final seconded motion that came forth from Med
 23 standards. This is regarding the New York City
 24 Rescue Medic Protocol changes which was brought up
 25 under new business. It was voted by the Med

Page 22

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 2 standards to send it here to SEMAC.
 3 And I understand there's some --
 4 there's some process questions or issues with how it
 5 got to SEMAC. So, you know, the -- these -- I don't
 6 know if you want to elaborate, but I can. That's the
 7 standard process is I believe it's at six weeks, is
 8 it? Six weeks prior to the meeting. So, the
 9 materials can be reviewed by the Commissioner, the
 10 department, and placed on the agenda and everyone can
 11 review them. That's generally the process that's
 12 followed. In this case, obviously that wasn't
 13 followed because it was -- it was sent late after
 14 that six-week deadline and was brought up as new
 15 business.
 16 There is -- it's really just kind of
 17 our standard practices that that's how, usually how
 18 we do things. So, unless there's an urgent need for
 19 the protocol, the recommendations were that this be
 20 then voted on in December, so that there is
 21 opportunity for people to further review and discuss.
 22 That's the -- I don't know if anyone
 23 else wants to add anything to that, but that's --
 24 **CHAIR DOYNOW:** Any discussion?
 25 **DR. ISAACS:** I'd like to respectfully

Page 23

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 2 request if it could be brought for a REMAC vote?
 3 Just there are some issues for us in terms of the
 4 city, in terms of training cycle and everything else,
 5 which is a huge cost to the fire department. And
 6 they are edits to existing protocols. They're not
 7 brand-new protocols.
 8 **CHAIR DOYNOW:** Any discussion on Dr.
 9 Isaacs?
 10 **DR. KUGLER:** I have a quick question.
 11 Just on Robert's Rules of Order. It comes to this
 12 body as a seconded motion from a sub-committee. And
 13 so, we have a stand -- an outstanding seconded motion
 14 and or a motion that needs a second. No -- Or I'm
 15 not sure exactly how --
 16 **DR. RABRICH:** It could be tabled to
 17 the next meeting. That's an action that could be
 18 taken.
 19 **DR. KUGLER:** I -- I don't know. I'm
 20 just asking.
 21 **DR. RABRICH:** Yeah.
 22 **DR. KUGLER:** You get it out here.
 23 **DR. RABRICH:** Yes. It's seconded
 24 motion. Something has to be done with it. It could
 25 be tabled. Right. But --

Page 24

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 2 **DR. GREENBERG:** Microphone, please.
 3 **CHAIR DOYNOW:** Yes. We need to
 4 decide, are we going to table it? Are we going to
 5 vote on it? So, if there's no discussion, then we
 6 need to decide where we're going.
 7 **DR. RABRICH:** I guess, there's no
 8 further discussion.
 9 **CHAIR DOYNOW:** Call to question.
 10 **DR. RABRICH:** Okay.
 11 **CHAIR DOYNOW:** You could just vote it.
 12 **DR. RABRICH:** Okay.
 13 **CHAIR DOYNOW:** So, it needs to be
 14 brought up for a vote. It would be a roll call vote.
 15 **DR. GREENBERG:** So, I guess we'll not
 16 need to get the mic on --
 17 **CHAIR DOYNOW:** I guess not.
 18 **DR. GREENBERG:** So, I think you'd have
 19 to know what the motion is. You know, if you're
 20 going to a vote if you're not -- it -- like I said or
 21 not, I said, the Chair said that, you know, part of
 22 the question comes down to the way that it was
 23 received. It was only received two weeks ago which
 24 is why it wasn't in the packet of documents that was
 25 sent out or available for the public. It didn't go

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 2 through, you know, the normal processes or changes
 3 that occur.
 4 I think, you know, the opportunity to
 5 discuss something if Dr. Isaacs wanted to have a
 6 discussion about it and then to know if there's any
 7 edits or changes that need to occur and then, you
 8 know, possibly vote on it in December would allow for
 9 that opportunity to go through it.
 10 And to train, I think between now and
 11 then, I don't know when, you know, they were looking
 12 to implement these changes or the urgency of the
 13 changes to occur.
 14 **DR. RABRICH:** Yeah. And I think the
 15 question is, right, so we have, there's a -- a
 16 regular cycle of protocols and then there's a reason,
 17 right? There certainly are reasons where something
 18 should be taken out of cycle, whether it's an
 19 emergent need for a change or something has changed
 20 significantly, where something should not follow that
 21 process because of the urgency.
 22 So, that's -- I mean, really a
 23 discussion and a decision of this body. If that's
 24 the case and you know, you want to vote. I -- Dr.
 25 Kugler, you said you call to question. I'm not sure

Page 26

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 2 what question you called. If it's the original
 3 motion or -- oh, sorry. Was it -- what -- what
 4 question were you calling?
 5 **DR. WINSLOW:** I just wanted to be
 6 clear on what the motion was.
 7 **DR. RABRICH:** So, the seconded motion
 8 --
 9 **DR. WINSLOW:** I can't --
 10 **DR. RABRICH:** -- from Med standards
 11 was to send for approval the rescue medic protocols
 12 to this body, to SEMAC.
 13 **DR. WINSLOW:** So, shouldn't the motion
 14 then be made here to approve them, which is not the
 15 same motion. Right, Doug? If you want them
 16 approved, make that as a motion?
 17 **DR. ISAACS:** Yes, I would like a
 18 motion to take a vote on the rescue medic protocols.
 19 **DR. WINSLOW:** I second the motion.
 20 **CHAIR DOYNOW:** All right. So, we have
 21 a motion on the floor. Do we have any discussion
 22 before we vote on it? And what I will say is if
 23 they're voted in, then the protocol go -- protocols
 24 go forward. If they're voted down, then we can
 25 always do a motion to table it until the next

Page 27

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 2 meeting.
 3 **DR. RABRICH:** And they still -- even
 4 if you approve them, they still need to go through
 5 that process with the Commissioner and everything
 6 else that they haven't yet. And so, you know, just -
 7 - just So, that everyone's aware that that process
 8 will still occur.
 9 **CHAIR DOYNOW:** That's the motion --
 10 the motion to approve New York City Rescue Medic
 11 protocols at this time. And we'll need a roll call
 12 vote.
 13 **SECRETARY ALLEN:** Dr. Berkowitz?
 14 **DR. BERKOWITZ:** Berkowitz, approved.
 15 **DR. RABRICH:** Microphone, if you have?
 16 **CHAIR DOYNOW:** He's So, loud though.
 17 **DR. BERKOWITZ:** So loud.
 18 **SECRETARY ALLEN:** Dr. Bombard?
 19 **DR. BOMBARD:** Bombard, yes.
 20 **SECRETARY ALLEN:** Dr. Cooper?
 21 **DR. COOPER:** Cooper, yes.
 22 **SECRETARY ALLEN:** Dr. Cushman?
 23 **DR. CUSHMAN:** Cushman, abstain.
 24 **SECRETARY ALLEN:** Dr. Doynow?
 25 **CHAIR DOYNOW:** I'm going to abstain on

Page 28

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 2 this as well.
 3 **SECRETARY ALLEN:** Dr. Dailey?
 4 **DR. DAILEY:** Approve.
 5 **SECRETARY ALLEN:** Dr. Isaacs?
 6 **DR. ISAACS:** Isaacs, yes.
 7 **SECRETARY ALLEN:** Dr. Kugler?
 8 **DR. KUGLER:** Yes.
 9 **SECRETARY ALLEN:** Dr. Murphy?
 10 **DR. MURPHY:** Murphy, yes.
 11 **SECRETARY ALLEN:** Dr. Rabrich?
 12 **DR. RABRICH:** Rabrich, yes.
 13 **SECRETARY ALLEN:** Dr. Seth?
 14 **DR. SETH:** Seth, abstain.
 15 **SECRETARY ALLEN:** Dr. Shin?
 16 **DR. SHIN:** Shin, abstain.
 17 **SECRETARY ALLEN:** Dr. Walters?
 18 **DR. WALTERS:** Walters, yes.
 19 **SECRETARY ALLEN:** Dr. Hallinan?
 20 **DR. HALLINAN:** Yes.
 21 **SECRETARY ALLEN:** And Dr. Winslow?
 22 **DR. WINSLOW:** Yes.
 23 **SECRETARY ALLEN:** Motion passes.
 24 **CHAIR DOYNOW:** Okay. Thank you. Dr.
 25 Rabrich?

Page 29

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 2 **DR. RABRICH:** That concludes the
 3 report from Medical Standards. Thank you.
 4 **CHAIR DOYNOW:** Okay, thank you. If we
 5 can move now to E.M.S.C., either Amy or Dr. Cooper?
 6 **DR. COOPER:** Thank you, Dr. Doynow.
 7 We had a very active meeting this past Monday. And
 8 of course, I want to thank Amy Eisenhower for all her
 9 diligence in making sure that the program stays on
 10 track. Many of you may know that Amy has received a
 11 well-deserved promotion.
 12 She'll still be assisting Director
 13 Ryan in overseeing the program. But a -- a --
 14 successor to her as the formal E.M.S.C. program
 15 coordinator is being posted. And we're told that the
 16 selection may be made by the time of the next
 17 meeting.
 18 Among all the other wonderful things
 19 that Amy's been doing, she's really been chasing the
 20 Always Ready for Children program very, very hard.
 21 And Amy, if you want to say anything about it, please
 22 do, but you know, the -- the -- the short of it is
 23 that you know, that we have many, many, many
 24 additional services that have signed up to be Always
 25 Ready for Children. And work continues on that -- on

Page 30

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 2 that -- that program every day.
 3 We spend a fair amount of time
 4 speaking about the educational program on pediatric
 5 agitation. The -- the first video is slated for
 6 filming this coming week. And Chief Pataki has
 7 promised that we will hopefully have a second video
 8 by the time of the next meeting.
 9 The three videos in addition to the --
 10 the didactic PowerPoint program that is well along in
 11 development, in fact nearing completion, the three
 12 scenarios involve a potentially suicidal child, a --
 13 an autistic child, and a -- an aggressive a
 14 potentially violent adolescent. So, these are all
 15 scenarios that we're all seeing all the time in our
 16 emergency departments and in our ambulance services.
 17 Dr. Van Der Jagt is the Vice Chair of
 18 the committee is leading a -- an effort on -- on
 19 pediatric sedation, which is primarily aimed at
 20 providers in emergency departments rather than field
 21 providers.
 22 Dr. Edward Conway will be spearheading
 23 a group to look at the -- the 2015 document, now
 24 almost ten years old, looking at you know, the
 25 current status of emergency department I.C.U. regs

Page 31

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 2 and so on to see if they require updating. We'll
 3 have more for you on that in December.
 4 And finally, not quite finally but
 5 almost finally, Dr. -- Dr. Maia Dorsett, who will be
 6 joining our committee as soon as she's vetted, which
 7 I -- I've being told is tomorrow, will be leading an
 8 effort to deal with developmental quality metrics for
 9 emergency medical services for children.
 10 A -- Director Ryan will be announcing
 11 the -- the awards to be given to all members of the
 12 E.M.S. community, with one exception. And I have the
 13 honor of letting you know that the E.M.S.C. committee
 14 voted unanimously this past Monday to provide that
 15 award, the Robert K. Cantor Leadership Award to Dr.
 16 Elise Van Der Jagt of Rochester.
 17 And -- and finally -- and finally,
 18 truly finally, Amy has asked me to remind us all that
 19 there are some terrific pre-conference programs on
 20 topics related to pediatrics at this year's vital
 21 signs. So, for those of you who are going to be
 22 attending Vital Signs, and I presume that means
 23 everyone in this room, please -- please sign up get
 24 your folks to sign up and make -- make them all a
 25 success. Thank you. Be happy to answer any

Page 32

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 2 questions that anyone may have.
 3 **CHAIR DOYNOW:** Any questions for Dr.
 4 Cooper? Okay. Ryan, are you ready?
 5 **DR. GREENBERG:** Still feel awkward
 6 doing like a thumbs up with this brace on. All
 7 right, couple things going on. Thanks, everybody.
 8 So, in regards to operations the Eastern Branch has
 9 been working on their two-year certification or,
 10 sorry, two-year full-service inspections. So,
 11 they'll be up for coming out and seeing a lot of your
 12 agencies again. It's crazy to think that it's, we've
 13 hit the full cycle of all the agencies and seeing
 14 everybody, and now we're circling back around. Just
 15 a reminder there's been a lot of expired stuff on the
 16 trucks. So, to everybody who is a part of their
 17 agencies Q.A. Q.I. process and checks and balances
 18 just a reminder to be checking on that one as well as
 19 the Part eighty inspections has been in some areas
 20 needing a little bit of attention and work.
 21 So, particularly for this group and
 22 our physicians, making sure that your agencies are
 23 following what they need to and staying on top of
 24 things, particularly with their paperwork.
 25 Just as a reminder, if any agency has

Page 33

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 2 a question about it before we come for an inspection,
 3 call us. Call the District Chief or anything else.
 4 We're happy to come out, we're happy to have a phone
 5 call. Maybe you have a brand-new narcotics officer
 6 who comes in and has, you know, the -- the other
 7 person left before they came in. We're here to help.
 8 We're here to help in that transition and things like
 9 that. Feel free to -- to give your local district
 10 chief a phone call, and we'd be happy to help you
 11 with that process.
 12 As well in the -- in the full-service
 13 inspections, just a reminder to be checking your
 14 oxygen tanks for expirations and your medications.
 15 These are all things that we're seeing more often as
 16 repetitive in nature as we go from agency to agency.
 17 On the administration side, we're
 18 doing really well in our spending. So, we're just
 19 over, I think, four million dollars in our aid to the
 20 counties going out and funding for this year, So,
 21 that's trailing well, I think. Steve Kroll will talk
 22 later about the finance side of things.
 23 But on the education side, you know,
 24 we're spending, last year at this same time, we were
 25 at about one point six million paid out in education.

Page 34

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 2 This year we're over two million paid out in
 3 education, So, we're happy to see that increase in
 4 spending, and I think Mr. Kroll is going to be
 5 working on figuring out how to spend even more. So,
 6 we appreciate finance committees and all their help
 7 on that front as well.
 8 On the NEMSIS transition, it has been
 9 going really well. In addition to three point five
 10 being released, we also have some new -- we have a
 11 new Fellow in the Data and Informatics Unit who is
 12 coming to us from SUNY Genesee. So, you'll see -- be
 13 seeing her more often.
 14 In addition, over ninety-five percent
 15 of the agencies have transitioned. We've had a
 16 couple that have had some roadblocks or -- or bumps
 17 in the road, but we believe in the next couple of
 18 months, they'll be all squared away as well.
 19 In January 2025, we'll do a minor
 20 release for some revisions and some updating to the
 21 dataset. But nothing too significant on this time,
 22 but keep your eyes open for that one, as well as, the
 23 team will be hosting with NEMSIS an ImageTrend a
 24 training session for those who are looking for some
 25 additional training related to data and some

Page 35

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 2 information on that.
 3 We'll be sharing that with our program
 4 agencies, and they'll be able to get that out. Just
 5 a reminder, when it comes to three point five your
 6 program agencies are an excellent resource. You
 7 know, if you as a frontline or first pass in -- in
 8 information on setting things up.
 9 We also had some great conversations
 10 yesterday, I believe during the Quality Committee
 11 with ImageTrend and E.S.O. about them providing a
 12 one-page document on how to really best access your
 13 data and how to be able to look at some of the core
 14 quality measures.
 15 I know Dr. Dorsett was, you know, big
 16 on the ability to look at it, and -- and now we're
 17 trying to figure out some ways that we can get things
 18 out there, so it is easy for them to look at.
 19 The next Stack meeting is October
 20 30th. For anyone who's looking to attend, please
 21 look on our website for additional information.
 22 E.M.S. for children, Dr. Cooper really gave the bulk
 23 of the report, but I will say at this year's Vital
 24 Signs, we have a big focus on pediatrics.
 25 And so, we're excited about the number

Page 36

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 2 of things that are coming up there, including a half
 3 day O.B. assessment pre-con, peds triage pre-con, and
 4 some other things on that front.
 5 But also, I want to thank everybody
 6 who filled out the peds readiness survey. We had
 7 about twenty-five response rate across the state,
 8 which is about two hundred and fifty agencies that,
 9 you know, if we -- if we look nationally that's a
 10 really good number for an individual state to be able
 11 to get so many agencies to respond.
 12 And so, we appreciate everybody who
 13 took the time on that, especially with the new survey
 14 that it was, which was a -- a little bit longer than
 15 what it's been in the past.
 16 Vital signs right around the corner.
 17 Thank you to many of you here who are some of our
 18 speakers for this year. Thank you, Dr. Cushman, for
 19 offering your city and really think it's going to be
 20 an excellent opportunity -- and -- and Wegmans, yes.
 21 And we think it's going to be an excellent
 22 opportunity. There's a lot of great things going on.
 23 The convention centers really laid out well for --
 24 for the conference, So, we're excited to -- to be
 25 there and to move things forward on that.

Page 37

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 2 We have a great Saturday night event
 3 at the Rochester Museum of Play, which is this, like,
 4 just this amazing museum that reminds you of all the
 5 video games I feel like we've known growing up. And
 6 you get to relive your childhood again.
 7 So, a lot of really, you know,
 8 opportunities there, including all the education, but
 9 also to see the City of Rochester, to visit Wegmans
 10 if you haven't visited with Wegmans or to -- So, if
 11 you're wondering why Wegmans is So, important, I did
 12 a ride along, probably one of the best ridealongs I
 13 ever did with Dr. Cushman. And so, we went out and
 14 probably saw one of the most critical patients I saw
 15 on a trauma patient. And that was really cool. And
 16 at the middle of the day, I said, doc, where are we
 17 going for dinner? And he goes, well, what do you
 18 want? And I was like, it's your city. It's up to
 19 you.
 20 And -- and he says well if you don't
 21 know, how about Wegmans? And I said, what's Wegmans?
 22 He goes, it's a supermarket. I go, doc, you're
 23 taking me to a supermarket for dinner? And we went
 24 into Wegmans, and I was just like, whoa.
 25 I've now judged every supermarket that

Page 38

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 2 I walked into compared to Wegmans. I haven't found
 3 one near me yet that compares, but he made the right
 4 choice for dinner, hands down. But for those of you
 5 who haven't been to Rochester, I'll tell you I
 6 learned the most about it this year planning this
 7 conference. It really is incredible. There's
 8 incredible health systems, the University of
 9 Rochester is actually going to be a big part of the
 10 conference this year as well. And we're really
 11 excited to have some new tracks, including special
 12 operations and a rescue track.
 13 We have a free pre-con for leadership
 14 that when we released it, it sold out, So, we
 15 actually had to add more seats to it. So, we're
 16 excited to -- to have that opportunity there to give
 17 some more educational opportunities. So, again, just
 18 a lot of things, go on to the website. You can find
 19 a lot going on there.
 20 I also, want to announce this year's
 21 award winners, which will be presented at Vital Signs
 22 this year. So, our A.L.S. provider of the year is
 23 Nathan Peters. Our B.L.S. provider of the year is
 24 Kyle Maxwell. Our E.M.S. Communication specialist of
 25 the year is Charles Vitale. Our E.M.S. Educator of

Page 39

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 2 the year is Amy (unintelligible)
 3 Our E.M.S. Agency of the Year is
 4 Northwell Health Center of E.M.S. Our Harriet Weber
 5 Leadership Award is Mark Philippi. Our registered
 6 Professional Nurse of Excellence is James Moore. Our
 7 Physician of the Year is Dr. Maia Dorsett, sitting
 8 behind us.
 9 Our Excellence in Quality is Michael
 10 Prezzano. Our Youth Provider of the year is Shalom
 11 Halberstein. And then for our Innovation Awards,
 12 which will be on Sunday, excellent opportunity to
 13 really learn more about some of the amazing
 14 innovation that's happening around the state.
 15 Our Clinical Delivery Innovation is
 16 Harper's Ferries -- Harper's Ferry Volunteer
 17 Ambulance Corps, which is a Binghamton University
 18 Collegiate E.M.S. Corps. Our Educational Institution
 19 for Innovation is Mentor Ambulance, Scott Clark. Our
 20 Organizational Innovation is Varna Volunteer Fire
 21 Company. Our Recruitment and Retention Innovation is
 22 Southern Tier Healthcare Systems, which is our
 23 program agency for Southern Tier. I think a round of
 24 applause for all of our -- this year's winners.
 25 The memorial is tomorrow for those of

Page 40

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 2 you who can attend. There are eight honorees going
 3 on the wall. And are you able to bring up that
 4 picture, Theresa? She's going to bring it up in a
 5 second. But this is a very special memorial for us.
 6 This is a memorial where, for those of you who can
 7 see the screen, I think we're pretty good here. Oh,
 8 nope. We couldn't. Now, we can? But this is our
 9 new memorial. So, the initial memorial was built in
 10 2004. It's been around for twenty years. And
 11 unfortunately, the tree was filled.
 12 And so, what you can't see as well
 13 here is on either side now is engravings of all the
 14 names. So, there's a hundred and seventeen names
 15 that are on either side that are engraved. The stars
 16 are in the middle on the Tree of Life. And the --
 17 the first ceremony with this will be tomorrow at
 18 eleven a.m. at the Plaza. We encourage everybody
 19 here to join us, those online, to either join us in
 20 person, and it also will be broadcast, it's on our --
 21 our website as well, so we -- we encourage you to --
 22 to join us.
 23 A big thank you also, to those SEMSCO
 24 members who were part of the planning committee to
 25 make this all possible to, you know, for what that

Page 41

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 2 next chapter of the E.M.S. Memorial looks like in New
 3 York State. So, thank you for that front.
 4 Couple other things closing out. We
 5 have a lot of regulatory change happening in a -- in
 6 a really good way. And so, thank you to everybody
 7 again here on SEMAC and SEMSCO who's helped with this
 8 process. Education regs are out June 6th. They were
 9 released. Really excited about those.
 10 The change log is up online as policy
 11 statement that was asked that people had. So,
 12 there's a new policy statement literally just put up
 13 today on that one. The vehicle and equipment regs
 14 was out for public comment. We got lots of public
 15 comment. We really appreciate it.
 16 That will drive it most likely to go
 17 out for public comment again, so expect to see that
 18 out for public comment, my guess, is sometime in
 19 November. It will go out in November and December,
 20 and then hopefully be back to this committee in
 21 February, not the December meeting, but in February
 22 for the final vote in order to go into regulations or
 23 for those regulations to change.
 24 The ambulance build regulations should
 25 be going out for public comments shortly. The blood

Page 42

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 2 regulations are in development right now. We're
 3 working in partnership with Wadsworth based on the
 4 information that this group and the technical
 5 advisory group has provided.
 6 The performance standards as -- the
 7 performance standards as well as the system standards
 8 for the system and agency performance standards
 9 groups are both in drafting right now. The -- the
 10 quality ones is in drafting as well, and community
 11 paramedicine is in a draft process. We actually have
 12 a community paramedicine advisory council that is
 13 being vetted right now as per the statute. And So,
 14 once those are in place, that document will get
 15 passed to them for kind of further fronts on that.
 16 For statutory change this year, and I
 17 -- I think Mr. Kroll will probably get to it a little
 18 bit later as well. But we are excited to -- that the
 19 governor did just release that blood is -- they took
 20 the blood statute, and which was originally just
 21 designed for air medical and now includes ground and
 22 air medical. Very excited about that. As well as
 23 TIP and TAD, TIP being Transport Treatment In Place
 24 and Transport to Alternative Destinations. So, nice
 25 work for everyone here.

Page 43

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 2 And -- and just a reminder, and
 3 really, you know, a -- a shout out to each of you
 4 that are here and everyone else who really are the --
 5 the advocates for E.M.S.. But we went, you know,
 6 over twenty years with no statutory change and now
 7 have seen statutory change multiple years in a row.
 8 It's very exciting to -- to watch this advance and to
 9 see the medicine advance and -- and things like that.
 10 So, thank you for everything that you're doing.
 11 Three policy statements twenty-four
 12 zero six, which is related to certification. Twenty-
 13 four zero seven, which is the A.L.S. Provider
 14 Practical Skills Exam, and twenty-four O eight, which
 15 is the education regulation change log have all been
 16 posted. They're up on our website. Please go.
 17 Please feel free to do there.
 18 You also might hear from some of our
 19 fellows. We have two new fellows that have started
 20 with us, one on policy and one on data. So, we're
 21 excited to have them to the team. As well as we're
 22 in a transition. So, the -- the bureau is in a
 23 transition, and over the next couple of months,
 24 you'll hear more about it.
 25 I know many of you have seen some of

Page 44

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1 9/18/2024 -- SEMAC Meeting -- Saratoga Springs, N.Y.
 2 the positions come up and -- and be posted. You've
 3 seen some of the things. We're excited about this
 4 transition. We're excited to bring you more
 5 information about it and kind of some restructuring,
 6 some -- some changes in some titles and things of
 7 that nature.
 8 So, more to come on that one. You'll
 9 see a lot more positions being posted. Please ask
 10 questions. If someone -- if you see a posting and
 11 someone has a question, you know, by all means feel
 12 free to -- to reach out to someone and ask what that
 13 position is about. You know, what does it mean?
 14 State service is a wonderful opportunity, So, we
 15 encourage you to -- to come be part of the team if
 16 you're interested in that.
 17 And then our -- my last thing -- I
 18 promise Dr. Cooper, it's my last thing, but I just
 19 wanted to -- to truly say thank you to -- to Dr.
 20 Cushman. He is one of the first physicians who had
 21 the opportunity to meet and work with when I joined
 22 here, crazy to think six and a half, almost seven
 23 years ago now. He's taught me a lot about the
 24 system, and I will give absolute -- I will fully say,
 25 you know, when it came to knowing Upstate, I thought

Page 45

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 2 everything Upstate was above Westchester. Come from
 3 Long Island, lived in the city for twenty years.
 4 And -- and Dr. Cushman really took the
 5 time to explain a lot about what the collaborative
 6 protocols was, which was not used downstate at that
 7 time, about what the systems upstate were, the
 8 different regions that were here, the opportunity to
 9 come and see Mel Ram's region, and everything that
 10 you're doing there is just outstanding. And for
 11 those of you who don't know, he's been part of the
 12 Council since 2009, part of the SEMAC. And so, I
 13 just want to say on behalf of myself, the Bureau, and
 14 the Department, thank you for your fifteen years of
 15 service.
 16 You're an incredible asset and you've
 17 done tremendous things for New York City E.M.S., many
 18 of which will probably -- many people of which will
 19 probably never know how much you've done, but we do
 20 and thank you.
 21 End of report.
 22 **CHAIR DOYNOW:** Any questions for Ryan?
 23 Okay, moving on. Ryan, this is a -- is a question
 24 for you. New York State Medical Director -- update
 25 position.

Page 46

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 2 **DR. GREENBERG:** It is in the org chart
 3 of things to be a permanent position in that
 4 restructuring that's going on, so we're just waiting
 5 for it to come to fruition where we see posted.
 6 **CHAIR DOYNOW:** Thank you. Anybody
 7 have any questions on that? Okay, iGel update one
 8 more time.
 9 **MR. VIOLANTE:** Okay, great. Thank
 10 you. I'm very happy to -- to give this presentation
 11 for those that didn't see it this morning. Theresa,
 12 if you could bring that up. And thank you all for
 13 all of the work on this in the data informatics for
 14 Med standards, for everybody here at SEMAC. It's
 15 been an absolute pleasure to work on this and
 16 continue working with everybody in this project. So,
 17 I'll -- I'll quickly go through this and please let
 18 me know if you have any questions. I'll bring up
 19 some things that came up in med standards earlier
 20 also.
 21 So, this was a supraglottic iGel pilot
 22 demonstration that came from Greenville back in the
 23 earlier part of 2000. Next slide. And so, we really
 24 want to give a huge thanks to the Hudson Valley
 25 Regional E.M.S. Council and staff, their leadership

Page 47

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 2 and medical advisory committee, everybody that's here
 3 and to the -- down informatics team of the state and
 4 the Bureau for all of their work with us as well.
 5 And so, we did this demonstration
 6 project to evaluate the feasibility of V.M.T.s using
 7 an iGel during treatment of cardiac arrest, adult
 8 patient, and cardiac arrest. And there were three
 9 really distinct and good reasons for doing this:
 10 better airway management and oxygenation related to
 11 difficulties in B.V.M. seal, reduced availability and
 12 access to A.L.S., and precedents set by other states
 13 already doing this. Next slide, please.
 14 So, here's the timeline of the
 15 project. We started the beginning of 2020. Who
 16 knew? And so, we brought this concept out, the
 17 pandemic had begun at that point. As we move forward
 18 it took a little bit of time to come up to the D.O.H.
 19 for approval as a pilot, develop it a bit. Finally,
 20 it was posted in Q one of 2023, and we went through
 21 the reporting period. And now we're at the final
 22 position of reporting to the state which began this
 23 morning. Next slide.
 24 We ended up having hundred and
 25 seventy-three agencies from across the state apply, a

Page 48

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 2 hundred and twenty-four completed the process, and we
 3 had almost two thousand E.M.T.s across the state do
 4 the didactic and practical components, assessment pro
 5 components and start using this.
 6 We had two things that we wanted to do
 7 in terms of data. One was a Drupal survey and the
 8 other was to have reports from data informatics
 9 weekly to the H.V. REMSCO. The Drupal survey came
 10 from the agency and was the first point of indication
 11 of use of this. And the second was from the state to
 12 the H.V. REMSCO from data informatics.
 13 It was important to do this because we
 14 realized some of the reports were not getting to the
 15 state, and some of the data wasn't getting to the
 16 state. So, we were able to then figure out which
 17 ones were not, go to agencies, go to regions, and
 18 figure out processes and ways to get the data up to
 19 the state and then go through that data there as
 20 well. Next slide.
 21 We looked at three primary safety and
 22 feasibility outcomes. So, the first is successful
 23 insertion and maintenance as reported by the crew.
 24 The second is confirmed by a higher-level provider,
 25 and then the third as verified by waveform

Page 49

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 2 capnography. Third -- or next slide, excuse me.
 3 So, a note about field terminations.
 4 We're not going to cover all three of those
 5 parameters then in field terminations because there
 6 are times when higher level providers were not there,
 7 or the patient was not trans -- transported to a
 8 hospital to get clarification and validation of
 9 insertion.
 10 And So, we looked at two things,
 11 success by the presence of documented by the provider
 12 and by documented capnography. When we didn't have
 13 those, So, in the absence of confirmation by a
 14 higher-level provider and or capnography values, we
 15 considered that a failure of the device. Next slide,
 16 please.
 17 So, here's the cases we have four
 18 hundred and nineteen for in the timeframe that we
 19 looked at from three of twenty-three to seven of
 20 twenty-four. Three hundred and twenty-seven were
 21 considered successful, fifty-nine were not in the
 22 repository. And we have no way of getting that data,
 23 So, we didn't include those. And thirty-three were
 24 excluded because while that appeared in the state
 25 report that it was done by B.L.S. provider, on

Page 50

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 2 further look at the data and to the agency, they were
 3 done by an A.L.S. provider. Reasons for that were
 4 that a person transitioned from a B.L.S. provider to
 5 an advanced level provider during the process, and
 6 they didn't catch it at the agency to update the
 7 person's information in the chart or some of the data
 8 just didn't come across. Next slide.
 9 So, here's some data of medians for
 10 age, weight, separation by gender. Next slide.
 11 Information about dispatch to the patient, which was
 12 somewhere around the seven-minute mark as a median.
 13 And from the at patient to first attempt being just
 14 less than seven minutes as a median also. Next
 15 slide.
 16 iGel sizes and EtCO2 values. So, one
 17 of the things that we should have done, didn't do our
 18 clarifying as we move forward is that we had thought
 19 providers would get an initial end-tidal, perform the
 20 procedure, look at the value, and then also have a
 21 final end-tidal.
 22 And what some places were doing were
 23 just inserting -- they were doing B.V.M.
 24 ventilations, inserting the iGel and then getting the
 25 value for end-tidal CO2 after that as a confirmation

Page 51

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 2 and then moving forward as continuous capnography
 3 continued. And So, this data may not appear to match
 4 because of those differences, but still medians look,
 5 look very good with this. Next slide.
 6 So, we have B.L.S. provider reported
 7 success at ninety-four percent. Capnography recorded
 8 at eighty-six percent, placement confirmed by high
 9 higher-level provider at eighty-three percent and
 10 confirmed by higher level provider and or capnography
 11 at ninety-six percent, which are fantastic numbers.
 12 Those are great. Next slide.
 13 So, here are some of the outcomes in
 14 terms of patient response. Two hundred and twelve
 15 unchanged. A hundred and twelve improved. Adverse
 16 events, three hundred and five, none. And then
 17 there's some other related adverse events like
 18 vomiting, apnea, combinations, nausea, et cetera.
 19 Discontinuation reasons, eighty-nine,
 20 from a field termination by my control order. Some
 21 were not recorded, and in going through the data, it
 22 was not able to get some of these things. I'll go
 23 into why some of that challenge -- some of those
 24 challenges occurred in a second here.
 25 Transfer of care at the hospital or

Page 52

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 2 ROSC occurred. Airway failure reasons two hundred
 3 and eighty-five, none. And then a variety of other
 4 things from difficult anatomy to secretions, blood
 5 and vomit, et cetera. There are some wonky ones in
 6 here because of how data came across and what some of
 7 these ideas were recorded as -- by the P.C.R.
 8 vendors.
 9 In terms of outcomes, one hundred and
 10 twenty-one expired in the field, seventy-two in the
 11 E.D. Ongoing resuscitation occurred for forty. ROSC
 12 in the field, thirty-one. ROSC in the E.D. twenty --
 13 thirty. And then some not recorded or applicable
 14 ones. Next slide.
 15 These are iGel insertions by region.
 16 And So, again, just a wide swath around New York
 17 state, which was absolutely wonderful and fantastic.
 18 Next slide.
 19 So, here's some of the data challenges
 20 that we faced. And so, this was probably one of the
 21 most difficult initial components for us as we
 22 wrangled around what the data was coming in, what it
 23 meant to us, and how we could make it cleaner and
 24 better and validate it.
 25 And so, for some folks, they

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 2 documented the iGel use in a narrative area and not
 3 in a tabulated field, so it didn't come across. And
 4 so, other indicators in the P.C.R. caused us to go to
 5 the agency and look at it and say, hey, did you guys
 6 do an iGel? Was it something else? What happened?
 7 You're like, oh, yeah, see it, it's in the narrative.
 8 We'll get it moved to the tabulated field. And we
 9 included those.
 10 Some of the E.P.C.R. vendors weren't
 11 using NEMSIS data configurations, or they weren't
 12 correctly configured. And Ss, for some vendors, it's
 13 straightforward. This is what it is, there's no
 14 ability to change it at the agency level. For some
 15 vendors, you can change it at the agency level. And
 16 some of those values just weren't coded correctly for
 17 the vendor by the agency. We were able to correct
 18 those and get a better flow of data for iGel.
 19 And so, some of the agencies didn't
 20 have data reaching either the regional repository and
 21 or the state repository, and some regions weren't
 22 sending data to the state. So, because of the use of
 23 the Drupal, we were able to figure out what agencies
 24 were using data and sending it and what was and was
 25 not getting through, and then able to backtrack to

Page 54

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 2 see did it come through a regional site and was there
 3 a problem there or was it just from an agency not
 4 getting up for whatever reasons and correct some of
 5 those.
 6 Again, huge thanks to the data
 7 informatics team for all of the work that they did on
 8 this and assisting us in getting data movement from
 9 agency up through. And everybody was super helpful
 10 from agencies and providers through vendors to the
 11 data informatics unit as a piece of this as well.
 12 So, we had to get correct mapping done
 13 and we had to get the reports in the data and the
 14 state repository. Some made it there. You saw that
 15 there were some that that actually did not, and we're
 16 continuing to work on some of that process.
 17 One of the biggest positive components
 18 out of this was follow up with agencies to get
 19 completed -- complete data sets. So, if they
 20 submitted a Drupal and we didn't see it in a weekly
 21 report, we would reach out to the agency.
 22 And then also, we sent out quarterly
 23 reports to agencies of what we had for their data.
 24 And then we would talk with them about what was
 25 working and what -- what was not working and try and

Page 55

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 2 improve it from there.
 3 When I say that data improved in the
 4 iGel program, that's true. But also, we found that
 5 data improved overall in a lot of different areas
 6 because we identified issues in getting P.C.R.s from
 7 agencies to regions to the state, and that meant that
 8 a variety of other components then also came through
 9 that hadn't previously been going through. So, this
 10 created a better data flow of other components as
 11 well. Next slide.
 12 And So, again, the solutions that we
 13 had just talked about, there are things that we had
 14 done to -- to fix these issues for data collection
 15 for the iGel project and overall other data
 16 collection. Next slide.
 17 So, our conclusion was that E.M.T.s
 18 can utilize an iGel in an S.G.A. in an adult patient
 19 in out of hospital cardiac arrest. And we think that
 20 the data clearly shows that. Next slide.
 21 Our recommendations are then for the
 22 bureau to develop an iGel B.L.S. policy, which we
 23 voted on, which is great, and we want to move
 24 forward. Thank you for that, to allow E.M.T.s to
 25 utilize and maintain an iGel in adult cardiac arrest,

Page 56

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 2 if trained and equipped with regional authorization
 3 and oversight, and that continuous waveform
 4 capnography be mandated in all uses. We also, want
 5 this demonstration project to conclude when that
 6 policy is in place and that's moving forward. Thank
 7 you for that.
 8 And finally, that we advocate that
 9 capnography and waveform interpretation be added to
 10 the B.L.S. scope of practice here in the state as we
 11 continue to move towards the national standard, since
 12 it's not in the current national scope of practice,
 13 but we believe it will be hopefully soon. We are
 14 trying to move this forward so, that we can advocate
 15 from our state to the nation of including this for
 16 B.L.S. providers. There are several other states
 17 that are already doing this now, and so we believe
 18 that it's possible and can be moved forward.
 19 We have some recommendations for
 20 future projects, and that's looking at smart
 21 objectives being specific, measurable, achievable,
 22 relevant, and time bound, to clearly communicate any
 23 challenges for many participants, the project itself
 24 and ensure that the project's aligned and it doesn't,
 25 you know, get derailed in some other way.

Page 57

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 2 That there's a good data set, and to
 3 test that data set for accuracy, effectiveness
 4 efficiency from the agencies, the vendors, the
 5 regions, the program agencies, the state, and
 6 everybody involved in it.
 7 So validate the data for accuracy and
 8 to include very specific documentation expectations
 9 and training rollouts, we did a wonderful training
 10 roll -- rollout program that was very clinical in
 11 doing it, and not totally on the documentation side.
 12 So, we had to do some work on that on the backend,
 13 which we did and worked out well. We recommend doing
 14 that up front versus waiting a little bit as to later
 15 in the program.
 16 And finally, to confer regularly with
 17 participating entities to look at consistent,
 18 reliable, accurate and validated data. And so, that
 19 is our -- our project and our program. We had some
 20 wonderful discussion earlier at Med standards and
 21 looking at confirmation process.
 22 And so, what we talked about in that
 23 was that B.V.M. versus an iGel, right? And so, there
 24 are issues in B.V.M.s related to having a good mask
 25 seal where for B.L.S. providers what they found was

Page 58

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 2 they could get a better seal with an iGel, and then
 3 have better ventilations because of using this than
 4 just using A B.V.M. with a mask seal.
 5 Some challenges were related to -- to
 6 money and funding in terms of other components to
 7 this, such as end-tidal CO2 for B.L.S. providers.
 8 But that -- that really wasn't an onerous component
 9 to this as well as some of those are -- are really
 10 available at lower cost than we believe.
 11 That doesn't mean that people have to
 12 go out and buy a forty thousand Zoll or LIFEPAK or
 13 anything like that, but certainly there are a couple
 14 thousand, maybe dollar end tidal CO2 monitors that
 15 could be useful for this and -- and will work
 16 completely.
 17 And finally, should have said this way
 18 upfront, apologies, is that we have no affiliations
 19 or any disclosures to make about any particular
 20 products or any components of this whatsoever. We're
 21 happy to do this, we're delighted to have done it.
 22 We think that anecdotally B.L.S.
 23 providers, from what we've heard, are just simply
 24 delighted to do this. They found another tool to
 25 really help them. It's something they can do,

Page 59

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 2 something they're proud of doing and has had a very
 3 net positive benefit for patients.
 4 So, thank you all again, So, very much
 5 from me, from the Hudson Valley region, from all
 6 those doing this. A huge thanks to everybody
 7 involved and I'm happy to take any questions.
 8 **CHAIR DOYNOW:** Any questions?
 9 **DR. SETH:** Yeah, Dr. Seth, REMSCO.
 10 Big Lakes. Did you compare the success of the B.L.S.
 11 providers to the success of A.L.S. providers when
 12 thinking about some of those adverse outcomes and
 13 failed airways? Sorry, I -- and I apologize, of
 14 course you realize I'm new, so if there's -- this has
 15 already been asked and answered, I apologize.
 16 **DR. GREENBERG:** Not asked and
 17 answered, no, we did not. We were really focusing on
 18 B.L.S. providers and their ability to insert this
 19 versus A.L.S., providers and their ability to insert
 20 this, if that's your question.
 21 **DR. SETH:** I think so. I just don't
 22 think I understood your answer. Sorry, you said you
 23 were comparing them to A.L.S., or you were not
 24 comparing them to A.L.S.?
 25 **DR. GREENBERG:** We were not comparing

Page 60

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 2 A.L.S., providers' ability to --
 3 **DR. SETH:** Okay.
 4 **DR. GREENBERG:** -- insert an i-Gel
 5 against B.L.S., providers' ability to insert an i-
 6 Gel.
 7 **DR. SETH:** Understood, thank you.
 8 **CHAIR DOYNOW:** Any other questions?
 9 Well, thank you. That was an excellent presentation
 10 and you've done an amazing job on this pilot project.
 11 It probably should be a framework for future pilot
 12 projects. Your methods have been excellent.
 13 Okay. If we have no old business to
 14 continue, let's move on to new business, Dr. Kugler,
 15 I believe you're up.
 16 **DR. KUGLER:** Well, thank you. I had,
 17 I thought the collaborative protocol discussion, but
 18 I guess we did that. All right, so forgive me while
 19 I just pull up my notes. Mr. Chairman, thank you for
 20 allowing me to bring this up under new business.
 21 First, I want to say thank you again
 22 to Dr. Cushman. So, I have two separate items that
 23 I'd like to bring to this body for consideration in
 24 the form of questions, and I will start with just
 25 providing some background.

Page 61

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 2 I'm hoping to engage a discussion with
 3 the leaders of this body, SEMAC, and then,
 4 ultimately, SEMSCO, regarding regional online medical
 5 control. Specifically, I'm hoping to clarify the
 6 current regulations as stipulated in Article thirty
 7 of the Public Health Law and Bureau of E.M.S. Policy
 8 eleven dash zero five..
 9 I believe that this discussion will
 10 facilitate getting each region and the regional
 11 providers to have the same understanding of the
 12 regulations, so that we're all conforming in an
 13 appropriate way. I do also understand that each
 14 region's online medical control may appear
 15 differently based on the needs of that region.
 16 So, I'd like to take this opportunity
 17 to bring everybody together to look at a larger scope
 18 of medical control. To help focus this discussion a
 19 little bit further, I propose the following question:
 20 who or what entity is ultimately responsible for the
 21 implementation and oversight of online medical
 22 control that's provided in a particular region.
 23 The posted regulations and policy
 24 describe how the REMAC may define and establish
 25 medical control, as well as credential and specify

Page 62

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 2 who may provide medical control. But it doesn't say
 3 who shall be implementing the medical control.
 4 For further clarity, I would ask,
 5 additionally, who owns the data generated by medical
 6 control activities. The quality of online medical
 7 control as stipulated in Policy eleven zero five
 8 contains that the REMAC is to ensure and participate
 9 in regional and agency-level quality assurance
 10 activities.
 11 Does this mean online medical control
 12 is an agency. Ultimate oversight on the provision of
 13 care as directed by online medical control; who's to
 14 be responsible for that. The credentialing of
 15 providers and physicians that provide medical control
 16 is stipulated in regulation and policy. And then,
 17 who is responsible for the application and design of
 18 online medical control systems.
 19 Lastly, with regards to this and I am
 20 seeking your guidance as leaders in E.M.S. I've been
 21 asked to seek a recommendation by this body to
 22 further codify medical control. But I implore that
 23 any regulations promulgated and recommended by this
 24 body and the SEMSCO intends to include the region in
 25 the development of the specifics locally.

Page 63

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 2 Because, as we know, as New York State
 3 is varied by resources, geographically, by
 4 topography, time, and distance to definitive care,
 5 which can be vertical or extrication or traffic or
 6 just plain mileage, as well as by population
 7 densities and each region has its own known areas of
 8 concern that they address best locally. Allowing
 9 only for the code to clarify quality and care issues
 10 rather than specific medical control designs.
 11 And I say that unless the state, I
 12 don't want, actually, I'll skip that. But so I bring
 13 that up for discussion to ask who's in charge of
 14 medical control and who owns the data?
 15 **CHAIR DOYNOW:** Thank you, Dr. Kugler.
 16 Well, do we have any discussion on the question?
 17 **DR. GREENBERG:** All right, you're
 18 looking right at me. So it's an excellent question
 19 and I think, look, especially knowing different parts
 20 of the state. It is, medical control is very
 21 different, region by region. Both in how it's run,
 22 both in who people call, in how people handle medical
 23 control. We have some regions where you call into
 24 medical control and everything's recorded and
 25 everything's documented and there's a log to things.

Page 64

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 2 There's other areas where you can call
 3 medical control and you're calling your medical
 4 director on his cell phone. And so, you know,
 5 there's a different dynamic there. There are regions
 6 that are very centralized in their medical control,
 7 meaning, you know, everyone in a given area calls one
 8 place. There's regions that are very fragmented.
 9 What hospital am I going to and based on that
 10 hospital is which medical control I would call. To
 11 date, there has not been regulations promulgated, you
 12 know, related to this.
 13 Some of the questions that you ask
 14 would, I would want to go back and not give you a
 15 quick answer today, but if you have a series of
 16 questions, we'd be happy to come back to you at the
 17 December meeting, you know, with answers, more
 18 specific answers, and legal backing behind them. By
 19 the way, legal counsel sitting next to us, so I'm
 20 pointing towards them, that we'd be happy to go back
 21 to it and, you know, provide you those answers so you
 22 had a starting point on some of these things.
 23 One of the things that is very clear
 24 is that the REMACs do designate who the medical
 25 control physicians are. And that is absolutely

Page 65

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 2 clear. I would say it's a little bit more vague on
 3 who does medical control, and I think up until now it
 4 just hasn't been too much of a question, which is why
 5 it hasn't come to a regulatory set or something of
 6 that nature.
 7 But it might be that time. I think,
 8 you know, technology has changed and things have
 9 changed in that forefront as well. When you talk
 10 about, you know, quality and quality assurance and
 11 different pathways that are there, there is no
 12 question that the REMAC is an active part of ensuring
 13 that the quality of care that's provided in a given
 14 area and there's no question that medical control and
 15 what happens when an E.M.S. provider is given
 16 guidance or direction is part of that process.
 17 And, you know, that should be -- they
 18 should be an active part of those discussions when
 19 you're discussing the quality of care that's given
 20 there. So, I think the short answer is the medical
 21 directors that are approved to provide medical
 22 control is very clearly in the onus of the REMAC to
 23 approve. Beyond that, it's a little bit grayer. And
 24 I don't know that it has to be. It's just the way
 25 that it is today.

Page 66

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 2 **DR. KUGLER:** So, thank you for that.
 3 And I look forward to hearing something back maybe
 4 even sooner than December. But, you know, there are
 5 some -- there are quality issues that need to, that
 6 are sort of pressing. And that, sort of push this
 7 question from my region's quality committee, which is
 8 a combined committee of the REMSCO and the REMAC and
 9 the program agency to me to bring to this body for
 10 sort of immediate sort of guidance.
 11 Because there's things outstanding
 12 that affect patient care. And so I would ask if even
 13 if you just nod your heads, if you just agree that
 14 the region should have access to the data that's
 15 acquired during the medical control process, like a
 16 telephone call -- like if we record a telephone
 17 conversation between a provider and medical control
 18 physician or medical control contacts are receiving
 19 facility to make a notification.
 20 And we have all that data recorded and
 21 there's a quality investigation that's occurring,
 22 shouldn't that data be available to the Q.A. Q.I.
 23 committee under the aspects of quality that this
 24 state pushes so hard to espouse?
 25 **DR. GREENBERG:** I would think that

Page 67

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 2 everybody who's involved with quality would want to
 3 engage in a collaborative approach to ensure that the
 4 patient care that's being given is the best that can
 5 be given, not only including medical controls, but
 6 hospitals and patient outcomes and things like that.
 7 There are some other guidance
 8 documents related to that specifically for hospitals
 9 as well, that advises them that these are positive
 10 conversations and should be collaborative in nature
 11 and sharing information.
 12 **DR. KUGLER:** So, the reason why I
 13 bring that forward, because we're not really having
 14 much of a discussion, is I'll just keep going. I'm
 15 trying to avoid giving very specific examples.
 16 **DR. GREENBERG:** So let me just ask
 17 this question.
 18 **DR. KUGLER:** Yeah.
 19 **DR. GREENBERG:** If you don't mind.
 20 **DR. KUGLER:** Please.
 21 **DR. GREENBERG:** To the room, because
 22 clearly you know your region. How are other regions'
 23 medical control run, do they participate actively in
 24 your quality assurance processes and what happens
 25 along, you know, those lines?

Page 68

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 2 **DR. BERKOWITZ:** So, I'll just say from
 3 -- in Westchester, it's actually depending on where -
 4 - depending on where you're going, the hospital.
 5 That's the model that -- that you described. So to
 6 Dr. Kugler's point about the data, you know, we've
 7 never had an incident where we've gone to a hospital
 8 and said, we think your hospital phone lines are
 9 recorded. Can you give us this, give us a recording
 10 of this and I think that that would probably --
 11 probably not be a very fruitful endeavor to ask that
 12 to happen.
 13 So I mean, I think that -- I think
 14 that because of the heterogeneity around medical
 15 control, issues around data and everything are going
 16 to be really hard to -- it's going to be hard, it's
 17 going to be very great to get to the answer.
 18 Especially when it comes to ownership of data. And I
 19 agree with you that there's a lot of ambiguity within
 20 statute. Again, because there's history and
 21 heterogeneity and things are just, it's a big state.
 22 So, I don't know how you can, I mean,
 23 to the point, I don't know if we can, this is an
 24 answerable question that -- that could be given that
 25 would apply to the entire state. And so an

Page 69

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 2 be some record of it.
 3 And so we require them to be recorded.
 4 One of the other requirements in that policy is that
 5 the -- whoever's giving that online medical control,
 6 they need to participate in a quality improvement
 7 Q.I., process and support that or release those
 8 records when required, right?
 9 I don't think in my region when I've
 10 had questions come up or as a medical director, I've
 11 just been Q.A.'ing charts myself and had questions
 12 and we've gone to a hospital and asked for those
 13 recordings. I've never had a hospital say, no, we're
 14 not giving them to you.
 15 I think just in the process of wanting
 16 to work together, right, as a bunch of stakeholders
 17 and trying to improve the quality that we're
 18 providing and make sure that we're all understanding
 19 the actual discussion that was had; I've never had a
 20 hospital say, no, we're not going to give you those
 21 recordings. Sometimes maybe they had issues with
 22 retrieving the recordings and that and it took some
 23 time, but no one's blatantly said, we're not going to
 24 participate in a quality improvement.
 25 So that seems a little strange to me

Page 71

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 2 alternative would be to say, how can we, if there are
 3 concerns that a member of the SEMAC is having about
 4 quality of the issue, maybe in their region, maybe
 5 the question is, how do we support them to help
 6 resolve conflict?
 7 And maybe, because that's something
 8 that -- that that we've seen, we see in this body,
 9 you know, occasionally. And maybe -- maybe the
 10 question is, how do we help folks resolve conflict
 11 rather than how do we try to litigate everything, so
 12 to speak because I think that that's -- there's
 13 challenges there. So just making -- just pointing
 14 out the heterogeneity and just making that
 15 suggestion.
 16 **DR. WALTERS:** So I'll just kind of
 17 speak from the western region and Dr. Clemancy or Dr.
 18 Seth can jump in because we just recently revised our
 19 online medical control policy in the last year. And
 20 making the requirement that, several requirements.
 21 One of them being that the medical
 22 direction needs to be recorded for quality
 23 improvement purposes or when some type of conflict or
 24 question or something comes up, right. These aren't
 25 like written orders in a hospital, so there needs to

Page 70

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 2 that a hospital wouldn't want to participate and make
 3 E.M.S., better and make sure that we're making the
 4 system better. And it seems to be, that's one of the
 5 issues you're having.
 6 **DR. GREENBERG:** Thank you. Dr.
 7 Walters, would you be willing to share your policy
 8 maybe with not just Nassau, but everyone?
 9 **DR. WALTERS:** Sure. It's right on our
 10 western region website, but I'm happy to share that
 11 link with anyone.
 12 **DR. GREENBERG:** Thanks.
 13 **CHAIR DOYNOW:** Jason.
 14 **DR. WINSLOW:** Yeah. I think it's the
 15 REMAC in each region that has the authority to decide
 16 how they're going to coordinate their medical
 17 control. And it may be decentralized or centralized.
 18 Our policy is on our website, suffolkremsco.com. You
 19 can read it.
 20 Suffolk County has a centralized
 21 medical control that requires all nine one one alarms
 22 to use. It's very successful that we not only record
 23 the information, but they use it as a place to also
 24 repository data, how many procedures were done, how
 25 many advanced airways were done, the cardiac arrest

Page 72

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 2 survival data.
 3 So we use our medical control also as
 4 a Q.I., audit tool and it works quite well. But yes,
 5 I do think it is a REMAC decision and Nassau, REMAC
 6 should be able to coordinate its medical control and
 7 get information through the REMAC, Q.I., subcommittee
 8 for any issue that is under quality improvement.
 9 **DR. GREENBERG:** Dr. Walters, just
 10 curiosity in your region, is it centralized, is it by
 11 county or is it you call the hospital you're going to
 12 or --
 13 **DR. WALTERS:** It's a variety. I would
 14 say the majority is point of destination, the
 15 hospital you're going to, and we've done that for
 16 that way for a long time. However, we do allow for
 17 agencies or systems to do their own medical
 18 direction.
 19 So for example, if I have an agency
 20 that's large enough or provides specific inter-
 21 facility transports or needs, you know, sometimes
 22 there's certain, I think there are certain cases that
 23 come up that maybe don't -- the average E.R. doctor
 24 at a hospital may not always be able to answer some
 25 of those nuanced questions, when they're a little

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 2 outside the box.
 3 So we do allow for agencies to -- or a
 4 system to have medical direction outside the hospital
 5 as well. As long as they're following the same
 6 rules.
 7 **DR. GREENBERG:** Thank you.
 8 **CHAIR DOYNOW:** Mike, did you want to
 9 comment on this region?
 10 **DR. DAILEY:** No.
 11 **DR. GREENBERG:** Let the record show
 12 that Dr. Dailey did not have any comments.
 13 **DR. DAILEY:** Prior to the record
 14 reflecting that. So we've required recorded
 15 conversations for years. It has been an
 16 extraordinary boon to our providers. Almost never do
 17 we go back to a provider and say, what were you
 18 asking for, what were you doing. It almost as always
 19 is a conversation with the physician that was taking
 20 the call of what were you thinking, why weren't you
 21 talking -- why were you talking to the paramedic that
 22 way? Or the E.M.T., cause we have all levels of
 23 folks that we'll call through for medical -- medical
 24 direction.
 25 I'm not really sure I understand

Page 74

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 2 because we work really in a collaborative -- I mean,
 3 I know that I use the word so much and almost becomes
 4 trite, but we work in a collaborative fashion across
 5 the hospitals in our region, in spite of the fact
 6 that these are -- are competing hospitals.
 7 And, you know, quite frankly, the
 8 chiefs in each one of the hospitals are extremely
 9 helpful when it comes to sharing information. The
 10 recordings are actually maintained by the region and
 11 not by any individual hospital, although some
 12 hospitals have redundant recording systems. So we
 13 can approach any one of those as -- as necessary, and
 14 then, just address it. But we've had providers,
 15 field providers who have kept their job because of
 16 those recordings. So I cannot speak highly enough of
 17 recording every consultation between a physician and
 18 a field provider.
 19 **DR. GREENBERG:** Just to understand
 20 your system, what is your model? Is it, they call
 21 the destination, is it centrally or --
 22 **DR. DAILEY:** Yes.
 23 **DR. MCEVOY:** The paramedic calls into
 24 a number, and then, dials the hospital that they wish
 25 to speak with.

Page 75

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 2 **DR. DAILEY:** Exactly. And that was a
 3 challenge in terms of developing that recording
 4 system. So we have a single phone number that people
 5 across the region call. They then dial an extension
 6 and get through to the specific hospital that they
 7 choose.
 8 They generally choose the destination,
 9 although then not all the time, because some
 10 hospitals have a zone phone that one physician will
 11 carry, and others will just put it into a pool and
 12 many physicians may answer.
 13 So, I think the last time we looked at
 14 it, somewhere in the neighborhood of sixty-five
 15 percent of the calls went to Albany Medical Center
 16 where we have one person answering those phones. But
 17 a significant number of the patients, particularly
 18 the ill patients, it's destination medical direction.
 19 **CHAIR DOYNOW:** Also, to add to that,
 20 they can call their medical director on their cell
 21 phone, and it will be recorded. So if it's something
 22 extraordinary, they can dial Mike, they can dial
 23 myself, they can dial other --
 24 **DR. DAILEY:** Yeah. There are about
 25 four or five physicians that actually have recorded

Page 76

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 2 extensions on that line as well.
 3 **DR. KUGLER:** So to provide some
 4 context to this source of questions, the region
 5 received a request for an investigation. The Q.A.,
 6 Q.I., committee reached out to the -- via the program
 7 agency to the medical director. A P.C.R., was
 8 requested, it was sent by the agency to the quality
 9 committee. And then, a request to listen to the
 10 audio tapes between the provider and medical control
 11 and medical control in the receiving facility were
 12 requested and were refused.
 13 There -- subsequent to that, we
 14 received letters saying you can subpoena us for the
 15 medical control tapes. So, that didn't go very well.
 16 And in that same context, but a different case, a
 17 hospital system complained about an ambulance case,
 18 and they wanted to inquire of the Q.A., Q.I.,
 19 committee to -- to promulgate an investigation.
 20 And in that email request to the Q.A.,
 21 Q.I. committee contained the statement, I reviewed
 22 the audio tape from medical control. I reviewed the
 23 video body of camera footage from the police
 24 department. And here's my findings. Please
 25 investigate this case. So here's a person who's not

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 2 are needed.
 3 **DR. KUGLER:** So I don't want to be
 4 adversarial, so I will say that's great, but let's
 5 put a timeline on that. Because as I get to point
 6 number two, which I apologize for dragging on this
 7 meeting, we'll see that there's something that's
 8 ongoing for quite some time.
 9 So I would ask that -- I'm happy to --
 10 to not push to the state attorney general's office,
 11 but we'll give you a month. Because it shouldn't
 12 take more than five minutes to get a recording that
 13 somebody else has already listened to. And I'm not
 14 asking for the police body camera footage, although
 15 while we're at it, we may as well. What I'm asking
 16 for is just for somebody who's not a party of the
 17 subject of investigation to give an unbiased listen
 18 to the audio tapes and provide an unbiased answer.
 19 And because this is an ongoing
 20 investigation that remains open, I can't provide
 21 remedy to the person who provided the complaint. And
 22 therefore, we can't provide remedy to that patient's
 23 family. We can't provide remedy to that agency. We
 24 can't provide education and remediation because this
 25 case is ongoing.

Page 79

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 2 a physician on the Q.A., Q.I., committee, not a
 3 member of the Q.A., Q.I., committee in the region,
 4 having access to HIPAA protected quality data and
 5 presenting it to us as an email finding, where the
 6 region is protected by state regulations to do
 7 quality, and we were being blocked from receiving
 8 this information.
 9 So, given that we have not received
 10 any assistance, I would ask that, and since the
 11 region has no attorneys assigned to it because we
 12 can't afford any and we are a subcommittee of the
 13 REMSCO and a subcommittee of the SEMAC and the
 14 CEMSCO, I would ask that we now ask the SEMAC to ask
 15 the state attorney general to subpoena those records
 16 on behalf of my region so that we can continue to
 17 perform quality assessments and patient care and make
 18 sure that there was no issue.
 19 **DR. GREENBERG:** You can make any ask
 20 that you would like. I would ask that maybe we can
 21 take a first step with the bureau possibly assisting
 22 in obtaining these things. I understand that you may
 23 feel like it's nowhere. But I think we would like to
 24 take the first step together with you on this one,
 25 and then, determine from there if additional things

Page 78

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 2 So I look forward to sending you those
 3 other questions. But I would ask that this be done
 4 in a very timely fashion. If one month you think is
 5 too short, then six weeks.
 6 **DR. GREENBERG:** I think it's one of
 7 those, let's have the conversation and understand
 8 what's needed. There's a couple of things that I
 9 think we have in our tool test to be able to help
 10 facilitate this.
 11 **DR. KUGLER:** Okay.
 12 **DR. GREENBERG:** And so I understand
 13 your timeline and let's work towards meeting those
 14 goals. The questions that you brought up before,
 15 too, if you do have a series of questions that you
 16 would like answers to related to medical control.
 17 My only ask would be is maybe post
 18 that on Boradable or something to see if there are
 19 others that other people would like to answer,
 20 because if we are going to ask legal to dive into it,
 21 it is easier to answer multiple questions --
 22 **DR. KUGLER:** Sure.
 23 **DR. GREENBERG:** -- related to a topic
 24 at once rather than -- while they're looking at it
 25 and --

Page 80

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 2 **DR. KUGLER:** Absolutely.
 3 **DR. GREENBERG:** -- providing an
 4 assessment than, you know, five, and then, all of a
 5 sudden we come back with five more or something of
 6 that nature.
 7 **DR. KUGLER:** So I'll place those under
 8 the discussion section on portable. And basically,
 9 we'll reiterate what I mentioned here so that the
 10 public can be aware because they can read our minutes
 11 and watch the tape.
 12 So thank you for the opportunity to
 13 present that first question. So now I have another
 14 one.
 15 **CHAIR DOYNOW:** Okay. Thank you, Dr.
 16 Kugler. Number two.
 17 **DR. KUGLER:** Thank you, sir. So Mr.
 18 Chairman and members of the SEMAC, my question for
 19 this body is when a region passes a quality issue up
 20 the chain to the bureau, is it a reasonable
 21 expectation that the region making the request be
 22 updated on the status of that request or
 23 investigation that were sent to the bureau in a
 24 timely manner. And what defines a timely manner.
 25 And I ask this because even though the

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 2 In regards to can the region know the
 3 final outcome of many things. I think in many cases
 4 the region does know the outcomes of many things. In
 5 many regions, you're reading at your REMAC or your
 6 REMSCO, this provider, you know, got this, this
 7 provider got that. That's, you know, our pathway to
 8 make notification.
 9 If there's a different pathway that
 10 you think needs to be made for specific complaints
 11 that come in from a REMAC, we'd be open to hearing
 12 what that pathway is.
 13 **DR. KUGLER:** So the one particular
 14 item I bring to provoke this question to this body is
 15 an item that's outstanding at the state level for
 16 over eight months.
 17 It involves compliance with first
 18 response and patient care, advanced life support
 19 patient care. And it was a complaint, comes out of a
 20 complaint that was given to the region by another
 21 agency's advanced life support provider. Again, we
 22 received minimal input and support from the -- that
 23 agency that we're querying, and then sent up to the
 24 state from their medical direction. The only answers
 25 we get from their medical directors are the answers

Page 83

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 2 regions are authorized to issue provider patient care
 3 restrictions as stipulated in D.O.H. Bureau V.M.S.
 4 Policy fourteen dash zero one and the quality is
 5 codified in New York State Article thirty, Section
 6 three zero zero six, the Section three zero zero six
 7 only describes quality at the agency level.
 8 And so my question is, what is an
 9 expected timeframe to hear back from the -- the
 10 bureau with regards to getting an answer for a
 11 quality investigation that was pushed up to them?
 12 **DR. GREENBERG:** I know you're probably
 13 not going to love this answer, but it varies. And
 14 part of the reason that varies is because of the
 15 process and the due process that Jason, feel free to
 16 chime in here to explain.
 17 Not only is it the investigation on
 18 our side, but once the investigation comes to us and
 19 the recommendation is made, then it goes up and goes
 20 through the adjudication process. And that process,
 21 like, what we see in many of the court systems, which
 22 is, you know, overseen by an Administrative Law
 23 Judge, could take weeks or could take months, is
 24 prioritized on what's coming in and what's going out
 25 and has a lot of variables that go to it.

Page 82

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 2 that their supervisors, their manager -- agency
 3 managers have provided to us.
 4 So, it's sort of this circle of -- of,
 5 you know, it's a merry-go-round. Every once in a
 6 while, you see the same answer over and over and over
 7 again. So, that's why we sent it to the state. And
 8 again, eight months, I think is quite a long time for
 9 a case to remain open.
 10 When I submitted a request to the
 11 regional investigator, the answer was we can't
 12 comment because we're still investigating our
 13 findings. I know what the findings are because I
 14 found them. I need you to tell me what you're doing
 15 about it because I can't -- my hands are tied.
 16 **DR. GREENBERG:** And unfortunately, you
 17 know, part of that is the due process and how long it
 18 takes, you know, in certain steps moving it along.
 19 The investigator probably was, you know, advising to
 20 the amount of information that they have as well.
 21 It sounds like there is an opportunity
 22 here to make sure that that we stay in contact with
 23 the REMAC to possibly, and I can work with legal to
 24 find out if we can advise them of where things are in
 25 a process, meaning, you know, has an investigation

Page 84

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2 concluded and now it's been passed off to
3 Administrative Law Judge or things like that, that at
4 least we would be able to demonstrate to you the
5 progress of things.
6 And sometimes when things are at a
7 certain point that's not moving and -- and it doesn't
8 move because, again, if we even look at our court
9 system, it doesn't always move quickly. But I think
10 that part is -- is important. You know, for our --
11 for our most critical or egregious things, there is a
12 process that is an expedited process that goes
13 immediately to the commissioner and to a different
14 pathway. But that is truly at some of the most
15 egregious things that we deal with.
16 **DR. KUGLER:** So, I think that eight
17 months is way too long for not hearing anything back.
18 We haven't -- I don't know if this went to an
19 administrative judge. I don't know if your
20 investigators reviewed the material and said we're
21 investigating, but that was it. The problem with us
22 digging very deep locally is that this is a
23 politically sensitive investigation.
24 So, we had to withdraw ourselves so
25 that people can't imply that the investigation was

Page 85

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2 providers, we'll get complaints from REMACs or
3 REMSCOs, we'll get complaints from a hospital system,
4 fill in the blank. I think there, you know, there's
5 an opportunity here for us to work with legal to
6 figure out at what point can we make different
7 notifications to you so at least you see the process
8 to move that things move on.
9 And, you know, reality is I also think
10 you have the opportunity to -- to look, you know, on
11 our website, we post many of the things that are
12 there. You can see when incidents, I believe you can
13 see when incidents occur, and you can see when things
14 are posted.
15 So that, you know, where the timelines
16 are on some of the things that occur.
17 **DR. KUGLER:** But when -- so let's take
18 regional quality out of this, let's take the REMAC
19 out of this. And I'm a customer buying a widget, and
20 I contact a company, and I say, what's the status.
21 They'll send you emails saying here's -- here's the
22 update.
23 Here, you know, we're the customer in
24 this case of the state and I'm asking for status
25 updates, and I'm getting nothing. At this point, you

Page 87

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2 promulgated due to anything other than quality or a
3 violation of state regulations. So I would ask that
4 -- it's not just that case there. I have six
5 outstanding cases in Nassau County, where I'm getting
6 no data, I'm getting no quality assistance, and so I
7 just wanted to see if there was a -- if you guys had
8 a timeline in your mind about how fast we should move
9 on a case that was on its face egregious. And a
10 sheer violation of regulations that are stipulated in
11 Article thirty.
12 So, you know, I bring this out into
13 the public so that everybody's aware of the
14 investigations that are ongoing to seek your
15 awareness and to also let you -- to see if anybody
16 else has any other outstanding cases that need to be
17 addressed, and also to please put this on your radar
18 to have more of an attention focused on it so it
19 could be mitigated in a more timely fashion.
20 **DR. GREENBERG:** I appreciate you
21 bringing it up and to the forefront. I think there's
22 an opportunity here again for us to keep particularly
23 the complaints that come in and complaints come in
24 from all different angles, right.
25 So we'll get complaints from other

Page 86

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2 know, then you go to the Better Business Bureau and
3 you say this company is ignoring my request. Here's
4 the chain of emails, they've charged me my money and
5 I'm not getting anything back in return, and then,
6 the Better Business Bureau or whatever regulatory
7 body will start investigating. And that's the reason
8 why I -- I think we need to keep pushing, we need to
9 get things resolved.
10 When quality is broached by a provider
11 or an agency or -- or region, patients' lives are at
12 stake and patient care and welfare are potentially
13 impacted. We need to make sure that this doesn't
14 become, instead of it a smoldering fire, just an over
15 wildfire that's uncontrollable.
16 And in order to do that, we need to
17 stop it right away. By allowing something to smolder
18 for eight months, and then allow these other things
19 to go on is empowering one that one particular agency
20 to continue with their malfeasance in a way that is
21 disruptive to improving regional quality in patient
22 care.
23 And I think having the State Bureau,
24 your resources if you're willing to apply them or the
25 State Attorney General to obtain that data for us, so

Page 88

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 2 we could do our own local investigation in a more
 3 expeditious fashion would be very helpful for us in
 4 our region in Nassau County. Thank you.
 5 **DR. GREENBERG:** Thanks. I look
 6 forward to working together even more.
 7 **DR. MCEVOY:** I would note too that
 8 there's a strong difference between a widget and
 9 professional negligence and -- and counsel can
 10 comment on this. But, you know, I think there's a
 11 tendency across the state with Child Protective, with
 12 O.P.M.C., to weaponize the government.
 13 And so there needs to be due process
 14 and does O.P.M.C., respond to people who make
 15 complaints?
 16 **DR. RIEGERT:** No, yeah. This is Jason
 17 Riegert. I'm an attorney with the Department of
 18 Health. So I can tell you that essentially we almost
 19 never give out any update on any active investigation
 20 regardless of who the complainant is.
 21 So the standard course would be to let
 22 our internal investigation play out, all of the due
 23 process, the challenges that they have, and then,
 24 when there's a final determination that's when we
 25 would let you know.

Page 89

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 2 **DR. KUGLER:** So I would counter that
 3 with, I -- we reached out to the agency to see if
 4 they've heard anything back from the state and what
 5 they said is, yes. So, we said, what did you hear;
 6 we're not telling you. Speak to the state.
 7 And we reached out to the state and
 8 the state said, we're not telling you. It's under
 9 investigation. So something was done. Something was
 10 concluded, and the body that precipitated the
 11 investigation and brought it up to the level of the
 12 state for their attention and investigation is not
 13 receiving any information back.
 14 So we can't provide that information
 15 back, and we can't make any corrective measures. We
 16 can't learn and grow as a region until we find out
 17 what happened.
 18 **CHAIR DOYNOW:** Well, thank you, Dr.
 19 Kugler. Hopefully, this will get resolved for you.
 20 **DR. WALTERS:** Dr. Doynow, I know I'm
 21 not a member of the committee, but can I bat clean-up
 22 for the Nassau region?
 23 **CHAIR DOYNOW:** Sure. Okay.
 24 **DR. WALTERS:** So, purposeful comedic
 25 pause there. Thanks for playing. So I know it's

Page 90

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 2 uncomfortable to have these conversations, but just
 3 for clarity, we bring this before SEMAC in
 4 conversations and at the urging of the bureau, hoping
 5 that this can spark a much larger conversation.
 6 The full acknowledgment is medical
 7 control is and needs to be dramatically different
 8 because we all come from different backgrounds and
 9 different necessities. So, I would respectfully
 10 suggest to this body, which in conjunction with Med
 11 Standards and SEMSCO continues to have these
 12 conversations about medical direction, quality,
 13 credentialing, and the like.
 14 As again, E.M.S. goes through a growth
 15 spurt, and we try and find our own way in the world.
 16 The question is, is what we've been doing working?
 17 If so, does the law actually say we should be doing
 18 that. If not, we'll change the law.
 19 If it is working, should we put that
 20 out as a best practice, and that's what I think, you
 21 know, not to speak for the bureau. But I hope the
 22 intent was about bringing this out here for public
 23 discussion rather than, you know, just dealing with
 24 it behind closed doors.
 25 Because we have had asks, and the

Page 91

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 2 initial ask to the bureau was, we're trying to play
 3 nice within the constraints of everything here. It
 4 was actually the bureau that said, I think you should
 5 bring this up at SEMSCO and SEMAC.
 6 So we come before you for that reason
 7 as a partner to the bureau to try and spark the
 8 conversation and keep this going as far as, from what
 9 I'm hearing, and again, not to interpret anybody.
 10 But my interpretation of what I'm hearing is, there
 11 seems to be an understood consensus that the REMAC
 12 does play a role in medical oversight of medical
 13 control. And if I'm misinterpreting that, I think
 14 now's the time to say that.
 15 **DR. RABRICH:** So I think that's my
 16 understanding, right, that a region is responsible
 17 for an overall medical control plan, right and A.L.S.
 18 plan. And that the region does determine who has met
 19 the qualifications to provide medical control or not.
 20 And I believe the region even has the
 21 ability to remove those privileges to provide medical
 22 control if they're not complying with the regional
 23 medical control plan. This is not the same, as far
 24 as I know, as an individual provider and whether
 25 their credentials can be removed or not.

Page 92

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 2 **DR. GREENBERG:** Thank you for
 3 separating out the individual provider. And Dr.
 4 Walters, it sounds like in your region that is part
 5 of what your policy is, is that there's requirements
 6 to provide that medical control in order to be one of
 7 those physicians?

8 **DR. WALTERS:** That's correct. And I
 9 believe, I'm just trying to find it real quick, in
 10 Article thirty, I believe it gives the REMAC the
 11 authority, right, for -- to approve online medical
 12 control. Okay.

13 **DR. GREENBERG:** Very clearly. And
 14 that is the opportunity too and this is one of those,
 15 you know, is -- and I think it was Dr. Berkowitz that
 16 says, you know, maybe we don't need more regs but,
 17 you know, there are benefits to regulations, too.
 18 Particularly ones that are driven by, you know, a
 19 group like this that's identified certain standards
 20 and in certain cases, certain minimums. So it's not
 21 saying you're trying to set the, you know, the sky.

22 You're trying to set the minimum. If
 23 the minimum, if everybody here turns and says the
 24 minimum is ninety percent of the time, all your
 25 medical control should be recorded because there are

Page 93

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 2 ten percent of the time, you know, certain
 3 circumstances or something happens or fill in the
 4 blank, I don't know, you know, those are
 5 opportunities.

6 And I'd have to go back and look at
 7 statute to see what the opportunity there is to, you
 8 know, possibly set some basic or, you know, limited
 9 maybe medical control things. Also recognizing that,
 10 again, times are changing.

11 We are seeing larger and larger E.M.S.
 12 systems that cover broader E.M.S., areas that, you
 13 know, may centralize their medical control in order
 14 to best meet their operational needs and how does
 15 that incorporate into things.

16 And how do, you know, how do you make
 17 sure that those needs are met as well, so that, you
 18 know, a paramedic in their time when they need to --
 19 when they that medical control assistance isn't
 20 trying to figure out where am I standing, who do I
 21 call, what's my process.

22 And kind of those going from that.
 23 Even in New York City, you know, it varies to a
 24 certain extent based on who you're working for, based
 25 on who you'll call. And so the -- the protocols of

Page 94

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 2 what they're going to follow remain the same, but the
 3 pathways sometimes are different.

4 **DR. ISAACS:** Well, just a
 5 clarification for that. So we do have a centralized
 6 online medical control for the Safe Route nine one
 7 one system. However, the region does approve of
 8 their online medical control worked extremely well in
 9 New York City.

10 So, if there's an issue, there's just
 11 forms that have to be filled out. We exchange those
 12 recordings and participate in the Q.A., Q.I., process
 13 for the region.

14 **DR. WALTERS:** I guess I would assume
 15 in most regions, right, if REMAC is approving online
 16 medical control systems, physicians, hospitals,
 17 whatever. This, however, it works in your system and
 18 or agency medical directors, right. There's a set of
 19 standards in your region that you say we will follow
 20 by these policies, and you have a defined policy that
 21 says, we will participate in Q.A., we will share
 22 information, we will do all these things.

23 If you have that defined in your
 24 policy and you're approving these physicians or
 25 hospitals to give online medical control and they're

Page 95

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 2 not meeting what they have agreed to. Then it seems
 3 that the REMAC could remove their ability to provide
 4 that online medical control or agency medical
 5 direction.

6 **DR. BERKOWITZ:** But I just want to
 7 make it clear, I think that this is, in the end, it
 8 comes down to what -- the setting the standards, that
 9 is -- that is what the REMAC is doing. So the
 10 standards need to be discrete, understandable, clear
 11 and, you know, not -- not capricious.

12 And I think that that's -- that's I
 13 think that that way -- I think that that is our
 14 responsibility to make sure that that these standards
 15 meet that that bar.

16 **DR. GREENBERG:** And I think, you know,
 17 Dr. Isaacs has really described part of that, right.
 18 So he described that there's a central medical
 19 control in New York City, and then, there's
 20 opportunities for others to do it, permitting you
 21 meet similar standards.

22 **DR. BERKOWITZ:** I know those standards
 23 for New York City medical control very well, and it's
 24 not a problem. And it's a very -- it's a very easy
 25 system that, you know, I have new doctors that come

Page 96

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2 on board, and they know how to do it.
3 It works well, it's -- it's actually a
4 great example of what it means to have a standard
5 that everyone knows how to achieve that standard.
6 **DR. GREENBERG:** And I think, you know,
7 really what it also outlines is there's mutual
8 expectations. There's expectations of this, if this
9 is what you're going to provide and you're going to
10 do it yourself, this is what you're going to meet and
11 this is what you're going to provide, including, you
12 know, participation at quality assurance.
13 **CHAIR DOYNOW:** Dr. Kugler, did you
14 want to bring up a motion to this body or just a
15 discussion, as we had today?
16 **DR. KUGLER:** I was bringing it up for
17 discussion.
18 **CHAIR DOYNOW:** Okay.
19 **DR. KUGLER:** And awareness and for
20 guidance. I don't have any particular motion to
21 bring up.
22 **CHAIR DOYNOW:** Okay. Don, did you --
23 **DR. GREENBERG:** Is there an ask going
24 forward? Is there a, you know, is it a -- I'd say,
25 but a technical advisory group or something that's

Page 97

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2 **DR. HUDSON:** So just to close on this,
3 I think the ask, then, is that you grant our meeting
4 request for our REMSCO and REMAC leadership to meet
5 with the bureau and your Bureau of Legal Affairs
6 about this.
7 **DR. GREENBERG:** So granted.
8 **CHAIR DOYNOW:** Any other discussion?
9 Dr. Cooper?
10 **DR. COOPER:** You know, the -- our
11 quality improvement process grants REMACs the
12 authority to ask questions. But it does not grant
13 them authority to insist on answers. And that is the
14 fundamental flaw in the system, you know, an entity
15 that chooses not to provide information when it is
16 asked to do so, you know.
17 The REMAC has no ability to compel
18 that that -- that information to be provided. That
19 has been a problem ever since the, you know, the
20 system was established. In the main, it, you know,
21 relies on the goodwill of all the participants
22 involved, wanting to make the system better.
23 But on occasion, you know, there are
24 reasons why a particular party may wish not to share
25 information, and then, something has to be done. So

Page 99

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2 coming up with something. Do you want to wait until
3 we get you back some questions to your answers?
4 **DR. KUGLER:** I think that would be
5 most prudent to hear what you have in terms of
6 follow-up.
7 **DR. GREENBERG:** Sure.
8 **DR. KUGLER:** And then, maybe we -- at
9 the December meeting, if the results aren't as one
10 would expect, then we could move forward with a
11 proposal for a motion to do something.
12 **DR. GREENBERG:** So I think the other
13 thing to, you know, think of the future and it won't
14 solve all your problems, but it may solve some of it.
15 But, you know, as a reminder, there's statute, then
16 there's regulation, normally goes further into detail
17 from what the statute says. And then, there's policy
18 that further explains, you know, different things
19 that are within that statute.
20 And so this could be, I don't want to
21 say it's simple, but step one could be, you know,
22 working with you for the bureau to come out with a
23 policy statement that discusses some of these points.
24 And points to either the statute or regulation that
25 directly correlates to it.

Page 98

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2 I would only ask that the department take a -- take a
3 look at this.
4 Because, you know, this is a recurring
5 problem that comes up from time to time, over the
6 years and it's something that I think all of us would
7 benefit from understanding in terms of, you know,
8 what the parameters really are and where a REMAC
9 should turn for help when necessary and so on. Thank
10 you.
11 **CHAIR DOYNOW:** Any other discussion,
12 Mike?
13 **DR. DAILEY:** Yeah, I think I would --
14 I would echo that by saying that the department has
15 vetted members of the SEMAC from each region. The
16 regionally amassed medical directors are generally
17 elected from their -- by their peers.
18 And physicians are well aware of the
19 need for confidentiality and maintaining that as part
20 of an investigatory process. The problem becomes the
21 black hole when there's no information returning.
22 But conversations in, that are
23 confidential, demonstrating that indeed progress is
24 being made on resolving these issues would go a long
25 way. I think for making regions more comfortable

Page 100

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2 through this process.

3 **CHAIR DOYNOW:** Any other discussion?

4 Okay. One other item to bring up and this is from
5 myself. E.M.S. wait times. I know all of us here
6 are probably on both sides of the aisle because we
7 work at the hospitals, where there are significant
8 wait times.

9 But here today we're representing
10 E.M.S. It's been well over a year-and-a-half, where
11 we've had this discussion about crews basically being
12 surrounded at hospitals for hours at a time. Which
13 is wreaking havoc on systems that don't have rigs to
14 go out to answer calls and have to go to mutual aid.

15 And sometimes the mutual aid agencies
16 are also stuck at the hospital not being able to
17 move. It also disturbs transferring people from
18 critical access hospitals, where the ambulance that
19 would be doing the transfer is also stuck at a
20 tertiary care center and can't leave.

21 I would make the suggestion that we
22 strongly recommend to the department and to the
23 commissioner that they look seriously into the
24 problem and see what can be done. I know there has
25 been some movement by D.O.H. locally. I cannot say

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2 whether that's occurred elsewhere in the state, but I
3 would ask that someone make a motion that the D.O.H.,
4 look into ambulance wait times and perhaps work with
5 the hospitals to -- to resolve this issue.

6 Because everything we've done to this
7 point has basically gone nowhere, I hate to say, but.
8 So any discussion on that point, anybody want to make
9 that motion?

10 **DR. KROLL:** Dr. Doynow, I'm not a
11 motion-making member, but I do have a comment. We
12 had a really excellent dialogue with the Public
13 Health -- the Public Health and Planning Council, a
14 little more than a year ago. Representatives of the
15 SEMAC and the SEMSCO presented information. The
16 Department of Health presented information, and I
17 believe this was referred to their planning committee
18 headed by Dr. Ruge.

19 Maybe if someone wants to make a
20 motion, or if we just want to make the suggestion
21 that it's time for us to again go back and visit with
22 our partner body within the partner, Department of
23 Health. Because that council advises the executive
24 on issues related to hospitals. We advise the
25 executive, us and the SEMSCO on issues related to

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2 E.M.S. There was some enthusiasm at the Public
3 Health and Planning Council for working on solutions
4 to this problem.

5 And perhaps we sort of have lost track
6 of that dialogue back and forth, and renewing that
7 would be a way to, number one, bring this issue back
8 into the spotlight. Number two, review what they
9 have done and three, work together with them to move
10 forward on this issue.

11 **CHAIR DOYNOW:** Would that be agreeable
12 to other members of the committee? Okay, Steve, so
13 can I charge you with that?

14 **DR. KROLL:** Yeah. Well, I think we
15 have to ask the director to help bridge, I mean, the
16 way it happened last time is I believe the Bureau of
17 E.M.S., within the Department of Health facilitated
18 bringing the parties together.

19 I would certainly be willing to, as a
20 representative of SEMAC and SEMSCO, to engage in that
21 dialogue, but we should include others. It shouldn't
22 just be a one-person group.

23 **DR. GREENBERG:** We're happy to
24 facilitate those conversations again. We have seen
25 an increase in offload delays in several different

Page 103

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2 regions. We very much appreciate all the E.M.S.
3 crews who have been filling out the offload delays
4 and providing that information.

5 It has been extremely valuable for us.
6 Often it's not information that we would see on a
7 P.C.R. We can pull from a P.C.R., to say, yeah, they
8 took this long to get offloaded or things like that.
9 But just that brief additional information that's on
10 those reports is extremely helpful.

11 If anybody's wondering where they can
12 find it, it's on the E.M.S. forms page. If anybody
13 would like the poster that has a Q.R., code directly
14 to it. We're happy to provide that too. That is in
15 many of the E.M.S. crew rooms, I guess you would call
16 it, in E.R.s and things like that.

17 So if they do want to provide that
18 information and -- and again, it is looked at. I
19 have caught a couple of E.M.S. providers off guard
20 because they do come directly to my email at times.
21 And so at ten o'clock at night, I will call them back
22 almost immediately to find out more information. So
23 don't be -- don't be surprised if you get a phone
24 call from myself or from Surge Operations Center just
25 looking for some additional information for it, so

Page 104

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 2 that we can try and address it. So happy to work
 3 with you on that one, Steve.
 4 **DR. KROLL:** And since I've been
 5 volatile, but I stepped right in it, so. I do think
 6 that one of the things that was really valuable in
 7 the conversation between the Public Health Planning
 8 Council and the E.M.S. community was the data brought
 9 by the Department of Health.
 10 Because we here have anecdotal
 11 stories, like what happened in my hospital last week
 12 or what my E.M.S. providers reported to me. I did a
 13 deep dive in the data for my personal, my agency, and
 14 I saw exactly where we were.
 15 And I saw, you know, very big
 16 difference between, say, 2022 and 2023. And I bet
 17 you if I went in there, I'd see a difference in 2024.
 18 At my particular agency, the number of instances of
 19 this has been decreasing, even though the length of
 20 the ones where we have delays are still -- I mean,
 21 so, you know, the number of delay times, we've had
 22 delay of drop loss has dropped by fifty percent.
 23 Which I consider to be progress. That doesn't help
 24 the paramedic that still is stuck for two-and-a-half
 25 hours, right?

Page 105

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 2 **DR. WINSLOW:** Yeah, thank you. I know
 3 we're getting near the end of the time. But I did
 4 want to inquire where we were with our credentialing
 5 working group. We were meeting quite regularly up
 6 until mid-May, early June. And then, the meetings
 7 stopped. So, we need to -- we need to get back to
 8 work. Credentialing is critically important.
 9 **CHAIR DOYNOW:** Thank you. Hopefully,
 10 those members will get in touch with you. Okay.
 11 We'll leave the E.M.S. wait times and see what
 12 happens and we'll discuss it at the next meeting.
 13 Anything else before we close? Mike?
 14 **DR. DAILEY:** So one thing that's being
 15 promulgated through the department, particularly the
 16 Office of Drug User Health, as well as through a
 17 group called Overdose Response Strategies, which is a
 18 combination of the Office of National Drug Control
 19 Policy and the C.D.C. Foundation, is leave behind
 20 Naloxone being moved to law enforcement as well as to
 21 E.M.S. provider.
 22 If you think about it, law enforcement
 23 has an opportunity to interact with the drug-using
 24 community that goes well beyond anything that E.M.S.
 25 will have the exposure to. So, if law enforcement is

Page 107

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 2 He or she is still pissed off when
 3 they get back from their call. But I imagine that
 4 part of this would be asking the bureau, what new
 5 data do you have since the last time we met? Is it
 6 worse, is it better, is it regional?
 7 I'm hearing anecdotally that there are
 8 certain regions of the state where this is worse than
 9 others. And I think that that's worthy, you know, of
 10 looking at, too.
 11 **DR. GREENBERG:** It's definitely
 12 partial -- it definitely has regional. Certain
 13 regions are worse than others, without question. One
 14 of the newer things that we're also dealing with now
 15 is it's not only for emergencies coming into an E.R.,
 16 but transfers going from one hospital to another. So
 17 they transfer them from one hospital to another, and
 18 then, that transfer patient is sitting for two or
 19 three hours out in the ambulance waiting to get into
 20 the hospital that they've been accepted to. So it's
 21 multifaceted, and I think that's probably a little
 22 bit different than what we saw back in that first
 23 look.
 24 **CHAIR DOYNOW:** Thank you, Ryan.
 25 Jason?

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 2 in a house, they happen to recognize that there is
 3 evidence of drug use in that house or somebody
 4 discloses that to them, the drug use is not raised to
 5 the level of criminality, those law enforcement
 6 officers will be given the opportunity to do leave
 7 behind Naloxone very similar to the way we are doing
 8 it with the -- with E.M.S.
 9 That's being pushed forward. I bring
 10 it to this group so that our program agencies can be
 11 aware in particular and our E.M.S. agencies that law
 12 enforcement may ask to partner with you to be their
 13 supplier, if you will, of Naloxone. And to assist
 14 them in developing cards that would be included in a
 15 leave behind program that would then bring local
 16 resources to people that use drugs and may be in
 17 potential trouble in each of the regions of our
 18 state.
 19 Each one of these regions is going to
 20 be different and have different opportunities for
 21 people to get help. But this is a great opportunity
 22 that hopefully will save some lives and give people a
 23 chance that they otherwise might not have. Thanks.
 24 **CHAIR DOYNOW:** Mike, thanks for all
 25 your help that you've done with Naloxone over the

Page 108

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2 years. You've really done a lot. Okay, if nobody
3 has anything else, we will --
4 **DR. BOMBARD:** Can you put the link to
5 that on Boardable?
6 **THE REPORTER:** Close?
7 **MS. BOMBARD:** Okay.
8 **THE REPORTER:** Absolutely.
9 **CHAIR DOYNOW:** If there's nothing
10 else, we'll close the meeting. Do we have a motion
11 to close? Dr. Cooper, second. All in favor?
12 (The meeting adjourned at 1:32 p.m.)
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Page 109

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2 STATE OF NEW YORK
3 I, DANIELLE CHRISTIAN, do hereby certify that the
4 foregoing was reported by me, in the cause, at the time
5 and place, as stated in the caption hereto, at Page 1
6 hereof; that the foregoing typewritten transcription
7 consisting of pages 1 through 109, is a true record of all
8 proceedings had at the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 3rd day of October, 2024.
11
12
13 DANIELLE CHRISTIAN, Reporter
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Page 110

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A	
A.H.A 15:22	advance 44:8, 9
A.L.S 39:22 44:13 48:12 51:3	advanced 16:2, 3 51:5 72:25
60:11, 19, 23, 24 61:2 92:17	83:18, 21
a.m 1:8 3:2 41:18	adversarial 79:4
ability 11:22 36:16 54:14 60:18	adverse 52:15, 17 60:12
60:19 61:2, 5 92:21 96:3 99:17	advise 84:24 102:24
able 20:21 36:4, 13 37:10 41:3	advises 68:9 102:23
49:16 52:22 54:17, 23, 25 73:6	advising 84:19
73:24 80:9 85:4 101:16	advisory 1:5 43:5, 12 48:2 97:25
absence 50:13	advocate 57:8, 14
absolute 45:24 47:15	advocates 44:5
absolutely 4:16 53:17 65:25	Affairs 99:5
81:2 109:8	affect 67:12
abstain 28:23, 25 29:14, 16	affiliations 59:18
accepted 106:20	afford 78:12
access 36:12 48:12 67:14 78:4	afternoon 7:23
101:18	age 51:10
accessibility 9:12 10:8	agencies 20:20, 24 33:12, 13, 17
accuracy 10:8 58:3, 7	33:22 35:15 36:4, 6 37:8, 11
accurate 58:18	48:25 49:17 54:19, 23 55:10, 18
achievable 57:21	55:23 56:7 58:4, 5 73:17 74:3
achieve 97:5	101:15 108:10, 11
acknowledgment 91:6	agency 4:13 21:7 33:25 34:16, 16
acquired 67:15	40:3, 23 43:8 49:10 51:2, 6
action 24:17	54:5, 14, 15, 17 55:3, 9, 21 63:12
active 30:7 66:12, 18 89:19	67:9 73:19 77:7, 8 79:23 82:7
actively 68:23	83:23 84:2 88:11, 19 90:3
activities 63:6, 10	95:18 96:4 105:13, 18
actual 71:19	agency's 83:21
acute 15:24	agency-level 63:9
add 15:12 16:24 23:23 39:15	agenda 23:10
76:19	agendas 8:13
added 57:9	aggressive 31:13
adding 15:9, 20 16:5, 13	agitated 15:11
addition 31:9 35:9, 14	agitation 31:5
additional 12:6 14:22 30:24	ago 10:17 25:23 45:23 102:14
35:25 36:21 78:25 104:9, 25	agree 67:13 69:19
additionally 63:5	agreeable 103:11
address 64:8 75:14 105:2	agreed 96:2
addressed 86:17	aid 34:19 101:14, 15
adjourned 109:12	Aiden 6:24
adjudication 82:20	aimed 31:19
adjustments 18:3	air 43:21, 22
administration 16:22 34:17	airway 16:22, 25 17:6, 8 48:10
administrative 82:22 85:3, 19	53:2
administrator 4:13	airways 19:14 60:13 72:25
adolescent 15:11 31:14	aisle 101:6
adult 15:12 17:2 48:7 56:18, 25	alarms 72:21
	Albany 76:15
	ALBERT 2:3

albuterol 15:10	anyways 4:10
ALDAN 2:3	apnea 52:18
aligned 57:24	apologies 16:3 59:18
allegiance 3:4,5	apologize 60:13,15 79:6
ALLEN 2:16 5:9,12,15,18,21,24	appear 52:3 62:14
6:2,5,7,10,13,15,17,19,21,23	APPEARANCES 2:2
7:2,5,7,9 11:12 13:9,11,13,15	appeared 50:24
13:17,19,21,23,25 14:3,5,7,9	applause 40:24
14:11,13 18:16 19:8 21:14,16	applicable 53:13
21:18,20,22,24 22:2,4,6,8,10	application 63:17
22:12,14,16,18 28:13,18,20,22	apply 11:16 48:25 69:25 88:24
28:24 29:3,5,7,9,11,13,15,17	appreciate 14:16 35:6 37:12
29:19,21,23	42:15 86:20 104:2
allow 16:8 18:12 26:8 56:24	approach 68:3 75:13
73:16 74:3 88:18	appropriate 11:25 62:13
allowed 20:3	approval 7:11 16:17 27:11 48:19
allowing 61:20 64:8 88:17	approve 11:8 27:14 28:4,10 29:4
alternative 43:24 70:2	66:23 93:11 95:7
amassed 100:16	approved 7:13 12:2 17:3 27:16
amazing 38:4 40:13 61:10	28:14 66:21
ambiguity 69:19	approving 95:15,24
ambulance 31:16 40:17,19 42:24	area 54:2 65:7 66:14
77:17 101:18 102:4 106:19	areas 10:6 33:19 56:5 64:7 65:2
America 3:6	94:12
amount 31:3 84:20	arrest 17:2 48:7,8 56:19,25
amputation 16:7	72:25
amputations 16:10	ARTHUR 2:4
Amy 30:5,8,10,21 32:18 40:2	Article 62:6 82:5 86:11 93:10
Amy's 30:19	asked 32:18 42:11 60:15,16
anatomy 53:4	63:21 71:12 99:16
anecdotal 105:10	asking 24:20 74:18 79:14,15
anecdotaly 59:22 106:7	87:24 106:4
angles 86:24	asks 91:25
announce 39:20	aspects 67:23
announcements 3:10	assessment 37:3 49:4 81:4
announcing 32:10	assessments 78:17
answer 8:19 20:23 32:25 60:22	asset 46:16
65:15 66:20 69:17 73:24 76:12	assigned 78:11
79:18 80:19,21 82:10,13 84:6	assist 108:13
84:11 101:14	assistance 78:10 86:6 94:19
answerable 69:24	assisting 30:12 55:8 78:21
answered 60:15,17	associated 16:12
answering 76:16	assume 95:14
answers 65:17,18,21 80:16 83:24	assurance 63:9 66:10 68:24
83:25 98:3 99:13	97:12
antibiotics 16:9	ate 8:10
anybody 4:12,23 7:12,12 13:5	atropine 15:19
21:6 47:6 86:15 92:9 102:8	attempt 51:13
104:12	attend 36:20 41:2
anybody's 104:11	attendance 5:8

attending 32:22
attention 33:20 86:18 90:12
attorney 78:15 79:10 88:25
 89:17
attorneys 78:11
audio 77:10,22 79:18
audit 73:4
austere 11:6,19 13:7
authority 72:15 93:11 99:12,13
authorization 57:2
authorized 82:2
autistic 31:13
availability 48:11
available 25:25 59:10 67:22
average 73:23
avoid 68:15
avoiding 10:21
award 32:15,15 39:21 40:5
awards 32:11 40:11
aware 28:7 81:10 86:13 100:18
 108:11
awareness 86:15 97:19
awkward 33:5

B

B.L.S 39:23 50:25 51:4 52:6
 56:22 57:10,16 58:25 59:7,22
 60:10,18 61:5
B.V.M 48:11 51:23 58:23 59:4
B.V.M.s 58:24
back 3:2 8:2 12:10 19:16 33:14
 42:20 47:22 65:14,16,20 67:3
 74:17 81:5 82:9 85:17 88:5
 90:4,13,15 94:6 98:3 102:21
 103:6,7 104:21 106:3,22 107:7
backend 58:12
background 61:25
backgrounds 91:8
backing 65:18
backtrack 54:25
bad 18:15
balances 33:17
bar 96:15
Barley 6:23
Barry 5:12
based 16:23 43:3 62:15 65:9
 94:24,24
basic 11:17 94:8
basically 11:18 81:8 101:11
 102:7

basis 9:22
bat 90:21
bathroom 5:5
began 48:22
beginning 48:15
begun 48:17
behalf 46:13 78:16
believe 8:7 10:16,17,25 23:7
 35:17 36:10 57:13,17 59:10
 61:15 62:9 87:12 92:20 93:9
 93:10 102:17 103:16
BEN 2:4
benefit 60:3 100:7
benefits 93:17
Berkowitz 2:11 5:10,11 13:9,10
 13:10 21:14,15 28:13,14,14,17
 69:2 93:15 96:6,22
best 10:20 11:3 36:12 38:12
 64:8 68:4 91:20 94:14
bet 105:16
better 48:10 53:24 54:18 56:10
 59:2,3 72:3,4 88:2,6 99:22
 106:6
beyond 12:16 20:6 66:23 107:24
big 3:19,19 9:18 36:15,24 39:9
 41:23 60:10 69:21 105:15
biggest 55:17
Binghamton 40:17
bit 12:7 33:20 37:14 43:18
 48:18,19 58:14 62:19 66:2,23
 106:22
black 100:21
blank 87:4 94:4
blatantly 71:23
blocked 78:7
blood 8:10 10:15,18,24 16:14,15
 42:25 43:19,20 53:4
board 97:2
Boardable 109:5
body 14:22 24:12 26:23 27:12
 61:23 62:3 63:21,24 67:9 70:8
 77:23 79:14 81:19 83:14 88:7
 90:10 91:10 97:14 102:22
Bombard 2:16 5:13,14 7:12 13:11
 13:12,12 21:16,17 28:18,19,19
 109:4,7
boon 74:16
Boradable 80:18
bound 57:22
box 74:2

brace 33:6
bradycardia 15:18,22
Branch 33:8
brand-new 24:7 34:5
break 7:25
breathing 15:24
Brian 2:5,5 7:13
bridge 103:15
brief 9:5 104:9
briefly 15:6 17:18
bring 14:22 41:3,4 45:4 47:12
 47:18 61:20,23 62:17 64:12
 67:9 68:13 83:14 86:12 91:3
 92:5 97:14,21 101:4 103:7
 108:9,15
bringing 86:21 91:22 97:16
 103:18
broached 88:10
broadcast 41:20
broader 94:12
brought 14:18 22:24 23:14 24:2
 25:14 48:16 80:14 90:11 105:8
build 42:24
built 41:9
bulk 36:22
bumps 35:16
bunch 71:16
bureau 18:20 44:22 46:13 48:4
 56:22 62:7 78:21 81:20,23
 82:3,10 88:2,6,23 91:4,21
 92:2,4,7 98:22 99:5,5 103:16
 106:4
business 8:25 22:25 23:15 61:13
 61:14,20 88:2,6
buy 59:12
buying 87:19

C

C.D.C 107:19
C.F.R 13:3
call 4:25 13:8 21:4,5,13 25:9
 25:14 26:25 28:11 34:3,3,5,10
 64:22,23 65:2,10 67:16 73:11
 74:20,23 75:20 76:5,20 94:21
 94:25 104:15,21,24 106:3
called 27:2 107:17
calling 27:4 65:3
calls 65:7 75:23 76:15 101:14
camera 77:23 79:14
Cantor 32:15

capnography 17:7 50:2,12,14
 52:2,7,10 57:4,9
capricious 96:11
caption 110:5
cardiac 15:17 17:2 48:7,8 56:19
 56:25 72:25
cards 108:14
care 4:4 9:16,18,24 52:25 63:13
 64:4,9 66:13,19 67:12 68:4
 78:17 82:2 83:18,19 88:12,22
 101:20
career 4:16
CARL 2:6
carry 76:11
case 23:12 26:24 77:16,17,25
 79:25 84:9 86:4,9 87:24
cases 50:17 73:22 83:3 86:5,16
 93:20
catch 51:6
caught 104:19
cause 74:22 110:4
caused 54:4
cell 65:4 76:20
CEMSCO 78:14
center 40:4 76:15 101:20 104:24
centers 37:23
central 96:18
centralize 94:13
centralized 65:6 72:17,20 73:10
 95:5
centrally 75:21
ceremony 41:17
certain 73:22,22 84:18 85:7
 93:19,20,20 94:2,24 106:8,12
certainly 26:17 59:13 103:19
certification 12:25 33:9 44:12
certified 11:18
certify 110:3
cetera 52:18 53:5
chain 81:20 88:4
Chair 1:9 3:2,9,17,21,23 4:12
 4:22 5:3,7,22,25 7:10,17,20
 8:7,21 11:10,13 13:4,18 14:14
 14:16 17:21 18:5 19:3,5,15,20
 20:9,11 21:5,11,23 22:19
 23:24 24:8 25:3,9,11,13,17,21
 27:20 28:9,16,25 29:24 30:4
 31:17 33:3 46:22 47:6 60:8
 61:8 64:15 72:13 74:8 76:19
 81:15 90:18,23 97:13,18,22

99:8 100:11 101:3 103:11 106:24 107:9 108:24 109:9	clearly 56:20 57:22 66:22 68:22 93:13
chairing 9:3	Clemency 2:5 70:17
Chairman 61:19 81:18	clinical 9:2 40:15 58:10
challenge 52:23 76:3	close 99:2 107:13 109:6,10,11
challenges 52:24 53:19 57:23 59:5 70:13 89:23	closed 91:24
chance 108:23	closing 42:4
change 16:19 20:13 26:19 42:5 42:10,23 43:16 44:6,7,15 54:14,15 91:18	CO2 51:25 59:7,14
changed 26:19 66:8,9	Coates 5:15
changes 14:20 15:4 17:15 22:24 26:2,7,12,13 45:6	code 64:9 104:13
changing 94:10	coded 54:16
chapter 42:2	codified 82:5
charge 64:13 103:13	codify 20:18 63:22
charged 88:4	cold 16:5
Charles 39:25	collaborative 4:5 10:16 14:18 46:5 61:17 68:3,10 75:2,4
chart 47:2 51:7	colleagues 16:4 18:13
charts 71:11	collecting 9:22 18:14
chasing 30:19	collection 56:14,16
checking 33:18 34:13	Collegiate 40:18
checks 33:17	combination 107:18
chest 15:21	combinations 52:18
chief 31:6 34:3,10	combined 67:8
chiefs 75:8	come 10:11 34:2,4 45:2,8,15 46:2,9 47:5 48:18 51:8 54:3 55:2 65:16 66:5 71:10 73:23 81:5 83:11 86:23,23 91:8 92:6 96:25 98:22 104:20
child 31:12,13 89:11	comedic 90:24
childhood 38:6	comes 24:11 25:22 34:6 36:5 69:18 70:24 75:9 82:18 83:19 96:8 100:5
children 30:20,25 32:9 36:22	comfortable 100:25
chime 82:16	coming 8:4,16 11:13 12:10 16:19 31:6 33:11 35:12 37:2 53:22 82:24 98:2 106:15
choice 39:4	commenced 3:2
choose 76:7,8	comment 15:6 42:14,15,17,18 74:9 84:12 89:10 102:11
chooses 99:15	commentary 14:23
CHRISTIAN 110:3,13	comments 17:18 42:25 74:12
circle 84:4	commissioner 23:9 28:5 85:13 101:23
circling 33:14	committee 1:5 4:6,6 9:7 31:18 32:6,13 36:10 41:24 42:20 48:2 67:7,8,23 77:6,9,19,21 78:2,3 90:21 102:17 103:12
circumstances 94:3	committees 35:6
city 22:23 24:4 28:10 37:19 38:9,18 46:3,17 94:23 95:9 96:19,23	communicate 57:22
clarification 20:20 50:8 95:5	Communication 39:24
clarify 62:5 64:9	
clarifying 51:18	
clarity 63:4 91:3	
Clark 40:19	
clean-up 90:21	
cleaner 53:23	
clear 16:17 27:6 65:23 66:2 96:7,10	

communications 11:20	considering 15:21
community 32:12 43:10,12 105:8 107:24	consistency 10:8 16:6
company 40:21 87:20 88:3	consistent 15:22 58:17
compare 60:10	consisting 110:7
compared 39:2	constraints 92:3
compares 39:3	consultation 75:17
comparing 60:23,24,25	contact 11:22 84:22 87:20
compel 99:17	contacts 67:18
competing 75:6	contained 77:21
complainant 89:20	contains 63:8
complained 77:17	context 77:4,16
complaint 79:21 83:19,20	continue 8:19 10:13 18:13 20:15 21:11 47:16 57:11 61:14 78:16 88:20
complaints 83:10 86:23,23,25 87:2,3 89:15	continued 52:3
complete 55:19	continues 30:25 91:11
completed 49:2 55:19	continuing 8:11 55:16
completely 59:16	continuous 52:2 57:3
completeness 10:7	contributors 10:7
completion 31:11	control 11:22 15:12 52:20 62:5 62:14,18,22,25 63:2,3,6,7,11 63:13,15,18,22 64:10,14,20,23 64:24 65:3,6,10,25 66:3,14,22 67:15,17,18 68:23 69:15 70:19 71:5 72:17,21 73:3,6 77:10,11 77:15,22 80:16 91:7 92:13,17 92:19,22,23 93:6,12,25 94:9 94:13,19 95:6,8,16,25 96:4,19 96:23 107:18
compliance 83:17	controls 68:5
complying 92:22	convention 37:23
component 59:8	conversation 67:17 74:19 80:7 91:5 92:8 105:7
components 49:4,5 53:21 55:17 56:8,10 59:6,20	conversations 8:12 36:9 68:10 74:15 91:2,4,12 100:22 103:24
compressions 15:21	Conway 31:22
concept 48:16	cool 38:15
concern 64:8	Cooper 2:4 5:16,17 13:13,14 21:18,19 28:20,21,21 30:5,6 33:4 36:22 45:18 99:9,10 109:11
concerns 70:3	coordinate 72:16 73:6
conclude 57:5	coordinator 30:15
concluded 85:2 90:10	core 36:13
concludes 30:2	corner 37:16
conclusion 56:17	Corps 40:17,18
confer 58:16	correct 54:17 55:4,12 93:8
conference 37:24 39:7,10	correcting 15:25
confidential 100:23	corrective 90:15
confidentiality 100:19	correctly 15:13 54:12,16
configurations 54:11	
configured 54:12	
confirmation 50:13 51:25 58:21	
confirmed 49:24 52:8,10	
conflict 70:6,10,23	
conforming 62:12	
Congress 1:11	
conjunction 91:10	
consensus 92:11	
Conservation 11:24	
consider 105:23	
consideration 61:23	
considered 50:15,21	

correlates 98:25
cost 24:5 59:10
council 43:12 46:12 47:25
 102:13,23 103:3 105:8
counsel 65:19 89:9
counter 90:2
counties 34:20
county 72:20 73:11 86:5 89:4
couple 33:7 35:16,17 42:4 44:23
 59:13 80:8 104:19
course 30:8 60:14 89:21
court 82:21 85:8
cover 50:4 94:12
crazy 33:12 45:22
created 56:10
credential 62:25
credentialing 63:14 91:13 107:4
 107:8
credentials 92:25
crew 49:23 104:15
crews 101:11 104:3
criminality 108:5
critical 38:14 85:11 101:18
critically 107:8
curiosity 73:10
current 31:25 57:12 62:6
curriculum 12:17
Cushman 2:10 4:3,7,19,21 5:18
 5:19 13:15,16,16 15:3,6,9
 17:10,12,22,23,23 21:20,21,21
 28:22,23,23 37:18 38:13 45:20
 46:4 61:22
customer 87:19,23
cycle 24:4 26:16,18 33:13

D

D.O.H 48:18 82:3 101:25 102:3
Dailey 2:13 5:21 10:22 12:8,17
 29:3,4 74:10,12,13 75:22 76:2
 76:24 100:13 107:14
DANIELLE 110:3,13
dash 62:8 82:4
data 9:2,9,9,10,12,14,15,17,21
 10:5,7 18:14 21:12 35:11,25
 36:13 44:20 47:13 49:7,8,12
 49:15,18,19 50:22 51:2,7,9
 52:3,21 53:6,19,22 54:11,18
 54:20,22,24 55:6,8,11,13,19
 55:23 56:3,5,10,14,15,20 58:2
 58:3,7,18 63:5 64:14 67:14,20

67:22 69:6,15,18 72:24 73:2
 78:4 86:6 88:25 105:8,13
 106:5
dataset 35:21
date 1:7 65:11
DAVID 2:6,7
day 31:2 37:3 38:16 110:10
deadline 23:14
deal 32:8 85:15
dealing 91:23 106:14
December 14:25 23:20 26:8 32:3
 42:19,21 65:17 67:4 98:9
decentralized 72:17
decide 25:4,6 72:15
decided 9:8,13
decision 26:23 73:5
decreasing 105:19
deep 85:22 105:13
define 9:7,23,23 10:10 62:24
defined 95:20,23
defines 81:24
definitely 106:11,12
definitive 64:4
delay 105:21,22
delays 103:25 104:3 105:20
deletion 15:25
delighted 59:21,24
Delivery 40:15
demonstrate 85:4
demonstrating 100:23
demonstration 18:8,19 19:11
 20:16 47:22 48:5 57:5
densities 64:7
department 1:3 11:23 16:16
 19:13,18 23:10 24:5 31:25
 46:14 77:24 89:17 100:2,14
 101:22 102:16,22 103:17 105:9
 107:15
departments 31:16,20
depending 69:3,4
Der 31:17 32:16
derailed 57:25
describe 62:24
described 69:5 96:17,18
describes 82:7
design 63:17
designate 65:24
designed 11:23 43:21
designs 64:10
desirable 15:17

<p>destination 73:14 75:21 76:8,18 Destinations 43:24 detail 98:16 determination 89:24 determine 78:25 92:18 develop 48:19 56:22 developing 10:4 76:3 108:14 development 31:11 43:2 63:25 developmental 32:8 device 50:15 dial 76:5,22,22,23 dialogue 8:11 102:12 103:6,21 dials 75:24 didactic 31:10 49:4 difference 89:8 105:16,17 differences 52:4 different 20:18 46:8 56:5 64:19 64:21 65:5 66:11 77:16 83:9 85:13 86:24 87:6 91:7,8,9 95:3 98:18 103:25 106:22 108:20,20 differently 62:15 difficult 53:4,21 difficulties 48:11 difficulty 15:24 digging 85:22 diligence 30:9 dimensions 10:5 dinner 38:17,23 39:4 directed 63:13 direction 66:16 70:22 73:18 74:4,24 76:18 83:24 91:12 96:5 directly 98:25 104:13,20 director 8:14 30:12 32:10 46:24 65:4 71:10 76:20 77:7 103:15 directors 66:21 83:25 95:18 100:16 discloses 108:4 disclosures 59:19 Discontinuation 52:19 discrete 96:10 discuss 23:21 26:5 107:12 discussed 18:7 discusses 98:23 discussing 66:19 discussion 8:25 10:15 11:9,11 14:19,19 16:12 17:13 19:2 20:11,22 21:3,6 23:24 24:8 25:5,8 26:6,23 27:21 58:20</p>	<p>61:17 62:2,9,18 64:13,16 68:14 71:19 81:8 91:23 97:15 97:17 99:8 100:11 101:3,11 102:8 discussions 66:18 dispatch 51:11 disruptive 88:21 dissimilar 11:25 distance 4:10 64:4 distinct 48:9 distribution 16:16 district 34:3,9 disturbs 101:17 dive 80:20 105:13 doc 38:16,22 doctor 73:23 doctors 96:25 document 20:8 31:23 36:12 43:14 documentation 9:11 58:8,11 documented 50:11,12 54:2 64:25 documents 25:24 68:8 doing 7:15 30:19 33:6 34:18 44:10 46:10 48:9,13 51:22,23 57:17 58:11,13 60:2,6 74:18 84:14 91:16,17 96:9 101:19 108:7 dollar 59:14 dollars 34:19 Don 7:21 97:22 Donald 1:9 2:7 doors 91:24 Dorsett 2:12 3:23 9:3,6 32:5 36:15 40:7 Doug 27:15 DOUGLAS 2:8 downstate 46:6 Doynow 1:9 3:2,9,17,21,23 4:12 4:22 5:3,7,22,24,25 7:10,17 7:20 8:7,21 11:10,13 13:4,17 13:18,18 14:14,16 17:21 18:5 19:3,5,15,20 20:9,11 21:5,11 21:22,23 22:19 23:24 24:8 25:3,9,11,13,17 27:20 28:9,16 28:24,25 29:24 30:4,6 33:3 46:22 47:6 60:8 61:8 64:15 72:13 74:8 76:19 81:15 90:18 90:20,23 97:13,18,22 99:8 100:11 101:3 102:10 103:11 106:24 107:9 108:24 109:9 Dr 3:12,13,14,17,17,19,21,22,23</p>
--	--

4:2,6,9,14,19,21 5:2,5,9,11
 5:12,12,14,15,15,17,18,19,21
 5:24 6:2,2,4,5,6,7,7,9,10,10
 6:12,13,14,15,16,17,18,19,20
 6:21,22,25 7:4,11,12,15,18
 8:22,23 9:3,6 10:12,22,22
 11:14 12:5,8,10,12,17 13:9,10
 13:11,12,13,14,15,16,17,19,20
 13:21,22,23,24,25 14:2,3,4,5
 14:6,7,8,9,10,11,12,15,17
 15:3,6,8,9,14 17:9,10,11,12
 17:14,21,23,23 18:4,6,7,17,25
 19:2,4,5,7,10,17 20:2,10,12
 20:19,23,25 21:2,9,14,15,16
 21:17,18,19,20,21,22,24,25
 22:2,3,4,5,6,7,8,9,10,11,12
 22:13,14,15,16,17,20,21 23:25
 24:8,10,16,19,21,22,23 25:2,7
 25:10,12,15,18 26:5,14,24
 27:5,7,9,10,13,17,19 28:3,13
 28:14,15,17,18,19,20,21,22,23
 28:24 29:3,4,5,6,7,8,9,10,11
 29:12,13,14,15,16,17,18,19,20
 29:21,22,24 30:2,5,6,6 31:17
 31:22 32:5,5,15 33:3,5 36:15
 36:22 37:18 38:13 40:7 45:18
 45:19 46:4 47:2 60:9,9,16,21
 60:25 61:3,4,7,14,16,22 64:15
 64:17 67:2,25 68:12,16,18,19
 68:20,21 69:2,6 70:16,17,17
 72:6,6,9,12,14 73:9,9,13 74:7
 74:10,11,12,13 75:19,22,23
 76:2,24 77:3 78:19 79:3 80:6
 80:11,12,22,23 81:2,3,7,15,17
 82:12 83:13 84:16 85:16 86:20
 87:17 89:5,7,16 90:2,18,20,20
 90:24 92:15 93:2,3,8,13,15
 95:4,14 96:6,16,17,22 97:6,13
 97:16,19,23 98:4,7,8,12 99:2
 99:7,9,10 100:13 102:10,10,18
 103:14,23 105:4 106:11 107:2
 107:14 109:4,11

draft 43:11

drafting 43:9,10

dragging 79:6

dramatically 91:7

drive 42:16

driven 93:18

drop 105:22

dropped 105:22

drug 107:16,18 108:3,4

drug-using 107:23

drugs 108:16

Drupal 49:7,9 54:23 55:20

due 82:15 84:17 86:2 89:13,22

dynamic 65:5

E

E.D 53:11,12

E.M.S 9:15 32:12 36:22 39:24,25

40:3,4,18 42:2 44:5 46:17

47:25 62:7 63:20 66:15 72:3

91:14 94:11,12 101:5,10 103:2

103:17 104:2,12,15,19 105:8

105:12 107:11,21,24 108:8,11

E.M.S.C 30:5,14 32:13

E.M.T 16:3,3,4,24 20:6 74:22

E.M.T.s 49:3 56:17,24

E.P.C.R 54:10

E.R 73:23 106:15

E.R.s 104:16

E.S.O 36:11

earlier 47:19,23 58:20

early 107:6

easier 80:21

Eastern 33:8

easy 36:18 96:24

echo 100:14

edema 15:25

edits 24:6 26:7

education 7:21,24 34:23,25 35:3

38:8 42:8 44:15 79:24

educational 31:4 39:17 40:18

Educator 39:25

Edward 31:22

effect 15:17

effectiveness 58:3

efficiency 58:4

effort 31:18 32:8

egregious 85:11,15 86:9

eight 41:2 44:14 83:16 84:8

85:16 88:18

eighty 33:19

eighty-five 53:3

eighty-nine 52:19

eighty-six 52:8

eighty-three 52:9

Eisenhower 30:8

either 11:2 16:8 18:3 30:5

41:13,15,19 54:20 98:24

elaborate 23:6
elected 100:17
eleven 41:18 62:8 63:7
Elise 32:16
email 77:20 78:5 104:20
emails 87:21 88:4
Embassy 1:10
emergencies 106:15
emergency 1:4 31:16,20,25 32:9
emergent 26:19
empowering 88:19
encourage 41:18,21 45:15
end-tidal 51:19,21,25 59:7
endeavor 69:11
ended 48:24
endorsed 16:15
endotracheal 17:5
enforcement 107:20,22,25 108:5
 108:12
engage 62:2 68:3 103:20
engraved 41:15
engravings 41:13
ensure 57:24 63:8 68:3
ensuring 66:12
enthusiasm 103:2
entire 69:25
entities 58:17
entity 62:20 99:14
environment 11:19
Environmental 11:24
environments 12:21
epinephrine 15:19,20
equipment 42:13
equipped 16:9,25 57:2
especially 37:13 64:19 69:18
espouse 67:24
essentially 89:18
establish 62:24
established 9:3 99:20
et 52:18 53:5
EtCO2 51:16
evaluate 48:6
event 38:2
events 52:16,17
everybody 4:21 33:7,14,16 37:5
 37:12 41:18 42:6 47:14,16
 48:2 55:9 58:6 60:6 62:17
 68:2 93:23
everybody's 86:13
everyone's 28:7

everything's 64:24,25
evidence 108:3
exactly 24:15 76:2 105:14
exam 8:15 44:14
example 73:19 97:4
examples 68:15
Excellence 40:6,9
excellent 7:10 18:9 22:19 36:6
 37:20,21 40:12 61:9,12 64:18
 102:12
exception 32:12
exchange 95:11
excited 36:25 37:24 39:11,16
 42:9 43:18,22 44:21 45:3,4
exciting 44:8
excluded 50:24
excuse 50:2
executive 102:23,25
existing 21:9 24:6
expect 42:17 98:10
expectation 81:21
expectations 58:8 97:8,8
expected 82:9
expedited 85:12
expeditious 89:3
expirations 34:14
expired 33:15 53:10
explain 46:5 82:16
explains 98:18
exposure 107:25
extension 76:5
extensions 77:2
extent 94:24
extraordinary 74:16 76:22
extremely 75:8 95:8 104:5,10
extrication 64:5
eyes 35:22

F

F.D.N.Y 12:13
face 86:9
faced 53:20
facilitate 62:10 80:10 103:24
facilitated 103:17
facility 67:19 73:21 77:11
fact 31:11 75:5
failed 60:13
failure 50:15 53:2
fair 31:3
family 79:23

fantastic 52:11 53:17	focus 9:8,8 36:24 62:18
far 4:17 92:8,23	focused 86:18
fashion 75:4 80:4 86:19 89:3	focusing 60:17
fast 86:8	folks 32:24 53:25 70:10 74:23
favor 18:16 109:11	follow 21:8 26:20 55:18 95:2,19
feasibility 48:6 49:22	follow-up 98:6
February 42:21,21	followed 23:12,13
feedback 14:21,23 17:16	following 33:23 62:19 74:5
feel 33:5 34:9 38:5 44:17 45:11 78:23 82:15	footage 77:23 79:14
Fellow 35:11	forefront 66:9 86:21
fellows 44:19,19	foregoing 110:4,6
Ferries 40:16	forest 12:14
Ferry 40:16	Forestry 11:24
field 31:20 50:3,5 52:20 53:10 53:12 54:3,8 75:15,18	forgive 8:10 61:18
fifteen 46:14	form 18:12 61:24
fifty 37:8 105:22	formal 30:14
fifty-nine 50:21	forms 95:11 104:12
figure 36:17 49:16,18 54:23 87:6 94:20	forth 8:5 14:18 22:22 103:6
figuring 35:5	forthcoming 18:20
fill 87:4 94:3	forty 53:11 59:12
filled 37:6 41:11 95:11	forward 8:20 11:6 13:7 27:24 37:25 48:17 51:18 52:2 56:24 57:6,14,18 67:3 68:13 80:2 89:6 97:24 98:10 103:10 108:9
filling 104:3	forwarded 8:4
filming 31:6	found 39:2 56:4 58:25 59:24 84:14
final 22:22 42:22 48:21 51:21 83:3 89:24	Foundation 107:19
finally 32:4,4,5,17,17,18 48:19 57:8 58:16 59:17	four 34:19 44:13 50:17 76:25
finance 34:22 35:6	fourteen 82:4
find 39:18 84:24 90:16 91:15 93:9 104:12,22	fracture 16:7
finding 78:5	fragmented 65:8
findings 77:24 84:13,13	framework 61:11
Finger 3:15	frankly 75:7
fire 24:5 40:20 88:14	free 34:9 39:13 44:17 45:12 82:15
first 3:10 9:6 11:18 15:20 31:5 36:7 41:17 45:20 49:10,22 51:13 61:21 78:21,24 81:13 83:17 106:22	front 35:7 37:4 42:3 58:14
five 9:21,24 10:3,5 35:9 36:5 52:16 62:8 63:7 76:25 79:12 81:4,5	frontline 36:7
fix 10:11 56:14	fronts 43:15
fixed 15:15	fruitful 69:11
flag 3:5	fruition 47:5
flaw 99:14	full 33:13 91:6
floor 27:21	full-service 33:10 34:12
flow 54:18 56:10	fully 45:24
	fundamental 99:14
	funding 34:20 59:6
	further 20:16 23:21 25:8 43:15 51:2 62:19 63:4,22 98:16,18
	future 10:14 11:3 57:20 61:11 98:13

G	
games 38:5	goodwill 99:21
GANDOLFO 2:6	government 89:12
Gel 61:6	governor 43:19
gender 51:10	grant 99:3,12
general 78:15 88:25	granted 99:7
general's 79:10	grants 99:11
generally 23:11 76:8 100:16	grayer 66:23
generated 63:5	great 36:9 37:22 38:2 47:9
Genesee 35:12	52:12 56:23 69:17 79:4 97:4
geographically 64:3	108:21
getting 49:14,15 50:22 51:24	GREENBERG 2:15 7:15,18 12:5,12
54:25 55:4,8 56:6 62:10 82:10	20:19,25 25:2,15,18 33:5 47:2
86:5,6 87:25 88:5 107:3	60:16,25 61:4 64:17 67:25
Gina 17:25	68:16,19,21 72:6,12 73:9 74:7
give 4:24,24 9:4 34:9 39:16	74:11 75:19 78:19 80:6,12,23
45:24 47:10,24 65:14 69:9,9	81:3 82:12 84:16 86:20 89:5
71:20 79:11,17 89:19 95:25	93:2,13 96:16 97:6,23 98:7,12
108:22	99:7 103:23 106:11
given 15:16 32:11 65:7 66:13,15	Greenville 47:22
66:19 68:4,5 69:24 78:9 83:20	ground 43:21
108:6	group 4:20 10:16,23 11:16 31:23
gives 93:10	33:21 43:4,5 93:19 97:25
giving 68:15 71:5,14	103:22 107:5,17 108:10
go 7:18,21 12:15 15:2 25:25	groups 10:3 12:2 43:9
26:9 27:23,24 28:4 34:16	grow 90:16
38:22 39:18 42:16,19,22 44:16	growing 38:5
47:17 49:17,17,19 52:22 54:4	growth 91:14
59:12 65:14,20 74:17 77:15	guard 104:19
82:25 88:2,19 94:6 100:24	guess 21:13 25:7,15,17 42:18
101:14,14 102:21	61:18 95:14 104:15
goal 12:19	guidance 8:16 18:21 19:12 20:14
goals 80:14	20:17 21:9 63:20 66:16 67:10
God 3:7	68:7 97:20
goes 9:11 38:17,22 82:19,19	guidelines 11:6 13:7 15:23
85:12 91:14 98:16 107:24	guys 21:12 54:5 86:7
going 3:12 4:7,10 9:22 17:20	H
19:21 25:4,4,6,20 28:25 32:21	H.V 49:9,12
33:7 34:20 35:4,9 37:19,21,22	Halberstein 40:11
38:17 39:9,19 41:2,4 42:25	half 37:2 45:22
47:4 50:4 52:21 56:9 65:9	Hallinan 2:12 3:21,22 6:19,20
68:14 69:4,15,16,17 71:20,23	14:9,10 22:14,15 29:19,20
72:16 73:11,15 80:20 82:13,24	Haloperidol 15:16
92:8 94:22 95:2 97:9,9,10,11	handle 64:22
97:23 106:16 108:19	hands 39:4 84:15
Gomez 6:2	happen 69:12 108:2
good 4:5 6:25 7:6,22,23 14:19	happened 54:6 90:17 103:16
14:21 37:10 41:7 42:6 48:9	105:11
52:5 58:2,24	happening 40:14 42:5
	happens 66:15 68:24 94:3 107:12

happy 3:15 8:18,19 15:4,6 32:25
 34:4,4,10 35:3 47:10 59:21
 60:7 65:16,20 72:10 79:9
 103:23 104:14 105:2
hard 30:20 67:24 69:16,16
Harper's 40:16,16
Harriet 40:4
hate 102:7
havoc 101:13
Haz-Tac 12:13
headed 102:18
heads 67:13
health 1:3 9:25 39:8 40:4 62:7
 89:18 102:13,13,16,23 103:3
 103:17 105:7,9 107:16
Health's 16:16
Healthcare 40:22
hear 18:9 44:18,24 82:9 90:5
 98:5
heard 18:9 59:23 90:4
hearing 67:3 83:11 85:17 92:9
 92:10 106:7 110:8
help 8:18 34:7,8,10 35:6 59:25
 62:18 70:5,10 80:9 100:9
 103:15 105:23 108:21,25
helped 42:7
helpful 55:9 75:9 89:3 104:10
helping 8:19
hereof 110:6
hereto 110:5
hereunto 110:9
heterogeneity 69:14,21 70:14
hey 54:5
Hi 3:14,19,19,22
high 52:8
higher 12:25 15:11 50:6 52:10
higher-level 49:24 50:14 52:9
highlight 4:16
highly 75:16
HIPAA 78:4
history 69:20
hit 33:13
hole 100:21
Honest 19:22
honestly 19:23
honor 32:13
honorees 41:2
hope 8:18 91:21
hopefully 31:7 42:20 57:13
 90:19 107:9 108:22

hoping 62:2,5 91:4
hospital 50:8 52:25 56:19 65:9
 65:10 69:4,7,8 70:25 71:12,13
 71:20 72:2 73:11,15,24 74:4
 75:11,24 76:6 77:17 87:3
 101:16 105:11 106:16,17,20
hospitals 68:6,8 75:5,6,8,12
 76:10 95:16,25 101:7,12,18
 102:5,24
hosting 35:23
hours 101:12 105:25 106:19
house 108:2,3
Hudson 2:7 7:21,22 8:9 16:24
 18:13 47:24 60:5 99:2
huge 24:5 47:24 55:6 60:6
hundred 37:8 41:14 48:24 49:2
 50:18,20 52:14,15,16 53:2,9

I

i- 61:5
i-Gel 61:4
I.C.U 31:25
I.T 19:15
idea 14:24
ideas 53:7
identified 10:2 56:6 93:19
iGel 16:24 18:8,18,21 19:9,11
 19:13 20:15 47:7,21 48:7
 51:16,24 53:15 54:2,6,18 56:4
 56:15,18,22,25 58:23 59:2
ignoring 88:3
ill 76:18
ImageTrend 35:23 36:11
imagine 106:3
immediate 67:10
immediately 85:13 104:22
impacted 88:13
implement 26:12
implementation 10:21,24 62:21
implemented 10:20
implementing 63:3
implies 20:13
implore 63:22
imply 85:25
important 38:11 49:13 85:10
 107:8
improve 9:14,18 56:2 71:17
improved 52:15 56:3,5
improvement 9:25 70:23 71:6,24
 73:8 99:11

improving 88:21
inadvertent 15:25
incident 69:7
incidents 87:12,13
include 50:23 58:8 63:24 103:21
included 54:9 108:14
includes 43:21
including 37:2 38:8 39:11 57:15
 68:5 97:11
incorporate 94:15
incorporates 9:10
incorporating 17:16
increase 35:3 103:25
incredible 39:7,8 46:16
indication 49:10
indicators 54:4
individual 37:10 75:11 92:24
 93:3
individuals 13:2
indivisible 3:7
informatics 35:11 47:13 48:3
 49:8,12 55:7,11
information 4:5 36:2,8,21 43:4
 45:5 51:7,11 68:11 72:23 73:7
 75:9 78:8 84:20 90:13,14
 95:22 99:15,18,25 100:21
 102:15,16 104:4,6,9,18,22,25
initial 17:7 41:9 51:19 53:21
 92:2
initiation 16:14
innovation 40:11,14,15,19,20,21
input 83:22
inquire 77:18 107:4
insert 60:18,19 61:4,5
inserting 51:23,24
insertion 49:23 50:9
insertions 53:15
insist 99:13
inspection 34:2
inspections 33:10,19 34:13
instances 105:18
Institution 40:18
integration 10:15
integrity 9:2,10
intends 63:24
intent 9:9 91:22
inter- 73:20
interact 107:23
interest 10:24
interested 45:16

internal 89:22
interpret 92:9
interpretation 57:9 92:10
intravenous 16:8
investigate 77:25
investigating 84:12 85:21 88:7
investigation 67:21 77:5,19
 79:17,20 81:23 82:11,17,18
 84:25 85:23,25 89:2,19,22
 90:9,11,12
investigations 86:14
investigator 84:11,19
investigators 85:20
investigatory 100:20
involve 31:12
involved 58:6 60:7 68:2 99:22
involves 83:17
ipratropium 15:10
Isaacs 2:8 6:3,4 10:22 13:19,20
 13:20 21:24,25,25 23:25 24:9
 26:5 27:17 29:5,6,6 95:4
 96:17
Island 46:3
issue 19:19 70:4 73:8 78:18
 81:19 82:2 95:10 102:5 103:7
 103:10
issued 18:21 19:12,17
issues 10:20 11:20 23:4 24:3
 56:6,14 58:24 64:9 67:5 69:15
 71:21 72:5 100:24 102:24,25
item 14:19 83:14,15 101:4
items 8:12,25 61:22

J

Jagt 31:17 32:16
James 40:6
January 35:19
Jason 2:8,9 72:13 82:15 89:16
 106:25
JEFFERY 2:10
Jeremy 2:10 4:23
job 61:10 75:15
John 2:11 7:7
join 21:8 41:19,19,22
joined 45:21
joining 32:6
JONATHAN 2:11
judge 82:23 85:3,19
judged 38:25
jump 70:18

June 42:8 107:6
justice 3:8

K

K 32:15
KATHLEEN 2:12
keep 35:22 68:14 86:22 88:8
 92:8
kept 75:15
key 17:5
kind 12:4 23:16 43:15 45:5
 70:16 94:22
knew 48:16
know 11:8 12:9,13,16,22 15:2
 20:21 23:5,6,22 24:19 25:19
 25:19,21 26:2,4,6,8,11,11,24
 28:6 30:10,22,23 31:24 32:13
 34:6,23 36:7,15,15 37:9 38:7
 38:21 41:25 44:3,5,25 45:11
 45:13,25 46:11,19 47:18 57:25
 64:2 65:4,7,12,17,21 66:8,10
 66:17,24 67:4 68:22,25 69:6
 69:22,23 70:9 73:21 75:3,7
 81:4 82:12,22 83:2,4,6,7 84:5
 84:13,17,18,19,25 85:10,18,19
 86:12 87:4,9,10,15,23 88:2
 89:10,25 90:20,25 91:21,23
 92:24 93:15,16,17,18,21 94:2
 94:4,4,8,8,13,16,18,23 96:11
 96:16,22,25 97:2,6,12,24
 98:13,15,18,21 99:10,14,16,19
 99:20,23 100:4,7 101:5,24
 105:15,21 106:9 107:2
knowing 45:25 64:19
known 38:5 64:7
knows 97:5
Kroll 2:15 7:5,6 34:21 35:4
 43:17 102:10 103:14 105:4
Kugler 2:6 6:5,6 7:11 13:21,22
 13:22 22:2,3 24:10,19,22
 26:25 29:7,8 61:14,16 64:15
 67:2 68:12,18,20 77:3 79:3
 80:11,22 81:2,7,16,17 83:13
 85:16 87:17 90:2,19 97:13,16
 97:19 98:4,8
Kugler's 69:6
Kyle 39:24

L

laid 37:23

Lake 3:19,20
Lakes 3:15 60:10
language 15:21
large 73:20
larger 62:17 91:5 94:11,11
Lastly 63:19
late 23:13
law 10:17 62:7 82:22 85:3 91:17
 91:18 107:20,22,25 108:5,11
leaders 62:3 63:20
leadership 32:15 39:13 40:5
 47:25 99:4
leading 31:18 32:7
learn 40:13 90:16
learned 39:6
leave 101:20 107:11,19 108:6,15
left 34:7
legal 65:18,19 80:20 84:23 87:5
 99:5
legislation 10:18
length 105:19
let's 61:14 79:4 80:7,13 87:17
 87:18
letters 77:14
letting 32:13
level 12:25 13:2,3 20:4,6 50:6
 51:5 52:10 54:14,15 82:7
 83:15 90:11 108:5
levels 15:9 74:22
liberty 3:8
life 41:16 83:18,21
LIFEPAK 59:12
limited 94:8
line 77:2
lines 68:25 69:8
link 72:11 109:4
listen 77:9 79:17
listened 79:13
literally 42:12
litigate 70:11
little 10:17 12:7 33:20 37:14
 43:17 48:18 58:14 62:19 66:2
 66:23 71:25 73:25 102:14
 106:21
lived 46:3
lively 8:24
lives 18:15 88:11 108:22
local 34:9 89:2 108:15
locally 63:25 64:8 85:22 101:25
located 13:2

LOCATION 1:10
log 42:10 44:15 64:25
long 46:3 73:16 74:5 84:8,17
 85:17 100:24 104:8
longer 37:14
look 31:23 36:13,16,18,21 37:9
 51:2,20 52:4,5 54:5 58:17
 62:17 64:19 67:3 80:2 85:8
 87:10 89:5 94:6 100:3 101:23
 102:4 106:23
looked 49:21 50:10,19 76:13
 104:18
looking 4:12 26:11 31:24 35:24
 36:20 57:20 58:21 64:18 80:24
 104:25 106:10
looks 10:4 42:2
loss 105:22
lost 103:5
lot 4:14 10:20 33:11,15 37:22
 38:7 39:18,19 42:5 45:9,23
 46:5 56:5 69:19 82:25 109:2
lots 9:17 42:14
loud 28:16,17
love 4:15 82:13
lower 59:10

M

M.T 15:10
Maia 2:12 32:5 40:7
main 99:20
maintain 56:25
maintained 75:10
maintaining 100:19
maintenance 49:23
majority 17:12 73:14
making 30:9 33:22 70:13,14,20
 72:3 81:21 100:25
malfeasance 88:20
management 16:22 48:10
manager 84:2
managers 84:3
mandated 57:4
manner 81:24,24
mapping 55:12
Marianne 7:3
mark 7:2 40:5 51:12
marked 15:22
Markowitz 6:7
mask 58:24 59:4
match 52:3

material 85:20
materials 23:9
Maxwell 39:24
McEvoy 2:13 7:3,4 75:23 89:7
mean 26:22 45:13 59:11 63:11
 69:13,22 75:2 103:15 105:20
meaning 65:7 84:25
means 32:22 45:11 97:4
meant 53:23 56:7
measurable 57:21
measures 36:14 90:15
med 8:22,24 11:7 14:20 15:12
 17:17 22:22,25 27:10 47:14,19
 58:20 91:10
median 51:12,14
medians 51:9 52:4
medic 22:24 27:11,18 28:10
medical 1:4 11:22 30:3 32:9
 43:21,22 46:24 48:2 62:4,14
 62:18,21,25 63:2,3,5,6,11,13
 63:15,18,22 64:10,14,20,22,24
 65:3,3,6,10,24 66:3,14,20,21
 67:15,17,18 68:5,23 69:14
 70:19,21 71:5,10 72:16,21
 73:3,6,17 74:4,23,23 76:15,18
 76:20 77:7,10,11,15,22 80:16
 83:24,25 91:6,12 92:12,12,17
 92:19,21,23 93:6,11,25 94:9
 94:13,19 95:6,8,16,18,25 96:4
 96:4,18,23 100:16
medications 34:14
medicine 44:9
medics 12:3,3
meet 45:21 94:14 96:15,21 97:10
 99:4
meeting 1:1,5 2:1 3:1,2 4:1,4
 5:1 6:1 7:1,25 8:1,2 9:1,7
 10:1 11:1,2 12:1 13:1 14:1,25
 15:1 16:1 17:1,20,24,24 18:1
 19:1 20:1 21:1 22:1 23:1,8
 24:1,17 25:1 26:1 27:1 28:1,2
 29:1 30:1,7,17 31:1,8 32:1
 33:1 34:1 35:1 36:1,19 37:1
 38:1 39:1 40:1 41:1 42:1,21
 43:1 44:1 45:1 46:1 47:1 48:1
 49:1 50:1 51:1 52:1 53:1 54:1
 55:1 56:1 57:1 58:1 59:1 60:1
 61:1 62:1 63:1 64:1 65:1,17
 66:1 67:1 68:1 69:1 70:1 71:1
 72:1 73:1 74:1 75:1 76:1 77:1

78:1 79:1,7 80:1,13 81:1 82:1
 83:1 84:1 85:1 86:1 87:1 88:1
 89:1 90:1 91:1 92:1 93:1 94:1
 95:1 96:1,2 97:1 98:1,9 99:1
 99:3 100:1 101:1 102:1 103:1
 104:1 105:1 106:1 107:1,5,12
 108:1 109:1,10,12 110:1
meetings 107:6
Mel 46:9
member 3:24 70:3 78:3 90:21
 102:11
members 3:11 4:17 32:11 41:24
 81:18 100:15 103:12 107:10
memorial 40:25 41:5,6,9,9 42:2
mention 8:14
mentioned 81:9
Mentor 40:19
merry-go-round 84:5
met 7:24 8:24 92:18 94:17 106:5
methods 61:12
metrics 32:8
mic 25:16
Michael 2:13,13 40:9
Microphone 25:2 28:15
mid-May 107:6
middle 38:16 41:16
Mike 7:3 74:8 76:22 100:12
 107:13 108:24
mileage 64:6
million 34:19,25 35:2
mind 7:15 68:19 86:8
minimal 83:22
minimum 93:22,23,24
minimums 93:20
minor 35:19
minutes 7:11 51:14 79:12 81:10
misinterpreting 92:13
mitigated 86:19
mixed 15:10
model 69:5 75:20
Monday 30:7 32:14
money 59:6 88:4
monitoring 17:7
monitors 59:14
month 79:11 80:4
months 16:19 35:18 44:23 82:23
 83:16 84:8 85:17 88:18
Moore 40:6
morning 6:25 7:6,23 8:24 17:17
 47:11 48:23

motion 8:4 11:5,8 13:6 14:13
 18:18,23,24 19:8,10 22:18,22
 24:12,13,14,24 25:19 27:3,6,7
 27:13,15,16,18,19,21,25 28:9
 28:10 29:23 97:14,20 98:11
 102:3,9,20 109:10
motion-making 102:11
move 13:6 30:5 37:25 48:17
 51:18 56:23 57:11,14 61:14
 85:8,9 86:8 87:8,8 98:10
 101:17 103:9
moved 54:8 57:18 107:20
movement 55:8 101:25
moving 46:23 52:2 57:6 84:18
 85:7
multifaceted 106:21
multiple 44:7 80:21
Murphy 2:14 5:2,5 6:8,9 13:23
 13:24,24 18:25 22:4,5,5 29:9
 29:10,10
museum 38:3,4
mutual 97:7 101:14,15

N

N.Y 1:1 2:1 3:1 4:1 5:1 6:1 7:1
 8:1 9:1 10:1 11:1 12:1 13:1
 14:1 15:1 16:1 17:1 18:1 19:1
 20:1 21:1 22:1 23:1 24:1 25:1
 26:1 27:1 28:1 29:1 30:1 31:1
 32:1 33:1 34:1 35:1 36:1 37:1
 38:1 39:1 40:1 41:1 42:1 43:1
 44:1 45:1 46:1 47:1 48:1 49:1
 50:1 51:1 52:1 53:1 54:1 55:1
 56:1 57:1 58:1 59:1 60:1 61:1
 62:1 63:1 64:1 65:1 66:1 67:1
 68:1 69:1 70:1 71:1 72:1 73:1
 74:1 75:1 76:1 77:1 78:1 79:1
 80:1 81:1 82:1 83:1 84:1 85:1
 86:1 87:1 88:1 89:1 90:1 91:1
 92:1 93:1 94:1 95:1 96:1 97:1
 98:1 99:1 100:1 101:1 102:1
 103:1 104:1 105:1 106:1 107:1
 108:1 109:1 110:1
Naloxone 107:20 108:7,13,25
name 110:10
names 41:14,14
narcotics 34:5
narrative 54:2,7
Nassau 72:8 73:5 86:5 89:4
 90:22

Nathan 39:23
nation 3:7 57:15
national 20:7 57:11,12 107:18
nationally 37:9
nature 34:16 45:7 66:6 68:10 81:6
nausea 52:18
NAVEEN 2:14
near 10:14 11:3 39:3 107:3
nearing 31:11
necessarily 20:4
necessary 75:13 100:9
necessities 91:9
need 13:8 19:6 21:13 23:18 25:3 25:6,16 26:7,19 28:4,11 33:23 67:5 71:6 84:14 86:16 88:8,8 88:13,16 93:16 94:18 96:10 100:19 107:7,7
needed 79:2 80:8
needing 33:20
needs 18:11,11,23 24:14 25:13 62:15 70:22,25 73:21 83:10 89:13 91:7 94:14,17
negligence 89:9
neighborhood 76:14
NEMSIS 35:8,23 54:11
net 60:3
never 46:19 69:7 71:13,19 74:16 89:19
new 1:2,12 3:11 4:13 11:21 20:3 21:7 22:23,25 23:14 28:10 35:10,11 37:13 39:11 41:9 42:2,12 44:19 46:17,24 53:16 60:14 61:14,20 64:2 82:5 94:23 95:9 96:19,23,25 106:4 110:2
newer 106:14
nice 3:3 43:24 92:3
night 38:2 104:21
nine 72:21 95:6
nineteen 50:18
ninety 93:24
ninety-five 35:14
ninety-four 52:7
ninety-six 52:11
nitroglycerin 16:2
nod 67:13
nope 41:8
normal 12:16 26:2
normally 12:24 98:16

Northwell 40:4
note 50:3 89:7
Noted 7:13
notes 61:19
notification 67:19 83:8
notifications 87:7
November 42:19,19
now's 92:14
nuanced 73:25
number 3:11 4:23 8:25 36:25 37:10 75:24 76:4,17 79:6 81:16 103:7,8 105:18,21
numbers 52:11
Nurse 40:6

O

O 44:14
o'clock 104:21
O'Connor 6:24,25
O.B 37:3
O.P.M.C 89:12,14
O'CONNOR 2:3
objectives 57:21
obtain 88:25
obtaining 78:22
obviously 23:12
occasion 99:23
occasionally 70:9
occur 26:3,7,13 28:8 87:13,16
occurred 52:24 53:2,11 102:2
occurring 67:21
October 36:19 110:10
offering 37:19
office 79:10 107:16,18
officer 34:5
officers 108:6
official 3:24
offload 103:25 104:3
offloaded 104:8
oh 27:3 41:7 54:7
Okay 3:9 5:9 6:23 7:13 8:9,22 12:12 13:6 14:14 18:5 21:13 25:10,12 29:24 30:4 33:4 46:23 47:7,9 61:3,13 80:11 81:15 90:23 93:12 97:18,22 101:4 103:12 107:10 109:2,7
Olanzapine 15:13
old 8:25 21:8 31:24 61:13
Olson 6:10
once 43:14 80:24 82:18 84:5

one's 71:23
one-page 36:12
one-person 103:22
onerous 59:8
ones 43:10 49:17 53:5,14 93:18 105:20
ongoing 17:7 53:11 79:8,19,25 86:14
online 41:19 42:10 62:4,14,21 63:6,11,13,18 70:19 71:5 93:11 95:6,8,15,25 96:4
onus 66:22
open 8:11,12 16:7 17:18 35:22 79:20 83:11 84:9
operational 94:14
operations 33:8 39:12 104:24
opportunities 38:8 39:17 94:5 96:20 108:20
opportunity 15:13 23:21 26:4,9 37:20,22 39:16 40:12 45:14,21 46:8 62:16 81:12 84:21 86:22 87:5,10 93:14 94:7 107:23 108:6,21
option 15:12 16:2
oral 16:8
order 7:16,19 24:11 42:22 52:20 88:16 93:6 94:13
orders 70:25
org 47:2
Organizational 40:20
original 8:15 27:2
originally 43:20
Orin 6:23
outcome 83:3
outcomes 49:22 52:13 53:9 60:12 68:6 83:4
outlines 97:7
outside 74:2,4
outstanding 24:13 46:10 67:11 83:15 86:5,16
overall 56:5,15 92:17
Overdose 107:17
overnights 12:23
overseeing 30:13
overseen 82:22
oversight 57:3 62:21 63:12 92:12
ownership 69:18
owns 63:5 64:14
oxygen 16:22 34:14

oxygenation 48:10

P

P.C.R 53:7 54:4 77:7 104:7,7
P.C.R.s 56:6
p.m 1:8 109:12
pack 16:6
packet 25:24
page 104:12 110:5
pages 110:7
paid 34:25 35:2
palms 16:5
PAMELA 2:14
pandemic 48:17
paperwork 33:24
paramedic 8:14 74:21 75:23 94:18 105:24
paramedicine 43:11,12
parameters 50:5 100:8
part 3:16 19:22 25:21 33:16,19 39:9 41:24 45:15 46:11,12 47:23 66:12,16,18 82:14 84:17 85:10 93:4 96:17 100:19 106:4
partial 106:12
participants 57:23 99:21
participate 21:2 63:8 68:23 71:6,24 72:2 95:12,21
participating 58:17
participation 97:12
particular 12:20,25 59:19 62:22 83:13 88:19 97:20 99:24 105:18 108:11
particularly 33:21,24 76:17 86:22 93:18 107:15
parties 103:18
partner 92:7 102:22,22 108:12
partnership 43:3
parts 11:21 64:19
party 79:16 99:24
pass 36:7
passed 43:15 85:2
passes 14:13 22:18 29:23 81:19
Pataki 31:6
patency 17:8
pathway 83:7,9,12 85:14
pathways 66:11 95:3
patient 9:24 15:11 17:2 38:15 48:8 50:7 51:11,13 52:14 56:18 67:12 68:4,6 78:17 82:2 83:18,19 88:12,21 106:18

<p>patient's 79:22 patients 9:18 12:23 15:20 38:14 60:3 76:17,18 patients' 88:11 pause 90:25 pediatric 15:18,19 31:4,19 pediatrics 32:20 36:24 peds 37:3,6 peers 100:17 people 11:16 20:15 23:21 42:11 46:18 59:11 64:22,22 76:4 80:19 85:25 89:14 101:17 108:16,21,22 percent 35:14 52:7,8,9,11 76:15 93:24 94:2 105:22 perform 51:19 78:17 performance 43:6,7,8 period 48:21 permanent 47:3 permitting 96:20 person 34:7 41:20 51:4 76:16 77:25 79:21 person's 51:7 personal 105:13 personnel 16:9 Peters 39:23 Philippi 7:2 40:5 phone 34:4,10 65:4 69:8 76:4,10 76:21 104:23 phones 76:16 physician 40:7 67:18 74:19 75:17 76:10 78:2 physicians 33:22 45:20 63:15 65:25 76:12,25 93:7 95:16,24 100:18 picture 9:19 41:4 piece 55:11 pillars 9:21,24 10:3 pilot 47:21 48:19 61:10,11 pissed 106:2 place 4:2 17:5 43:14,23 57:6 65:8 72:23 81:7 110:5 placed 23:10 placement 16:6,25 52:8 places 51:22 placing 20:2 plain 64:6 plan 16:16 92:17,18,23 planning 39:6 41:24 102:13,17 103:3 105:7</p>	<p>play 38:3 89:22 92:2,12 playing 90:25 Plaza 41:18 pleasant 3:3 please 25:2 30:21 32:23,23 36:20 44:16,17 45:9 47:17 48:13 50:16 68:20 77:24 86:17 pleasure 47:15 Pledge 3:4,5 point 5:23 18:10 19:21 20:19 34:25 35:9 36:5 48:17 49:10 65:22 69:6,23 73:14 79:5 85:7 87:6,25 102:7,8 pointing 65:20 70:13 points 17:5 98:23,24 police 77:23 79:14 policies 95:20 policy 8:13 18:12,20 19:12 21:8 42:10,12 44:11,20 56:22 57:6 62:7,23 63:7,16 70:19 71:4 72:7,18 82:4 93:5 95:20,24 98:17,23 107:19 politically 85:23 pool 76:11 population 64:6 portable 81:8 Portoro 7:3 position 45:13 46:25 47:3 48:22 positions 45:2,9 positive 55:17 60:3 68:9 possible 41:25 57:18 possibly 26:8 78:21 84:23 94:8 post 80:17 87:11 posted 30:15 44:16 45:2,9 47:5 48:20 62:23 87:14 poster 104:13 posting 45:10 potential 108:17 potentially 31:12,14 88:12 PowerPoint 31:10 practical 8:15 44:14 49:4 practice 20:7 57:10,12 91:20 practices 10:21 11:4 23:17 pre-con 37:3,3 39:13 pre-conference 32:19 pre-hospital 9:16 precedents 48:12 precipitated 90:10 prehospital 16:14 presence 50:11</p>
--	---

present 7:6,8 81:13
presentation 47:10 61:9
presented 14:24 39:21 102:15,16
presenting 78:5
pressing 67:6
presume 32:22
pretty 12:15 41:7
previous 8:12
previously 56:9
Prezzano 40:10
primarily 31:19
primary 49:21
prior 23:8 74:13
prioritized 82:24
privileges 92:21
pro 49:4
probably 16:21 38:12,14 43:17
 46:18,19 53:20 61:11 69:10,11
 82:12 84:19 101:6 106:21
problem 7:20 9:24 10:10 55:3
 85:21 96:24 99:19 100:5,20
 101:24 103:4
problems 98:14
procedure 51:20
procedures 72:24
proceedings 110:8
process 10:4 23:4,7,11 26:21
 28:5,7 33:17 34:11 42:8 43:11
 49:2 51:5 55:16 58:21 66:16
 67:15 71:7,15 82:15,15,20,20
 84:17,25 85:12,12 87:7 89:13
 89:23 94:21 95:12 99:11
 100:20 101:2
processes 26:2 49:18 68:24
product 16:15
products 16:15 59:20
professional 40:6 89:9
profile 15:17
program 4:13 20:21 30:9,13,14
 30:20 31:2,4,10 36:3,6 40:23
 56:4 58:5,10,15,19 67:9 77:6
 108:10,15
programs 32:19
progress 85:5 100:23 105:23
project 16:24 18:8,10,19 19:11
 20:16 47:16 48:6,15 56:15
 57:5,23 58:19 61:10
project's 57:24
projector 19:16
projects 57:20 61:12

promise 45:18
promised 31:7
promotion 30:11
promulgate 77:19
promulgated 63:23 65:11 86:2
 107:15
proposal 98:11
propose 62:19
protected 78:4,6
Protection 11:24
Protective 89:11
protocol 11:15 12:20 19:22,23
 20:3,6 22:24 23:19 27:23
 61:17
protocols 4:5 11:7,17,23 12:2
 14:18 16:7,18 17:19 24:6,7
 26:16 27:11,18,23 28:11 46:6
 94:25
proud 60:2
provide 32:14 63:2,15 65:21
 66:21 77:3 79:18,20,22,23,24
 90:14 92:19,21 93:6 96:3 97:9
 97:11 99:15 104:14,17
provided 14:21 17:16 43:5 62:22
 66:13 79:21 84:3 99:18
provider 39:22,23 40:10 44:13
 49:24 50:11,14,25 51:3,4,5
 52:6,9,10 66:15 67:17 74:17
 75:18 77:10 82:2 83:6,7,21
 88:10 92:24 93:3 107:21
providers 17:5 31:20,21 50:6
 51:19 55:10 57:16 58:25 59:7
 59:23 60:11,11,18,19 62:11
 63:15 74:16 75:14,15 87:2
 104:19 105:12
providers' 61:2,5
provides 73:20
providing 16:6 36:11 61:25
 71:18 81:3 104:4
provision 63:12
provoke 83:14
prudent 98:5
public 9:25 25:25 42:14,14,17
 42:18,25 62:7 81:10 86:13
 91:22 102:12,13 103:2 105:7
pull 61:19 104:7
pulmonary 15:25
purpose 9:6,13
purposeful 90:24
purposes 9:21 70:23

push 67:6 79:10
pushed 82:11 108:9
pushes 67:24
pushing 88:8
put 11:11 18:11 19:3,24 42:12
 76:11 79:5 86:17 91:19 109:4

Q

Q.A 33:17 67:22 77:5,18,20 78:2
 78:3 95:12,21
Q.A.'ing 71:11
Q.I 33:17 67:22 71:7 73:4,7
 77:6,18,21 78:2,3 95:12
Q.R 104:13
qualifications 92:19
quality 9:9,10,11,14,25 10:5,7
 32:8 36:10,14 40:9 43:10 63:6
 63:9 64:9 66:10,10,13,19 67:5
 67:7,21,23 68:2,24 70:4,22
 71:6,17,24 73:8 77:8 78:4,7
 78:17 81:19 82:4,7,11 86:2,6
 87:18 88:10,21 91:12 97:12
 99:11
quarterly 55:22
querying 83:23
question 24:10 25:9,22 26:15,25
 27:2,4 34:2 45:11 46:23 60:20
 62:19 64:16,18 66:4,12,14
 67:7 68:17 69:24 70:5,10,24
 81:13,18 82:8 83:14 91:16
 106:13
questions 8:19,22 12:6 13:6
 17:19,21 18:5 20:9 21:7 23:4
 33:2,3 45:10 46:22 47:7,18
 60:7,8 61:8,24 65:13,16 71:10
 71:11 73:25 77:4 80:3,14,15
 80:21 98:3 99:12
quick 24:10 65:15 93:9
quickly 15:4 47:17 85:9
quite 32:4 73:4 75:7 79:8 84:8
 107:5
quorum 3:12 7:9

R

Rabrich 2:10 6:11,12 8:22,23
 10:12 11:14 12:10 13:25 14:2
 14:2,15,17 15:8,14 17:9,11,14
 18:4,6,7,17 19:2,4,5,7,10,17
 20:2,10,12,23 21:2,9 22:6,7,7
 22:20,21 24:16,21,23 25:7,10

25:12 26:14 27:7,10 28:3,15
 29:11,12,12,25 30:2 92:15
radar 86:17
raised 108:4
Ram's 46:9
ranger 11:6 13:7
rangers 11:18,25 12:8,15
rate 37:7
re-ordering 15:18
reach 10:25 45:12 55:21
reached 77:6 90:3,7
reaching 54:20
read 72:19 81:10
readiness 37:6
reading 83:5
ready 7:14 14:24 30:20,25 33:4
real 93:9
reality 87:9
realize 60:14
realized 49:14
really 4:2 9:9,15 12:20 23:16
 26:22 30:19 34:18 35:9 36:12
 36:22 37:10,19,23 38:7,15
 39:7,10 40:13 42:6,9,15 44:3
 44:4 46:4 47:23 48:9 59:8,9
 59:25 60:17 68:13 69:16 74:25
 75:2 96:17 97:7 100:8 102:12
 105:6 109:2
reason 26:16 68:12 82:14 88:7
 92:6
reasonable 81:20
reasons 26:17 48:9 51:3 52:19
 53:2 55:4 99:24
received 14:23 25:23,23 30:10
 77:5,14 78:9 83:22
receiving 67:18 77:11 78:7
 90:13
recognize 108:2
recognizing 94:9
recommend 58:13 101:22
recommendation 63:21 82:19
recommendations 9:14 23:19
 56:21 57:19
recommended 63:23
record 67:16 71:2 72:22 74:11
 74:13 110:7
recorded 52:7,21 53:7,13 64:24
 67:20 69:9 70:22 71:3 74:14
 76:21,25 93:25
recording 69:9 75:12,17 76:3

79:12	released 8:15 35:10 39:14 42:9
recordings 71:13,21,22 75:10,16	relevant 57:22
95:12	reliable 58:18
records 71:8 78:15	relies 99:21
Recruitment 40:21	relive 38:6
recurring 100:4	REMAC 16:15 24:2 62:24 63:8
reduced 48:11	66:12,22 67:8 72:15 73:5,5,7
redundant 75:12	83:5,11 84:23 87:18 92:11
referred 102:17	93:10 95:15 96:3,9 99:4,17
reflected 15:19	100:8
reflecting 74:14	REMACs 65:24 87:2 99:11
refused 77:12	remain 84:9 95:2
regarding 10:21 11:6 15:21	remains 79:20
17:19 18:21 19:13 22:23 62:4	remediation 79:24
regardless 89:20	remedy 79:21,22,23
regards 33:8 63:19 82:10 83:2	remind 8:5,5 11:15 32:18
region 3:15 46:9 53:15 60:5	reminder 33:15,18,25 34:13 36:5
62:10,15,22 63:24 64:7,21,21	44:2 98:15
67:14 68:22 70:4,17 71:9	reminds 38:4
72:10,15 73:10 74:9 75:5,10	remote 12:21
76:5 77:4 78:3,6,11,16 81:19	remove 15:16 92:21 96:3
81:21 83:2,4,20 88:11 89:4	removed 92:25
90:16,22 92:16,18,20 93:4	REMSCO 49:9,12 60:9 67:8 78:13
95:7,13,19 100:15	83:6 99:4
region's 62:14 67:7	REMSCOs 87:3
regional 47:25 54:20 55:2 57:2	renewing 103:6
62:4,10 63:9 84:11 87:18	repetitive 34:16
88:21 92:22 106:6,12	report 9:2 30:3 36:23 46:21
regionally 17:3 100:16	50:25 55:21
regions 11:4 46:8 49:17 54:21	reported 49:23 52:6 105:12
56:7 58:5 64:23 65:5,8 82:2	110:4
83:5 95:15 100:25 104:2 106:8	Reporter 109:6,8 110:13
106:13 108:17,19	reporting 48:21,22
regions' 68:22	reports 49:8,14 55:13,23 104:10
registered 40:5	repository 50:22 54:20,21 55:14
regs 31:25 42:8,13 93:16	72:24
regular 10:19 26:16	representative 103:20
regularly 58:16 107:5	Representatives 102:14
regulation 44:15 63:16 98:16,24	representing 101:9
regulations 10:19 42:22,23,24	republic 3:6
43:2 62:6,12,23 63:23 65:11	request 24:2 77:5,9,20 81:21,22
78:6 86:3,10 93:17	84:10 88:3 99:4
regulatory 42:5 66:5 88:6	requested 77:8,12
reimbursement 10:2	require 32:2 71:3
reinforces 16:14	required 71:8 74:14
reiterate 81:9	requirement 70:20
related 8:5,14 32:20 35:25	requirements 70:20 71:4 93:5
44:12 48:10 52:17 58:24 59:5	requires 72:21
65:12 68:8 80:16,23 102:24,25	rescue 12:3 22:24 27:11,18
release 35:20 43:19 71:7	28:10 39:12

research 9:25
resolve 70:6,10 102:5
resolved 88:9 90:19
resolving 100:24
resource 36:6
resources 64:3 88:24 108:16
respectfully 23:25 91:9
respond 37:11 89:14
responder 11:18
response 37:7 52:14 83:18
 107:17
responsibility 96:14
responsible 62:20 63:14,17
 92:16
rest 18:14
restate 19:6
restrictions 82:3
restructuring 45:5 47:4
results 98:9
resuscitation 53:11
Retention 40:21
retrieving 71:22
return 88:5
returning 100:21
review 23:11,21 103:8
reviewed 23:9 77:21,22 85:20
revised 70:18
revising 17:4
revisions 35:20
ride 38:12
ridealongs 38:12
Riegert 2:8 89:16,17
right 5:3 8:23 18:4,22 19:2
 20:8,21 21:3,12 24:25 26:15
 26:17 27:15,20 33:7 37:16
 39:3 43:2,9,13 58:23 61:18
 64:17,18 70:24 71:8,16 72:9
 86:24 88:17 92:16,17 93:11
 95:15,18 96:17 105:5,25
rigs 101:13
road 35:17
roadblocks 35:16
Robert 32:15
Robert's 24:11
Rochester 32:16 38:3,9 39:5,9
rock 4:4
role 92:12
roll 13:8 21:3,5,13 25:14 28:11
 58:10
rollout 58:10

rollouts 58:9
room 4:15 12:9 16:4 32:23 68:21
rooms 104:15
ROSC 53:2,11,12
round 40:23
Route 95:6
row 44:7
Rugge 102:18
rules 24:11 74:6
run 15:3 64:21 68:23
Ryan 2:15 30:13 32:10 33:4
 46:22,23 106:24

S

S.G.A 56:18
Safe 95:6
safety 49:21
Saratoga 1:1,12 2:1 3:1 4:1 5:1
 6:1 7:1 8:1 9:1 10:1 11:1
 12:1 13:1 14:1 15:1 16:1 17:1
 18:1 19:1 20:1 21:1 22:1 23:1
 24:1 25:1 26:1 27:1 28:1 29:1
 30:1 31:1 32:1 33:1 34:1 35:1
 36:1 37:1 38:1 39:1 40:1 41:1
 42:1 43:1 44:1 45:1 46:1 47:1
 48:1 49:1 50:1 51:1 52:1 53:1
 54:1 55:1 56:1 57:1 58:1 59:1
 60:1 61:1 62:1 63:1 64:1 65:1
 66:1 67:1 68:1 69:1 70:1 71:1
 72:1 73:1 74:1 75:1 76:1 77:1
 78:1 79:1 80:1 81:1 82:1 83:1
 84:1 85:1 86:1 87:1 88:1 89:1
 90:1 91:1 92:1 93:1 94:1 95:1
 96:1 97:1 98:1 99:1 100:1
 101:1 102:1 103:1 104:1 105:1
 106:1 107:1 108:1 109:1 110:1
Saturday 38:2
save 108:22
saw 5:5 38:14,14 55:14 105:14
 105:15 106:22
saying 77:14 87:21 93:21 100:14
says 38:20 93:16,23 95:21 98:17
scenarios 31:12,15
scope 11:17 20:7 57:10,12 62:17
Scott 40:19
screen 41:7
seal 48:11 58:25 59:2,4
seats 39:15
second 7:12 18:23 24:14 27:19
 31:7 41:5 49:11,24 52:24

109:11
seconded 11:5,8 18:24,25 22:22
 24:12,13,23 27:7
SECRETARY 5:9,12,15,18,21,24
 6:2,5,7,10,13,15,17,19,21,23
 7:2,5,7,9 11:12 13:9,11,13,15
 13:17,19,21,23,25 14:3,5,7,9
 14:11,13 18:16 19:8 21:14,16
 21:18,20,22,24 22:2,4,6,8,10
 22:12,14,16,18 28:13,18,20,22
 28:24 29:3,5,7,9,11,13,15,17
 29:19,21,23
secretions 53:4
section 81:8 82:5,6
sedation 31:19
see 12:24 18:2 32:2 35:3,12
 38:9 41:7,12 42:17 44:9 45:9
 45:10 46:9 47:5,11 54:7 55:2
 55:20 70:8 79:7 80:18 82:21
 84:6 86:7,15 87:7,12,13,13
 90:3 94:7 101:24 104:6 105:17
 107:11
seeing 10:13 31:15 33:11,13
 34:15 35:13 94:11
seek 63:21 86:14
seeking 63:20
seen 44:7,25 45:3 70:8 103:24
selection 30:16
SEMAC 1:1 2:1 3:1 4:1 5:1 6:1
 7:1 8:1 9:1 10:1 11:1,7 12:1
 13:1 14:1 15:1 16:1 17:1 18:1
 19:1 20:1 21:1 22:1 23:1,2,5
 24:1 25:1 26:1 27:1,12 28:1
 29:1 30:1 31:1 32:1 33:1 34:1
 35:1 36:1 37:1 38:1 39:1 40:1
 41:1 42:1,7 43:1 44:1 45:1
 46:1,12 47:1,14 48:1 49:1
 50:1 51:1 52:1 53:1 54:1 55:1
 56:1 57:1 58:1 59:1 60:1 61:1
 62:1,3 63:1 64:1 65:1 66:1
 67:1 68:1 69:1 70:1,3 71:1
 72:1 73:1 74:1 75:1 76:1 77:1
 78:1,13,14 79:1 80:1 81:1,18
 82:1 83:1 84:1 85:1 86:1 87:1
 88:1 89:1 90:1 91:1,3 92:1,5
 93:1 94:1 95:1 96:1 97:1 98:1
 99:1 100:1,15 101:1 102:1,15
 103:1,20 104:1 105:1 106:1
 107:1 108:1 109:1 110:1
SEMSCO 4:17 8:6,8,9 13:7 41:23

42:7 62:4 63:24 91:11 92:5
 102:15,25 103:20
send 23:2 27:11 87:21
sending 21:12 54:22,24 80:2
SENSENBACH 2:4 4:9,14
sensitive 85:23
sent 11:7 23:13 25:25 55:22
 77:8 81:23 83:23 84:7
separate 61:22
separating 93:3
separation 51:10
September 1:7
series 9:20 65:15 80:15
seriously 101:23
sero 82:6
service 4:19 45:14 46:15
services 30:24 31:16 32:9
serving 4:19
session 35:24
set 12:20 48:12 58:2,3 66:5
 93:21,22 94:8 95:18
Seth 2:14 3:18,19 6:13,14 14:3
 14:4 22:8,9 29:13,14,14 60:9
 60:9,21 61:3,7 70:18
sets 55:19
setting 36:8 96:8
seven 44:13 45:22 50:19 51:14
seven-minute 51:12
seventeen 41:14
seventy-three 48:25
seventy-two 53:10
Shalom 40:10
share 11:3 72:7,10 95:21 99:24
sharing 36:3 68:11 75:9
She'll 30:12
sheer 86:10
Shin 3:12,13,14,17 6:15,16 14:5
 14:6,6 22:10,11,11 29:15,16
 29:16
shock 16:11,12
short 30:22 66:20 80:5
shortly 8:17 42:25
shout 44:3
show 74:11
shows 56:20
side 15:17 18:3 34:17,22,23
 41:13,15 58:11 82:18
sides 101:6
sign 32:23,24
signed 10:17 30:24

significant 35:21 76:17 101:7
significantly 26:20
signs 32:21,22 36:24 37:16
 39:21
similar 12:13 96:21 108:7
simple 98:21
simply 15:18 59:23
SIN 2:3
single 76:4
sir 4:20 81:17
sit 17:25
site 55:2
sitting 40:7 65:19 106:18
six 23:7,8 34:25 44:12 45:22
 80:5 82:6,6 86:4
six-week 23:14
sixty-five 76:14
sizes 51:16
skills 8:15 44:14
skip 64:12
sky 93:21
slated 31:5
slide 47:23 48:13,23 49:20 50:2
 50:15 51:8,10,15 52:5,12
 53:14,18 56:11,16,20
smaller 18:2
smart 57:20
smolder 88:17
smoldering 88:14
sold 39:14
soles 16:5
solutions 10:11 56:12 103:3
solve 98:14,14
somebody 79:13,16 108:3
soon 32:6 57:13
sooner 67:4
sorry 5:9 27:3 33:10 60:13,22
sort 9:20 10:4 67:6,6,10,10
 84:4 103:5
sounds 84:21 93:4
source 77:4
Southern 3:22 40:22,23
spark 91:5 92:7
speak 70:12,17 75:16,25 90:6
 91:21
speakers 37:18
speaking 31:4
spearheading 31:22
special 39:11 41:5
specialist 39:24

specialized 12:14
specific 11:16 12:2,15 57:21
 58:8 64:10 65:18 68:15 73:20
 76:6 83:10
specifically 11:23 16:11 62:5
 68:8
specifics 63:25
specify 62:25
spelled 15:13
spend 12:22 31:3 35:5
spending 34:18,24 35:4
spite 75:5
spotlight 103:8
Springs 1:1,12 2:1 3:1 4:1 5:1
 6:1 7:1 8:1 9:1 10:1 11:1
 12:1 13:1 14:1 15:1 16:1 17:1
 18:1 19:1 20:1 21:1 22:1 23:1
 24:1 25:1 26:1 27:1 28:1 29:1
 30:1 31:1 32:1 33:1 34:1 35:1
 36:1 37:1 38:1 39:1 40:1 41:1
 42:1 43:1 44:1 45:1 46:1 47:1
 48:1 49:1 50:1 51:1 52:1 53:1
 54:1 55:1 56:1 57:1 58:1 59:1
 60:1 61:1 62:1 63:1 64:1 65:1
 66:1 67:1 68:1 69:1 70:1 71:1
 72:1 73:1 74:1 75:1 76:1 77:1
 78:1 79:1 80:1 81:1 82:1 83:1
 84:1 85:1 86:1 87:1 88:1 89:1
 90:1 91:1 92:1 93:1 94:1 95:1
 96:1 97:1 98:1 99:1 100:1
 101:1 102:1 103:1 104:1 105:1
 106:1 107:1 108:1 109:1 110:1
spurt 91:15
squared 35:18
Ss 54:12
Stack 36:19
staff 47:25
stake 88:12
stakeholder 10:2
stakeholders 9:15 71:16
stand 3:3 4:9 24:13
standard 23:7,17 57:11 89:21
 97:4,5
standards 8:22,24 11:7 14:20
 17:17 22:23 23:2 27:10 30:3
 43:6,7,7,8 47:14,19 58:20
 91:11 93:19 95:19 96:8,10,14
 96:21,22
standing 94:20
stands 3:7

<p>stars 41:15 start 49:5 61:24 88:7 started 44:19 48:15 starting 10:15,23 65:22 state 1:2,4 11:21 20:4 37:7,10 40:14 42:3 45:14 46:24 48:3 48:22,25 49:3,11,15,16,19 50:24 53:17 54:21,22 55:14 56:7 57:10,15 58:5 64:2,11,20 67:24 69:21,25 78:6,15 79:10 82:5 83:15,24 84:7 86:3 87:24 88:23,25 89:11 90:4,6,7,8,12 102:2 106:8 108:18 110:2 stated 11:17 19:24 110:5 statement 18:12,20 19:12 42:11 42:12 77:21 98:23 statements 8:13 44:11 states 3:6 48:12 57:16 status 31:25 81:22 87:20,24 statute 43:13,20 69:20 94:7 98:15,17,19,24 statutory 43:16 44:6,7 stay 84:22 staying 33:23 stays 30:9 steering 4:6 step 78:21,24 98:21 stepped 105:5 steps 84:18 Steve 7:5 34:21 103:12 105:3 STEVEN 2:15 stipulated 62:6 63:7,16 82:3 86:10 stop 88:17 stopped 107:7 stopping 20:17 stories 105:11 straightforward 54:13 strange 71:25 Strategies 107:17 Street 1:11 striking 4:10 strong 89:8 strongly 101:22 stuck 101:16,19 105:24 studied 10:6 study 18:10 stuff 33:15 sub-committee 24:12 subcommittee 73:7 78:12,13</p>	<p>subject 16:15 79:17 submitted 55:20 84:10 subpoena 77:14 78:15 subscribed 110:10 subsequent 77:13 substantive 16:21 success 16:23 32:25 50:11 52:7 60:10,11 successful 49:22 50:21 72:22 successor 30:14 sudden 81:5 Suffolk 72:20 suffolkremsco.com 72:18 suggest 91:10 suggestion 18:18 70:15 101:21 102:20 suicidal 31:12 Suites 1:10 summarize 17:8 summary 17:15 18:10 summer 3:3 7:25 Sunday 40:12 sunset 18:19 19:8,10 SUNY 35:12 super 55:9 supermarket 38:22,23,25 supervisors 84:2 supplier 108:13 support 70:5 71:7 83:18,21,22 supraglottic 16:25 17:6 19:14 47:21 sure 3:11 7:20 8:14 24:15 26:25 30:9 33:22 71:18 72:3,9 74:25 78:18 80:22 84:22 88:13 90:23 94:17 96:14 98:7 Surge 104:24 surprised 104:23 surrounded 101:12 survey 9:23,23 10:4 37:6,13 49:7,9 surveys 10:14 survival 73:2 swath 53:16 swing 8:3 system 43:7,8 45:24 72:4 74:4 75:20 76:4 77:17 85:9 87:3 95:7,17 96:25 99:14,20,22 systems 39:8 40:22 46:7 63:18 73:17 75:12 82:21 94:12 95:16 101:13</p>
--	--

T	
table 25:4 27:25	Theresa 2:16 41:4 47:11
tabled 24:16,25	thing 12:4 18:15 45:17,18 98:13 107:14
tabulated 54:3,8	things 8:3 12:13,24 18:3 23:18
tactical 12:3	30:18 33:7,24 34:8,15,22 36:8
TAD 43:23	36:17 37:2,4,22,25 39:18 42:4
tag 9:2,5,7	44:9 45:3,6 46:17 47:3,19
take 27:18 60:7 62:16 78:21,24 79:12 82:23,23 87:17,18 100:2 100:2	49:6 50:10 51:17 52:22 53:4
taken 24:18 26:18	56:13 64:25 65:22,23 66:8
takes 84:18	67:11 68:6 69:21 78:22,25
talk 34:21 55:24 66:9	80:8 83:3,4 84:24 85:3,5,6,11
talked 56:13 58:22	85:15 87:8,11,13,16 88:9,18
talking 74:21,21	94:9,15 95:22 98:18 104:8,16
tanks 34:14	105:6 106:14
tape 77:22 81:11	think 10:10 11:12 12:11 17:10
tapes 77:10,15 79:18	18:2 19:5,6 20:12 25:18 26:4
taught 45:23	26:10,14 33:12 34:19,21 35:4
team 3:16 35:23 44:21 45:15 48:3 55:7	37:19,21 40:23 41:7 43:17
technical 43:4 97:25	45:22 56:19 59:22 60:21,22
technology 66:8	64:19 66:3,7,20 67:25 69:8,10
telephone 67:16,16	69:13,13 70:12 71:9,15 72:14
tell 39:5 84:14 89:18	73:5,22 76:13 78:23 80:4,6,9
telling 90:6,8	83:3,10 84:8 85:9,16 86:21
ten 31:24 94:2 104:21	87:4,9 88:8,23 89:10 91:20
tendency 89:11	92:4,13,15 93:15 96:7,12,13
termination 52:20	96:13,16 97:6 98:4,12,13 99:3
terminations 50:3,5	100:6,13,25 103:14 105:5
terms 24:3,4 49:7 52:14 53:9 59:6 76:3 98:5 100:7	106:9,21 107:22
terrific 32:19	thinking 60:12 74:20
tertiary 101:20	third 49:25 50:2
test 58:3 80:9	thirty 53:13 62:6 82:5 86:11
texted 15:14	93:10
thank 3:9 4:2,7,18,20,21,22 5:19 7:10,22 8:20,21,23 10:12 13:4 14:14,15 15:8,14 17:9	thirty-one 53:12
20:25 22:19 29:24 30:3,4,6,8	thirty-three 50:23
32:25 37:5,17,18 41:23 42:3,6	thought 45:25 51:18 61:17
44:10 45:19 46:14,20 47:6,9	thousand 49:3 59:12,14
47:12 56:24 57:6 60:4 61:7,9	three 31:9,11 35:9 36:5 44:11
61:16,19,21 64:15 67:2 72:6	48:8 49:21 50:4,19,20 52:16
74:7 81:12,15,17 89:4 90:18	82:6,6 103:9 106:19
93:2 100:9 106:24 107:2,9	thumbs 33:6
thanks 3:14,17 18:3 33:7 47:24 55:6 60:6 72:12 89:5 90:25 108:23,24	tidal 59:14
	tied 84:15
	Tier 3:22 40:22,23
	TIFFANY 2:16
	time 1:8 18:19 19:11 20:14,16
	28:11 30:16 31:3,8,15 34:24
	35:21 37:13 46:5,7 47:8 48:18
	57:22 64:4 66:7 71:23 73:16
	76:9,13 79:8 84:8 92:14 93:24
	94:2,18 100:5,5 101:12 102:21

103:16 106:5 107:3 110:4
timeframe 50:18 82:9
timeline 48:14 79:5 80:13 86:8
timelines 87:15
timeliness 10:8
timely 80:4 81:24,24 86:19
times 50:6 94:10 101:5,8 102:4
 104:20 105:21 107:11
TIP 43:23,23
titles 45:6
today 3:12 42:13 65:15 66:25
 97:15 101:9
told 30:15 32:7
tomorrow 3:24 32:7 40:25 41:17
tool 59:24 73:4 80:9
top 33:23
topic 80:23
topics 32:20
topography 64:4
totally 58:11
touch 12:5 107:10
track 30:10 39:12 103:5
tracks 39:11
traffic 64:5
trailing 34:21
train 26:10
trained 16:9 17:2 57:2
training 7:24 11:25 12:15 24:4
 35:24,25 58:9,9
trans 50:7
transcription 110:6
transfer 52:25 101:19 106:17,18
transferring 101:17
transfers 106:16
transition 34:8 35:8 44:22,23
 45:4
transitioned 35:15 51:4
Transport 43:23,24
transported 50:7
transports 73:21
trauma 1:4 16:11 38:15
treatment 43:23 48:7
tree 41:11,16
tremendous 16:23 46:17
triage 37:3
trite 75:4
trouble 108:17
trucks 33:16
true 56:4 110:7
truly 32:18 45:19 85:14

try 55:25 70:11 91:15 92:7
 105:2
trying 20:18 36:17 57:14 68:15
 71:17 92:2 93:9,21,22 94:20
tube 17:6
turn 100:9
turns 93:23
twelve 52:14,15
twenty 41:10 44:6 46:3 53:12
Twenty- 44:12
twenty-five 37:7
twenty-four 44:11,14 49:2 50:20
twenty-one 53:10
twenty-seven 50:20
twenty-three 50:19
two 25:23 35:2 37:8 44:19 49:3
 49:6 50:10 52:14 53:2 61:22
 79:6 81:16 103:8 106:18
two-and-a-half 105:24
two-year 33:9,10
type 70:23
typewritten 110:6

U

Ultimate 63:12
ultimately 62:4,20
unanimously 32:14
unbiased 79:17,18
unchanged 52:15
uncomfortable 91:2
uncontrollable 88:15
understand 23:3 62:13 74:25
 75:19 78:22 80:7,12
understandable 96:10
understanding 62:11 71:18 92:16
 100:7
understood 60:22 61:7 92:11
unfortunately 21:12 41:11 84:16
unintelligible 3:20 40:2
unit 35:11 55:11
United 3:6
units 12:13,14
University 39:8 40:17
update 9:5 46:24 47:7 51:6
 87:22 89:19
updated 81:22
updates 19:24 87:25
updating 32:2 35:20
upfront 59:18
upstairs 4:15

upstate 45:25 46:2,7
urgency 26:12,21
urgent 23:18
urging 91:4
use 9:22 16:8 18:21 19:13 20:3
 20:15 49:11 54:2,22 72:22,23
 73:3 75:3 108:3,4,16
useful 59:15
User 107:16
uses 57:4
usually 23:17
utilize 17:6 56:18,25

V

V.M.S 82:3
V.M.T.s 48:6
vague 66:2
validate 53:24 58:7
validated 58:18
validation 50:8
Valley 16:24 18:14 47:24 60:5
valuable 104:5 105:6
value 51:20,25
values 50:14 51:16 54:16
Van 31:17 32:16
variables 82:25
varied 64:3
varies 82:13,14 94:23
variety 53:3 56:8 73:13
Varna 40:20
vehicle 42:13
vendor 54:17
vendors 53:8 54:10,12,15 55:10
 58:4
ventilations 51:24 59:3
verbiage 16:13
verified 49:25
versus 58:14,23 60:19
vertical 64:5
vett 32:6 43:13 100:15
Vice 31:17
video 31:5,7 38:5 77:23
videos 31:9
VIOLANTE 2:7 47:9
violation 86:3,10
violent 31:14
virtual 7:24
visit 38:9 102:21
visited 38:10
vital 32:20,22 36:23 37:16

39:21
Vitale 39:25
volatile 105:5
Volunteer 40:16,20
vomit 53:5
vomiting 52:18
vote 13:8 17:20 21:13 24:2 25:5
 25:11,14,14,20 26:8,24 27:18
 27:22 28:12 42:22
voted 14:24 22:25 23:20 27:23
 27:24 32:14 56:23
voting 13:5

W

Wadsworth 43:3
wait 98:2 101:5,8 102:4 107:11
waiting 47:4 58:14 106:19
walked 39:2
wall 5:6 41:3
Walters 2:5 6:17,18 14:7,8
 22:12,13 29:17,18,18 70:16
 72:7,9 73:9,13 90:20,24 93:4
 93:8 95:14
want 11:9,11 15:2,3 19:18 23:6
 26:24 27:15 30:8,21 37:5
 38:18 39:20 46:13 47:24 56:23
 57:4 61:21 64:12 65:14 68:2
 72:2 74:8 79:3 96:6 97:14
 98:2,20 102:8,20 104:17 107:4
wanted 14:21 17:17 26:5 27:5
 45:19 49:6 77:18 86:7
wanting 71:15 99:22
wants 4:24 21:7 23:23 102:19
Washko 2:11 7:7,8
wasn't 23:12 25:24 49:15 59:8
waste 10:21
watch 44:8 81:11
waveform 17:6 49:25 57:3,9
way 20:18 25:22 42:6 50:22
 57:25 59:17 62:13 65:19 66:24
 73:16 74:22 85:17 88:20 91:15
 96:13 100:25 103:7,16 108:7
ways 36:17 49:18
we'll 7:25 16:19 28:11 32:2
 35:19 36:3 54:8 74:23 79:7,11
 81:9 86:25 87:2,3 91:18
 107:11,12 109:10
we're 3:11 4:7 8:2 9:22 10:3,9
 17:19 20:17,17 25:6 30:15
 31:15 33:14 34:4,4,7,8,15,17

34:18,24 35:2,3 36:16,25
 37:24 39:10,15 41:7 43:2
 44:20,21 45:3,4 47:4 48:21
 50:4 55:15 59:20,21 62:12
 68:13 71:13,17,18,20,23 72:3
 79:15 83:23 84:12 85:20 87:23
 90:6,8 92:2 101:9 103:23
 104:14 106:14 107:3
we've 10:2 12:2 33:12 35:15
 38:5 59:23 69:6,7 70:8 71:12
 73:15 74:14 75:14 91:16
 101:11 102:6 105:21
we'll 25:15
weaponize 89:12
Weber 40:4
website 36:21 39:18 41:21 44:16
 72:10,18 87:11
week 31:6 105:11
weekly 49:9 55:20
weeks 16:19 23:7,8 25:23 80:5
 82:23
Wegmans 37:20 38:9,10,11,21,21
 38:24 39:2
weight 51:10
welcome 3:11
welfare 88:12
well-deserved 30:11
went 38:13,23 44:5 48:20 76:15
 85:18 105:17
weren't 54:10,11,16,21 74:20
Westchester 46:2 69:3
western 70:17 72:10
whatsoever 59:20
WHEREOF 110:9
whoa 38:24
whoever's 71:5
wide 53:16
widget 87:19 89:8
wildfire 88:15
willing 72:7 88:24 103:19
winners 39:21 40:24
Winslow 2:9 6:21,22 14:11,12
 22:16,17 27:5,9,13,19 29:21
 29:22 72:14 107:2
wish 75:24 99:24
withdraw 85:24
WITNESS 110:9
wonderful 30:18 45:14 53:17
 58:9,20
wondering 38:11 104:11

wonky 53:5
word 75:3
words 20:4,15
work 4:15 8:20 9:16 10:13 11:3
 12:21 16:23 30:25 33:20 43:25
 45:21 47:13,15 48:4 55:7,16
 58:12 59:15 71:16 75:2,4
 80:13 84:23 87:5 101:7 102:4
 103:9 105:2 107:8
worked 58:13 95:8
working 9:5 10:9,16,23,24 11:21
 12:8,17 33:9 35:5 43:3 47:16
 55:25,25 89:6 91:16,19 94:24
 98:22 103:3 107:5
works 12:7 73:4 95:17 97:3
world 91:15
worse 106:6,8,13
worthy 106:9
wouldn't 72:2
wrangled 53:22
wreaking 101:13
written 70:25

X

Y

yeah 11:12,18 19:17 20:10,12,13
 20:23 22:21 24:21 26:14 54:7
 60:9 68:18 72:14 76:24 89:16
 100:13 103:14 104:7 107:2
year 34:20,24 35:2 37:18 39:6
 39:10,22,22,23,25 40:2,3,7,10
 43:16 70:19 102:14
year's 32:20 36:23 39:20 40:24
year-and-a-half 101:10
years 31:24 41:10 44:6,7 45:23
 46:3,14 74:15 100:6 109:2
yesterday 36:10
York 1:2,12 11:21 20:3 22:23
 28:10 42:3 46:17,24 53:16
 64:2 82:5 94:23 95:9 96:19,23
 110:2
Youth 40:10

Z

zero 44:12,13 62:8 63:7 82:4,6
 82:6,6
Zoll 59:12
zone 76:10

0	78:1 79:1 80:1 81:1 82:1 83:1
	84:1 85:1 86:1 87:1 88:1 89:1
1	90:1 91:1 92:1 93:1 94:1 95:1
1 110:5,7	96:1 97:1 98:1 99:1 100:1
1:32 1:8 109:12	101:1 102:1 103:1 104:1 105:1
109 110:7	106:1 107:1 108:1 109:1 110:1
11:32 1:8 3:2	
18 1:7	
2	
2000 47:23	
2004 41:10	
2009 4:19 46:12	
2015 31:23	
2020 48:15	
2022 105:16	
2023 48:20 105:16	
2024 1:7 105:17 110:10	
2025 35:19	
3	
30th 36:20	
3rd 110:10	
4	
5	
6	
6th 42:8	
7	
8	
86 1:11	
9	
9/18/2024 1:1 2:1 3:1 4:1 5:1	
6:1 7:1 8:1 9:1 10:1 11:1	
12:1 13:1 14:1 15:1 16:1 17:1	
18:1 19:1 20:1 21:1 22:1 23:1	
24:1 25:1 26:1 27:1 28:1 29:1	
30:1 31:1 32:1 33:1 34:1 35:1	
36:1 37:1 38:1 39:1 40:1 41:1	
42:1 43:1 44:1 45:1 46:1 47:1	
48:1 49:1 50:1 51:1 52:1 53:1	
54:1 55:1 56:1 57:1 58:1 59:1	
60:1 61:1 62:1 63:1 64:1 65:1	
66:1 67:1 68:1 69:1 70:1 71:1	
72:1 73:1 74:1 75:1 76:1 77:1	