10-19-2021 - SEMAC - WEBEX
NEW YORK STATE
DEPARTMENT OF HEALTH

SEMAC STANDARDS

DATE: OCTOBER 19, 2021

TIME: 2:40 p.m. to 5:11 p.m.

CHAIR: DR. LEWIS MARSHALL

VENUE: WebEx

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2   **APPEARANCES:**
     PETER BRODIE
3   DAVID MARKOWITZ
     AMY EISENHAUER
4   BRIAN WALTERS
     DEBRA SOTTOLANO
5   EDWARD MAGER
     JACOB DEMAY
6   JEFFREY RABRICH
     JEREMY CUSHMAN
7   JONATHAN BERKOWITZ
     JONATHAN WASHKO
8
     JOSHUA LYNCH
     LEWIS MARSHALL
9
     MARYANNE PORTORO
10   MICHAEL BAGOZZI
     MIKE MCEVOY
11   NIKOLAOS ALEXANDROU
     PAMELA MURPHY
12   ROBERT WICELINSKI
     RYAN GREENBERG
13   STEVEN DZIURA
     JOE BART
14   DAN OLSSON
     DAVID KUGLER
15
     GREGSON PIGOTT
     MATTHEW TALBOT
16
     MARK PHILIPPY
     CHRIS CHIN
17
     AIDEN O'CONNOR
18   ALAXANDER KACZOR
     ART BREAULT
19   BEN SENSENBACK
     BETH MCGOWN
20   BRETT ROBERTS
     BRIAN LEVINKSY
21   BRIAN WILCOX
     BRYAN BRAUNER
22   CAROL BRANDT
     CHARLOTTE CRAWFORD
23
     DANA JONAS
     DAVID BEN-ELI
24
     DEAN ROMANO
25   DONALD DUVALL

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2   DONNA KAHM
     GENNA VANCORT
3   GREGORY GILL
     HOWARD HUTH
4   MICHAEL COX
     MICHELE FORNESS
5   OREN BARZILAY
     PAMELA LAI
6   PAUL DIVVERS
     PAUL SUGRUE
7   ROBERT CRUPI
     ROBERT DONNARUMMA
8
     SCOTT CHIANG
     STEVEN BLOCKER
9
     TIM MIRABILE
10   STEPHEN GOMEZ
     STEVEN KROLL
11   BRIAN WIEDMAN
     CHERISSE BERRY
12   JOHN VANAUKER
     JONATHAN BEHRENS
13   JOSEPH TINKLEPAUGH
     MARIE DIGLIO
14   YEDIDYAH LANGSAM
     JASON WINSLOW
15
     STEVEN BLOCK
     ANN SMITH
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2   (The hearing commenced at 2:40 p.m.)
3   **MR. DOYNOW:** Are we recording? Okay.
4   Looks like we're good. All right. Everybody let's
5   sit down and start the meeting. Sorry for the delay.
6   There were some technical issues that we needed to
7   address. I would like to welcome everybody back to
8   SEMAC. It's good to see some people here in person
9   and hopefully maybe the next time we'll be able to do
10   even more.
11   If we could stand for the Pledge of
12   Allegiance.
13   Pledge of Allegiance to the flag of
14   the United States of America and to the Republic for
15   which it stands, One nation under God, indivisible,
16   with liberty and justice for all.
17   **MR. DOYNOW:** Thank you all. Val, if
18   we can have roll call?
19   **MS. OZGA:** Okay. Good afternoon,
20   everyone. Thank you for your patience and I will do
21   roll call. Dr. Alexandro?
22   **MR. ALEXANDRO:** Here. Thank you.
23   **MS. OZGA:** Dr. Bart?
24   **MR. BART:** Bart here.
25   **MS. OZGA:** Dr. Berkowitz?

1 (Pages 1 to 4)

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2   **MR. BERKOWITZ:** Here.
3   **MS. OZGA:** Dr. Berry? Is Dr. Berry
4   on? Cherisse Berry? Dr. Bombard is here.
5   **MS. BOMBARD:** Here.
6   **MS. OZGA:** Dr. Cooper?
7   **MR. COOPER:** Here.
8   **MS. OZGA:** Dr. Cushman?
9   **MR. CUSHMAN:** Cushman here.
10   **MS. OZGA:** Dr. Dailey?
11   **MR. DAILEY:** Dailey here.
12   **MS. OZGA:** Dr. Detraglia? Dr.
13   Detraglia? Dr. Doynow?
14   **MR. DOYNOW:** Here.
15   **MS. OZGA:** Dr. Gomez?
16   **MR. GOMEZ:** Here.
17   **MS. OZGA:** Dr. Kugler?
18   **MR. KUGLER:** Dr. Kugler here.
19   **MS. OZGA:** Dr. Lynch?
20   **MR. LYNCH:** Here.
21   **MS. OZGA:** Dr. Markowitz?
22   **MR. MARKOWITZ:** Dave Mar -- Dave
23   Markowitz here.
24   **MS. OZGA:** Dr. Marshall?
25   **MR. MARSHALL:** Dr. Marshall here.

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2   present.
3   **MS. OZGA:** Mike McEvoy?
4   **MR. MCEVOY:** McEvoy is here.
5   **MS. OZGA:** Steve Kroll?
6   **MR. KROLL:** Present.
7   **MS. OZGA:** Mark Philippy?
8   **MR. PHILIPPY:** Present.
9   **MS. OZGA:** And Dr. Rabrich?
10   **MR. RABRICH:** Here.
11   **MS. OZGA:** Roll call is complete, and
12   we have quorum.
13   **MR. DOYNOW:** Excellent. Thank you.
14   We have approval of the -- it's about twenty-five
15   minutes. Anybody want to make a motion?
16   **MR. KUGLER:** Kugler.
17   **MR. DOYNOW:** Who is that?
18   **MR. KUGLER:** David Kugler.
19   **MR. DOYNOW:** Motion from Dr. Kugler.
20   How about a second?
21   **MR. PHILIPPY:** I second.
22   **MR. DOYNOW:** And that was from?
23   **MR. PHILIPPY:** Mark Philippy.
24   **MR. DOYNOW:** Okay. All in favor.
25   **ALL:** Aye.

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2   **MS. OZGA:** Dr. Maynard?
3   **MR. MAYNARD:** Dr. Maynard here.
4   **MS. OZGA:** Dr. Murphy?
5   **MS. MURPHY:** Dr. Murphy here.
6   **MS. OZGA:** Dr. Olsson?
7   **MR. OLSSON:** Olsson here.
8   **MS. OZGA:** Dr. Pigott?
9   **MR. PIGGOT:** Dr. Piggot here
10   virtually, but Suffolk County should be well
11   represented in the room.
12   **MS. OZGA:** Thank you.
13   **MR. DOYNOW:** They are.
14   **MS. OZGA:** Dr. Walters?
15   **MR. WALTERS:** Walters here.
16   **MS. OZGA:** And Dr. Wicelinski?
17   **MR. WICELINSKI:** Robert Wicelinski
18   here.
19   **MS. OZGA:** And our non-voting members.
20   Aiden O'Connor?
21   **MR. O'CONNOR:** Good afternoon,
22   present.
23   **MS. OZGA:** Welcome, Aiden. Oren
24   Barzilay? Maryanne Portoro?
25   **MS. PORTORO:** Maryanne Portoro

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2   **MR. DOYNOW:** Motion passes.
3   **MS. OZGA:** I just need to -- I forgot
4   one non-voting member, John Washko.
5   **MR. WASHKO:** Present.
6   **MS. OZGA:** I think he's on?
7   **MR. WASHKO:** Yes, present.
8   **MR. DOYNOW:** He's present.
9   **MS. OZGA:** Okay. Sorry about that,
10   John.
11   **MR. WASHKO:** Okay.
12   **MR. DOYNOW:** If we can have the bureau
13   staff report?
14   **MR. GREENBERG:** Sure. Thank you.
15   Just a reminder for everybody too all the voting
16   members, please remain on camera whenever possible
17   with the -- I would say with the exception of Dr.
18   Piggot right now as -- I think you're driving, I want
19   you to be safe.
20   So thanks for being here, and thanks
21   everybody for the patience today. It's nice to see
22   some -- some of you back in person and some of you
23   virtually, but as we move towards this and having
24   this option to be hybrid, like I said, thank you to -
25   - to everybody including deputy chief ... back there

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on team who helped make this possible today.
    So staff report on what's going on.
You know, as many of you know, we still continue
within the Bureau highly operating in COVID
operations. We still are out at many of the sites,
the vaccination sites, and different COVID
activities. And that is taking up a great deal of
our -- our bandwidth at the moment.
    However, we are starting to align back
to some of our core functions. So thank you for
being patient with us. Our field investigations and
responses and some of the other daily activities
still continue on.
    From the operations' point of view or
from the operations and our deputy chiefs of
operations, they wanted to express -- they are
hearing a lot more concerns about offload times at
hospitals. They also wanted to just touch on some of
the different areas and some of the different regions
as state that are having D.O.H. diversions.
    So many of you may have seen from your
program agencies or we send them out at D.O.H.
diversion hospitals within a given area that are
having problems, capacity wise or other reasons that

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Buffalo regions, extended delays in hospitals.
    And we understand that many of the
E.M.S. agencies have expressed their concerns on why
is -- hospital issues becoming an E.M.S. issue. I --
I think it's important here to stress that we are an
ecosystem within the healthcare system and -- and the
healthcare system E.M.S. plays a key role of that
component, but it's one piece.
    And as one part of the healthcare
system is affected, it has a domino effect on others.
And one of those things that we need to do, and I
think this counsel does on a regular basis. I think
some of our committees do an excellent job of is
communicating when those concerns are in trying to
find resolutions.
    I will tell you that we've had lots of
new ideas and different things come up to try and
combat and work with some of those delays and issues
that have -- that have -- that seemed to be more
regular right now and -- and I appreciate and applaud
everybody for that and working towards it.
    Just a reminder. Please make sure,
you know, to be open and forth front as we start with
those different alternatives, to make sure that they

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need to go on diversion would call the search and
flex operation center within the Department of Health
and the search and flex operation center would put
out notifications of that diversion.
    Normally, either in two or four-hour
increments. We have -- if things -- we're looking a
little bit better particularly in the Syracuse area.
And then we have seen lately more diversions going on
for a series of different reasons and we continue to
monitor that.
    Also working with D.O.H. leadership to
work on some resolutions with those hospitals. And
also want to say just thank you to the -- the
hospital leadership in relation to this diversion to
have been very communi -- have -- have been working
with search and flex and talking on a regular basis
trying to make sure that, you know, the hospitals
that need to go on diversion that there's still
capacity at the other hospitals and -- and can do it
in organized manner.
    And that is one of the benefits of
those diversions going through the search and flex
operation center. We are seeing again in some other
regions, particularly in the Rochester region and the

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are within compliance and regulations both on the
hospital side and the E.M.S. side.
    On the administration side of the
house, lots going on, particularly in processing just
invoices both in COVID and non-COVID related. And
we're excited to be adding hopefully some new staff
in -- in the administration unit of the Bureau by the
end of the year.
    On the community paramedic side, we're
over fifty agencies and community paramedicine. We
cover over just about forty counties right now.
We're just nearing forty counties. The ultimate goal
is to have one community paramedic agency per County
at minimum.
    We have some counties like Saratoga,
who have really done wonders in working as a
collaborative and so that each agency doesn't have to
do it on their own. But that they can work under a
county kind of model, but working, you know, in -- in
where they really developed a county kind of plan and
then each agency rolled out and participate in that
county plan.
    If any of the counties or any of the
Docs in this room are -- are looking to possibly

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1
2 bring that into their county, please feel free to
3 reach out to us. We're happy to share information.
4 We're happy to share the templates in order to try
5 and achieve our goal of having at least one community
6 paramedic program per county.
7   The other good part on that one is our
8 current executive orders, which we'll get to in a
9 little bit, does now allow for community
10 paramedicine. There was a brief period of time where
11 community paramedicine was back to where our current
12 regs are, but the executive order today does allow
13 that.
14   On the education front, there are --
15 we are printing cards again and the new cards are
16 actually being issued. And the other thing is, there
17 are two new policy statements that if we're not up
18 already, we'll be up probably by early tomorrow
19 morning.
20   One is related to distance learning
21 and -- and coursework in that sense. We have seen
22 some great models come up during the pandemic and we
23 want to encourage agencies and -- and co-sponsors to
24 continue that excellent work.
25   Part of continuing that is having a

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2 clear understanding of different terms and
3 definitions related to distance learning, so that
4 everybody can be on the same page. And so that is
5 one of the policy statements that has come up.
6   Second to that is the expansion of
7 B.L.S. clinical hours for all the positions. I'm
8 sure you know that our -- in our E.M.T. side, you
9 have to do a certain number of hours in -- normally
10 in an E.R. Well, we've looked at that. We know that
11 many hospitals right now are hard to get into,
12 particularly for an E.M.T. student who's only going
13 to do a short period of time.
14   Thank you to all the hospitals who've
15 really been helping in getting paramedic students in.
16 But as part of that clinical and we do -- educators
17 in the state feel that, that those clinical hours are
18 important that we are moving towards an opportunity
19 for other ways to receive those ten patient contacts
20 and actually moving towards ten patient contacts
21 opposed to ours.
22   So going forward with the new policy,
23 they'll be able to get those ten patient contacts,
24 whether it be in a doctor's office an E.R. and E.M.S.
25 agency a number of different things. Hopefully,

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2 event medicine was another one that came up as a --
3 as a suggestion from the instructors. So really
4 excited to see that expansion.
5   On the data side, obviously -- not
6 obviously, but you know, Peter is continuing to send
7 out lots of emails. But definitely from the last
8 meeting to now, the biggest thing that we have is all
9 patient care reports are coming in in some shape,
10 way, or form electronically.
11   So agencies that are charting on paper
12 now have a portal to submit to scan and submit their
13 paperwork as well as a -- we've seen a nice increase
14 in the number of agencies that are actually charting
15 electronically.
16   This helps us in getting paperwork in
17 -- in a timely manner. Just to give you an idea that
18 the paper P.C.R.s prior to this would take twelve to
19 eighteen months to get back to the Bureau. So we
20 wouldn't even be able to accurately report on call
21 volume until twelve to eighteen months after that
22 date had passed in order to tell you. Well, this is
23 what our call volume was for previous year. So happy
24 to see that part.
25   On the E.M.S. for children program, we

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2 continue to grow our PACK programs and -- and our
3 PACK coordinators and Amy has asked that -- oops,
4 she's not over there right now. Amy has asked that
5 we remind people that there's an E.M.S. for children
6 pre con at vital signs that actually registrations
7 zoom very well for, and so take a look at that when
8 you have the opportunity.
9   On the trauma side, we have a new
10 trauma program manager who will be starting by the
11 end of the year. So we'll have more information on
12 that by our next meeting. Site visits for trauma
13 center verifications continue virtually and the new
14 data dictionary has been released.
15   There's also a super chair committee
16 that continues to meet the super chair committee
17 includes the STAC, the SEMSCO, the SEMAC and the
18 E.M.S. for children programs, and really excited to
19 see this move forward. I would say that probably not
20 moving at the pace that we wanted to but
21 understanding with everything going on.
22   But I think this -- this group and the
23 group of chairs coming together to talk and talk
24 about how things look around the state in the future
25 of emergency response and trauma around the state

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2   really can be beneficial as they continue their
3   workload.
4   Vital signs -- vital signs conference.
5   So vital signs is November 11th through the 14th. It
6   is a hybrid this year. So if you have the
7   opportunity to join us in person in Saratoga, that'd
8   be wonderful. If you don't, then you can join us up
9   as Val shows the pamphlet. If not, you can join us
10   virtually, whether it be just for pre con or for the
11   main sessions.
12   There is a vaccine mandate. So you do
13   have to be vaccinated in order to attend the
14   conference. And everybody who does attend would need
15   to show proof of vaccination when you pick up your
16   event credentials.
17   But also, just want to -- there's just
18   a lot of great things going on. And one of the
19   things I really wanted to highlight particularly to
20   this group and -- and a thank you to everybody who's
21   participating. But the New York and -- M.S.P. pre-
22   conference innovations in medical oversight.
23   This is a panel of twelve different
24   physicians from around the state talking about
25   medical oversight and talking about innovation in

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2   E.M.S. and where we can go in the future. And -- and
3   just to emphasize for, you know, the Docs here who
4   are -- are helping in presenting, thank you. For
5   those who aren't, who can join and -- and maybe take
6   away some of those ideas excellent.
7   But also that this is really an
8   excellent opportunity for -- for leaders and for
9   paramedics and -- and E.M.T.s who, within their
10   organization, they're trying to determine, well,
11   what's the next steps we can take. We want something
12   more advanced.
13   And so again, vital signs just trying
14   to take things to that next level and share those
15   ideas. And here's an excellent opportunity. We're
16   going to have shared ideas. So if you're -- maybe
17   someone from your agency, if not you, can join.
18   Again, just another example of some things going on
19   at vital signs.
20   The memorial just happened. This was
21   one that was delayed several times. There were
22   seventeen names that went up on the memorial this
23   year. It's a really nice event. The weather was
24   held out for us. I will tell you there was a point
25   in there where we thought it was going to rain and it

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2   was pretty much almost right as we were about to have
3   to read the names.
4   It looked like the sky was just going
5   to open up and -- and -- and rain and I don't under -
6   - it was just kind of one of those amazing moments.
7   The sky did open up, but the clouds moved to the side
8   and the sun literally came down for the time where we
9   shared those names and got to present those family
10   members with the memorial items.
11   This year, we did do something a
12   little bit different. We added not only with the
13   family member get a star of life, get -- get a star,
14   which is the same as what goes up onto the tree. But
15   we also added a flag ceremony to it, which was a flag
16   that was flown over the Capitol in -- with the name
17   of the individual who had lost their life -- life in
18   the line of duty.
19   And so thank you to everybody who
20   helped make that possible and -- and a special thank
21   you to our on the guard this year from the Bureau who
22   put that all together and made it run so smoothly.
23   So from the director's office from seeing myself,
24   weekly E.M.S. leadership calls continue.
25   They operate on the -- or they happen

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2   on the first and third Thursday of every month.
3   There's a few occasions where they do get postponed
4   or cancelled. But we encourage everybody to please,
5   you know, have your E.M.S. leaders be a part of that.
6   It also gives them the opportunity to ask questions
7   and interact with Bureau staff and all the
8   leadership, you know, in one centralized place.
9   There also is going to be scheduled
10   starting in September, I believe, once a month an
11   education session, I think that will either happen on
12   the second or fourth Thursday, was at the two -- no,
13   on the third. So sorry. Lined up with leadership
14   but I think the hour before.
15   So on the third Thursday of every
16   month, there's an education update as well. There's
17   two new committees that, I think, they'll be talking
18   a little bit today about the quality metrics in the
19   E.M.S. innovation -- innovation committees. Just
20   want to thank both of those chairs for starting up
21   this committees and starting to get the work moving
22   forward on them, really exciting stuff coming from
23   that.
24   The search and flex operation center
25   that I mentioned before, that is something it's a

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2   little bit -- it's been going on now for close to two
3   years is -- is across the Department of Health, but
4   it is run by the department -- by the Bureau of
5   E.M.S. and trauma systems at the direction for the
6   most part of Deputy Director ...
7   And that center is really there as a
8   centralized point for any hospitals, nursing homes,
9   facilities that are having problems that need to
10   either alert us to something or looking for
11   assistance, looking for a return-to-work waivers.
12   So there is a portion, a large
13   portion, of work that goes into that in staffing.
14   And that is another role that the Bureau has taken on
15   over this -- over the pandemic. Regulations, we
16   weren't due or we were trying for some emergency
17   regulations related to some issues that were going
18   on.
19   And they are currently on hold mainly
20   because the executive orders that came out achieved
21   most of the items that were going to be covered under
22   the emergency regulations. So we are moving forward
23   on, you know, putting those into a regulate --
24   regulation packet. But right now, with the executive
25   order in place, that was a resolution to it in a

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2   shorter period of time.
3   From a training point of view, there
4   are two new classes that just got released. We just
5   had our beta program for our two-day E.M.S.
6   supervisor leadership training. It's a statewide
7   class. It was developed through a grant. We're very
8   excited about that one. We just did the beta test in
9   the train, the trainer that will be being expanded
10   and hopefully brought out around the state.
11   If there are medical directors around
12   here who would like to see it in their particular
13   area coming next, we're going to try and find some
14   additional funding to take that on the road. There
15   was also a one-day mental health and substance abuse
16   class that just had two beta -- beta tests in that
17   class.
18   Finished, it is a grant that was
19   through the -- in partnership with Oasis, and that
20   grant is actually being extended this year as well.
21   And that one -- that class will go on -- on the road
22   and be around the state and happy to bring it into
23   agencies and hopefully do a collaborative within
24   regions but posted at local agencies.
25   The executive orders did come out

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2   recently and as many of you know, there are several
3   things on there that affect E.M.S. The first one
4   that's on there is E.M.S. providers being able to
5   work in non-traditional environments. This is
6   something that that was put in there to try and help
7   the E.M.S. community as well as the -- the workflow
8   and -- and some of the problems that we're seeing in
9   some of the regions offload times in decreasing
10   offload times and some other the things.
11   I know that some E.M.S. agencies and
12   hospitals have shared with the Bureau some of their
13   postings for having those E.M.S. providers work in
14   non-traditional environments. Our community
15   paramedicine continues because the executive orders,
16   if anybody would like to move forward with the
17   community paramedic agency and they're not one now
18   and they want to find out more information, feel free
19   to reach out to Deputy Chief Negozi. If you don't
20   have his contact information, feel free to reach out
21   to me and I'd be happy to connect you.
22   The executive order -- orders also
23   allow for telemedicine and treatment in place as well
24   as there's a number of things in there for education
25   and certification. National registry is currently --

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2   as long as the executive orders in place, national
3   registry is accepted. There are some forms that you
4   need to fill out in order to submit your national
5   registry to get your state form.
6   We will be turning back on the
7   electronic portal to submit that. That is not fully
8   operational yet, but we'll get that back on the same
9   way it was in the first go round. And that will be
10   going to John McMillan.
11   One of the biggest questions I
12   probably got when the executive orders went out was,
13   are we extending certifications for another year?
14   Just reminded everybody and we've shared this once
15   before and there will be policy guidance and all the
16   executive orders. But the executive order that came
17   out said to the extent necessary.
18   At this time, we are not extending.
19   We are not extending. We are not extending
20   certifications in additional year. But it is there.
21   Should something happen, should the pandemic take a
22   different pathway and we need to reevaluate things
23   that is there so that it is a pathway should it be
24   needed.
25   And the last executive order's related

6 (Pages 21 to 24)

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2   to alternative medical control where under the
3   supervision of a physician, other practitioners would
4   be able to provide medical control to the -- to
5   E.M.S. providers in the field.
6   Last, but far from least, I just want
7   to say we're excited to say that we are growing the
8   Bureau a little bit. And hopefully our -- the people
9   that we bring in will, you know, exceed the number of
10   people who are retiring for wonderful reasons one way
11   or another.
12   But -- but the -- so we have new
13   positions. So we have a new trauma program manager.
14   We have two new district chiefs or unit chiefs that
15   are coming in. We have one new support person coming
16   in as -- as well as we are in the process of hiring a
17   new part time data person for the E.M.S. for children
18   program.
19   So nice to see some additional growth
20   of, you know, four or five people in the next couple
21   months or possibly by the end of the year. And, you
22   know, to continue to move forward to be able to meet
23   our missions and meet the needs of our councils,
24   including this council on many of the requests that
25   we have.

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2   flex operation center is really watching, is giving
3   us real time data, real time issues to be able to
4   immediately direct it. And -- and I will tell you.
5   There -- there's a number of those forms that come in
6   that we look at and we go okay, you had to wait
7   thirty-two minutes, probably not addressing that one.
8   But we've also had some that come in
9   that whether it be trauma or strokes or other things
10   that -- that had prolonged periods, or just longer
11   than we would like that we've been able to -- to, you
12   know, immediately address.
13   And we address some -- with hospitals
14   and facilities in real time which allows them to
15   really, you know, come back or, you know, identify
16   things as well.
17   MR. KUGLER: Ryan, it's David Kugler.
18   Another question?
19   MR. GREENBERG: Dr. Cooper?
20   MR. KUGLER: It's David Kugler, not
21   Dr. Cooper, sorry. Thank you. It's -- I'm not the
22   handsome one. He is. Quick question about the
23   alternative medical control under supervision of a
24   physician. How does this affect the New York State
25   regulations and policies on regional -- regional

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2   Happy to take any questions or answer
3   anything otherwise, end of report.
4   MR. DOYNOW: Okay. Thank you, Ryan.
5   Anybody have any questions real quick?
6   UNIDENTIFIED SPEAKER: Have one quick
7   question. The -- the state was collecting data
8   through a website on hospital wait times. Is that
9   data that's produced any information?
10   MR. GREENBERG: It hasn't been -- it
11   hasn't produced any wait times. What it does is
12   really helped us in being able to work with those
13   hospitals. We've identified hospitals that we didn't
14   realize were problem areas and -- and that's helped
15   facilitate us in discussions of trying to figure out
16   why it's happening. Are there other things that we
17   can do to help navigate those problems or wait to it.
18   We have not formally analyzed that
19   data. It's been more. What we were facing before
20   that -- that form was put together was, well, I had
21   to wait three hours three weeks ago. Well, I can't
22   help you with that because you can't even tell me,
23   you know, for the most part when it was or why it
24   was.
25   And what that does, and the search and

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2   policies of medical control?
3   MR. GREENBERG: So this is a -- as
4   it's a very new thing for us and the goal would be is
5   that it would go through the region. So this will
6   give the ability for a region to use it under
7   permission and -- and with the guidance of the
8   Bureau.
9   But it would still go through. We
10   would want the region to recognize and determine how
11   that's going to happen and overly work into a system
12   for it. We've only had one region reach out and
13   request or have interest in this being used.
14   So it hasn't done that yet. During we
15   -- you know, during some of the earlier waves, it
16   looked like it was going to be more of a thing. It
17   didn't end up actually being a thing. But since then
18   and -- and more recently, it looks like it -- it
19   could be. But we would work with those regions for
20   it. We wouldn't do it ... from the regions.
21   MR. KUGLER: Okay. Thank you for the
22   clarification.
23   MR. GREENBERG: Yeah. I mean -- and
24   the other thing I would say and -- and Don, maybe
25   this is, you know, for you if there is maybe guidance

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2   that the -- the State Council would like to come out,
3   the SEMAC would like to come out related to something
4   like that, that could be a good thing, maybe between
5   now and January if it doesn't get done before.
6   MR. DOYNOW: Certainly, something we
7   can look into. Any other questions for the director?
8   MR. DAILEY: Yes, please. Director
9   Greenberg, just a quick question if you don't mind, I
10   apologize. So you had -- you had said that there was
11   going to be a new pathway for assuring that protocols
12   were going to be reviewed by the commissioner's
13   office in a timely manner.
14   And since mid-standards today actually
15   approved some protocols for the fire department in
16   the city of New York that they want to implement in
17   January. And you were just telling us that the
18   protocols that the collaborative had brought to you
19   nearly a year ago had finally been almost approved.
20   I just wanted to make sure that
21   indeed, this is going to work out in a timely manner
22   for the -- for the city of New York. Would you mind
23   just reviewing that for us, please?
24   MR. GREENBERG: Absolutely. So the
25   new process, I do believe, would actually get both

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2   Okay. Moving on to the standing
3   subcommittee's education, Dr. McEvoy?
4   MR. MCEVOY: Yes, I'm Mike McEvoy.
5   And education met this afternoon actually, few things
6   that were on our agenda that we discussed. The
7   Bureau staff report talked about some retirements
8   that are coming up, and we'll hope to delay some of
9   those as long as we can.
10   They're holding a C.I.U. a Certified
11   Instructor Update at vital signs. So the C.L.I.
12   C.I.C.s who need hours per instructor recertification
13   can get those virtually or in person at vital signs,
14   very short forms.
15   So co-sponsors who are on the E.M.T.,
16   A.M.T. and paramedic programs have to file a short
17   form every other certification period and a long form
18   every other one this year at the end of the year,
19   December 31st. All of them have to file a short
20   form.
21   And short forms have gone out to
22   everybody. So if there's co-sponsors out there that
23   didn't get one, they should contact the Bureau to get
24   the form. Instructor portal there is an email that
25   has been created to send the instructor paperwork in.

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2   the collaborative backlog that was there out as well
3   as the new protocols especially considering there
4   were no changes. It would be a little bit more
5   concerning if the changes and those -- we've talking
6   about academy and then rates and things like that,
7   that would become more problematic.
8   But I do think that there'll be able
9   to get out. And the ultimate goal is to have that
10   done within -- I mean, sort of formatting and -- and
11   components of that, you know, for documents that we
12   need to work on. But from a commissioner approval
13   within six -- roughly about sixty days from the point
14   of the meeting, if not sooner.
15   And -- and again, Dr. Dailey, the goal
16   will be is that this process that was created now in
17   order to move this forward would maintain and is a
18   good one, and then so going forward in future
19   collaborative things, we'd still be in a good place.
20   MR. DAILEY: Thank you very much.
21   MR. DOYNOW: Any other questions for
22   the director? Also, just to remind folks, when you
23   do speak, if you could just say who's speaking.
24   Sometimes we don't recognize the voice, and it will
25   help with the transcription.

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2   The email is ems.instructors@health.ny.gov.
3   So C.M.E. paperwork audit, that sort
4   of thing that needed to go into the Bureau can all go
5   through that one single email address. There was a
6   discussion about the retention of C.I.C.s and we
7   talked about this at the last meeting.
8   I proposed some language that we
9   floated around on the boardable site. And what was
10   settled on was it seemed reasonable to the Bureau
11   from their perspective of tracking C.I.C.s for their
12   recertification, and for the necessity of having some
13   duplication of C.I.C.s and courses as well as to
14   facilitate opportunities for C.I.C.s to teach, so
15   that they can recertify to make a sixty-forty split
16   in courses, so that there could be a C.I.C. of record
17   for the class and a second C.I.C. who would be the
18   assisting C.I.C.
19   That seemed to sit well with the
20   committee, seemed to sit well with the Bureau. And I
21   think we really didn't need a motion to do that.
22   That's up to the Bureau to do the implementation of
23   probably the most complicated part of which will be
24   changing a form that needs to be submitted to apply
25   for a class.

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2   So that will be helpful because I
3   think that will markedly improve retention of
4   certified instructor coordinators. I think that was
5   about it. We ran out of time for a meeting, so we're
6   going to work on a mission statement and committee
7   description through boardable.
8   We did throw onto our agenda for a
9   future discussion a little bit more about the scope
10   of practice of A.M.G.s. So unless there's any
11   questions, those are pretty much the things that we
12   discussed. I think Ryan mentioned two policy
13   statements that came out. They're going up on the
14   bureau website. They were on boardable for people
15   who are in this meeting.
16   One is on clinical rotations and talks
17   a little bit about patient contacts as opposed to
18   hours. And so people would be required at the E.M.T.
19   level to have ten patient contacts of any sort. I
20   think you could do those anywhere there's humans,
21   probably not in a vet clinic, but in any human
22   opportunity to see patients.
23   And then the distance learning policy
24   is, pertains to defining things, like for example,
25   this meeting that we're in right now would be

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2   considered while you might be virtual on it, there's
3   the ability to interact. And so they would consider
4   that synchronous learning as though you were actually
5   sitting in a classroom.
6   And that has been ill defined and sort
7   of during COVID, we needed to get some grip on what
8   we're calling what, what's distance learning, what's
9   not. That policy spells that out to the best of the
10   ability right now.
11   And it was noted that there are some
12   concerns about augmented reality, virtual reality and
13   CAPCE the accreditation group for the national
14   registry is working on definitions along those lines,
15   and we expect that that will eventually get folded
16   into this policy.
17   But it's the beginning of helping to
18   define that what is what when you're talking about
19   hybrid and synchronous and asynchronous learning.
20   MR. GREENBERG: So those policies same
21   instruction now up on the website.
22   MR. MCEVOY: See, Valerie's amazing.
23   Thank you.
24   MR. DOYNOW: Excellent. Thank you.
25   Any questions for Dr. McEvoy? Okay. Dr. Cooper, if

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2   you're there, any report on the E.M.S.?
3   MR. COOPER: Indeed, yes. It's Dr.
4   Cooper. And again, I'd like to thank Amy Eisenhower,
5   our phenomenal E.M.S. the children program manager
6   coordinator for all her incredible work in keeping
7   things on track.
8   In our recent meeting a week ago from
9   today, we addressed three issues of importance. The
10   first has to do with the reportable workgroup, which
11   we had established to look at the treatment of --
12   agitation of pediatric patients in the field.
13   This group did an enormous amount of
14   work with, a huge tremendous amount of literature and
15   is in the process of finalizing a potential approach
16   to agitation of pediatric patients in the field, just
17   based largely upon a document that is in circulation
18   with the American Academy of Child and Adolescent
19   Psychiatry.
20   Hopefully, we will have that
21   information for you ... SEMAC January meeting for
22   consideration. The second issue that we deal with is
23   another workgroup established to look at pediatric
24   sepsis issues. As you all are aware, recognition or
25   -- or early recognition of sepsis appealed the

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2   challenging for adults and children, but especially
3   for children.
4   And that is looking to recommend
5   potentially the changes to the -- to the protocol in
6   terms of early recognition sepsis, more on that after
7   the January meeting as well after those
8   recommendations are finalized. And last but not
9   least, perhaps most importantly, I think in many
10   ways, well, certainly equally important in many ways,
11   was a discussion about the potential need for our
12   E.M.S. providers to be vaccinated against COVID.
13   So after a very, very lengthy
14   discussion, the committee voted to unanimously send a
15   letter to the commissioner asking that the
16   commissioner strongly recommend to all E.M.S.
17   providers in New York State that they be vaccinated.
18   We're particularly concerned as an E.M.S. committee
19   about this because, of course, the great majority of
20   adolescents at this point still, and all children
21   under the age of -- under the age of twelve who are
22   not yet permitted to get the vaccine are potentially
23   at risk.
24   If -- if a -- an E.M.S. provider,
25   unbeknownst to him or her is -- because he or she may

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2   be –- may be asymptomatic, but actively be
3   transmitting the virus. That letter is in transit, I
4   am told. And I mentioned it this time because our
5   sister committee SEMAC may wish to make a similar
6   recommendation.
7   But I will leave that to the chair to
8   potentially open discussion about that either now or
9   at a later point during the meeting. I will -- that
10   concludes my -- my report and we will be happy to
11   answer any questions you might have. Thank you.
12   MR. DOYNOW: Thank you, Dr. Cooper.
13   Does anybody have any questions for Dr. Cooper?
14   Okay. Nothing heard. Let's move to Dr. Marshall,
15   Med Standards, which I suspect will have an open
16   discussion.
17   MR. MARSHALL: Thank you, Dr. Doynow.
18   MR. DOYNOW: You're welcome.
19   MR. MARSHALL: Thank you, Dr. Doynow.
20   Good afternoon, everyone. Medical Standards met
21   immediately prior to SEMAC, and we have three action
22   items to bring forward. And then I'll mention a
23   couple of discussion items. The first action item is
24   a motion to approve the New York City HASTAC
25   Protocols.

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2   As discussed, the changes to these
3   protocols -- there was some dosing changes to bring
4   the protocol into agreement with the unified
5   protocols in New York City. Until other formatting
6   changes were made that didn't substantially affect
7   the protocol itself. And there was a change in the
8   cyanide and organophosphate protocols.
9   If you recall, in the past, use of
10   these protocols required a class order for an N.C.O.
11   the use requirement for a class order was removed to
12   allow the HASTAC units to utilize the protocols in
13   smaller settings. And that was -- that came, passed
14   unanimously and comes as a second in motion to this
15   body.
16   MR. DOYNOW: Okay. Thank you, Dr.
17   Marshall. So we'll need a roll call vote on that,
18   Val, if we can.
19   MS. OZGA: Okay. I think Brian's
20   going to bring it up on the screen. Okay. All
21   right. So Dr. Alexandrou?
22   MR. ALEXANDROU: Yes.
23   MS. OZGA: Dr. Bart?
24   MR. BART: Yes.
25   MS. OZGA: Dr. Berkowitz?

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2   MR. BERKOWITZ: Yes.
3   MS. OZGA: Dr. Berry?
4   MS. BERRY: Yes.
5   MS. OZGA: Dr. Bombard?
6   MS. BOMBARD: Yes.
7   MS. OZGA: Dr. Cooper?
8   MR. COOPER: Yes.
9   MS. OZGA: Dr. Cushman?
10   MR. CUSHMAN: Cushman, yes.
11   MS. OZGA: Dr. Dailey?
12   MR. DAILEY: Dailey, yes.
13   MS. OZGA: Dr. Detraglia, did he get
14   on? Dr. Doynow?
15   MR. DOYNOW: Yes.
16   MS. OZGA: Dr. Gomez?
17   MR. GOMEZ: Gomez, yes.
18   MS. OZGA: Dr. Kugler?
19   MR. KUGLER: Yes.
20   MS. OZGA: Dr. Lynch?
21   MR. LYNCH: Lynch, yes.
22   MS. OZGA: David Markowitz, Dr.
23   Markowitz?
24   MR. MARKOWITZ: Markowitz, yes.
25   MS. OZGA: Dr. Marshall?

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2   MR. MARSHALL: Marshall, yes.
3   MS. OZGA: Dr. Maynard?
4   MR. MAYNARD: Maynard, yes.
5   MS. OZGA: Dr. Murphy?
6   MS. MURPHY: Murphy, yes.
7   MS. OZGA: Dr. Olsson?
8   MR. OLSSON: Olsson, yes.
9   MS. OZGA: Dr. Pigott, are you still
10   on? Brian Walt -- Dr. Walters.
11   MR. WALTERS: Yes.
12   MS. OZGA: And Dr. Wicelinski?
13   MR. WICELINSKI: Rob Wicelinski, yes.
14   MS. OZGA: Okay. Motion passes.
15   MR. DOYNOW: Okay. Thank you. Dr.
16   Marshall, if you'd like to go with the second action
17   item.
18   MR. MARSHALL: Yeah. So the second
19   action item comes as a second in motion to approve
20   the New York City rescue paramedic protocols. These
21   rescue paramedic protocols have been in place for
22   quite a number of years. And there were some dosing
23   changes for benzodiazepines, opioids to be consistent
24   with the unified protocols for regular paramedic
25   protocols.

10 (Pages 37 to 40)

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2   The addition is a repeat dosing for
3   morphine understanding order, and dosages of Toradol
4   and ketamine were also discussed. Toradol at 15
5   milligrams per kilogram -- I mean, fifteen milligrams
6   period and ketamine at point three milligrams per
7   kilogram I.V. and one milligram per kilogram I.M.
8   There was some discussion about the
9   one milligram per kilogram I.M. and it was felt that
10   this is a dosage that's used by other organizations
11   and has actually been in the New York City current
12   rescue paramedic protocols for over a decade. And so
13   this comes forward as a second motion. New York City
14   Fire Department has agreed to supply the data on
15   ketamine use within the region.
16   **MR. DOYNOW:** That will need a roll
17   call vote for this as well, please.
18   **MR. MARSHALL:** Just to add that
19   ketamine is a maximum dose, maximum of two doses.
20   **MS. OZGA:** Okay. Dr. Alexandrou?
21   **MR. ALEXANDROU:** Yes.
22   **MS. OZGA:** Dr. Bart?
23   **MR. BART:** Bart, yes.
24   **MS. OZGA:** Dr. Berkowitz?
25   **MR. BERKOWITZ:** Yes.

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2   **MS. OZGA:** Dr. Murphy?
3   **MS. MURPHY:** Murphy, yes.
4   **MS. OZGA:** Dr. Olsson?
5   **MR. OLSSON:** Olsson, yes.
6   **MS. OZGA:** Dr. Pigott? Dr. Walters?
7   **MR. WALTERS:** Walters, yes.
8   **MS. OZGA:** And Dr. Wicelinski?
9   **MR. WICELINSKI:** Wicelinski, yes.
10   **MS. OZGA:** Motion passes.
11   **MR. DOYNOW:** Okay. Thank you, Val.
12   Dr. Marshall, do you want to continue.
13   **MR. MARSHALL:** Yes. So we have one
14   more action item and there was some discussion and
15   this is item that will be familiar -- familiar to
16   many. And the motion is that SEMAC respectfully
17   requests that the commissioner establish the position
18   of state E.M.S. Medical Director. This E.M.S.
19   physician will report directly to the commissioner,
20   advise the Bureau of E.M.S. and trauma and provides
21   subject matter expert guidance on the state to the
22   state on issues of E.M.S. and pre-hospital care.
23   Notice comes forward as a second in motion.
24   **MR. DOYNOW:** Okay. Thank you, Dr.
25   Marshall. Val, roll call vote, please.

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2   **MS. OZGA:** Dr. Cherisse Berry?
3   **MS. BERRY:** Yes.
4   **MS. OZGA:** Dr. Bombard?
5   **MS. BOMBARD:** Yes.
6   **MS. OZGA:** Dr. Cooper?
7   **MR. COOPER:** Yes.
8   **MS. OZGA:** Dr. Cushman?
9   **MR. CUSHMAN:** Cushman, yes.
10   **MS. OZGA:** Dr. Dailey?
11   **MR. DAILEY:** Dailey, yes.
12   **MS. OZGA:** Dr. Doynow?
13   **MR. DOYNOW:** Yes.
14   **MS. OZGA:** Dr. Gomez?
15   **MR. GOMEZ:** Gomez, yes.
16   **MS. OZGA:** Dr. Kugler?
17   **MR. KUGLER:** Yes.
18   **MS. OZGA:** Dr. Lynch?
19   **MR. LYNCH:** Lynch, yes.
20   **MS. OZGA:** Dr. Markowitz?
21   **MR. MARKOWITZ:** Markowitz, yes.
22   **MS. OZGA:** Dr. Marshall?
23   **MR. MARSHALL:** Marshall, yes.
24   **MS. OZGA:** Dr. Maynard?
25   **MR. MAYNARD:** Maynard, yes.

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2   **MS. OZGA:** Dr. Alexandrou?
3   **MR. ALEXANDROU:** Yes.
4   **MS. OZGA:** Dr. Bart?
5   **MR. BART:** Bart, yes.
6   **MS. OZGA:** Dr. Berkowitz?
7   **MR. BERKOWITZ:** Yes.
8   **MS. OZGA:** Dr. Berry?
9   **MS. BERRY:** Yes.
10   **MS. OZGA:** Dr. Bombard?
11   **MS. BOMBARD:** Absolutely, yes.
12   **MS. OZGA:** Dr. Cooper?
13   **MR. COOPER:** Yes.
14   **MS. OZGA:** Dr. Cushman?
15   **MR. CUSHMAN:** Cushman, yes.
16   **MS. OZGA:** Dr. Dailey?
17   **MR. DAILEY:** Dailey, yes.
18   **MS. OZGA:** Dr. Doynow?
19   **MR. DOYNOW:** Yes.
20   **MS. OZGA:** Dr. Gomez?
21   **MR. GOMEZ:** Gomez, yes.
22   **MS. OZGA:** Dr. Kugler?
23   **MR. KUGLER:** Yes, please.
24   **MS. OZGA:** Dr. Lynch?
25   **MR. LYNCH:** Lynch, yes.

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2   **MS. OZGA:** Dr. Markowitz?
3   **MR. MARKOWITZ:** Markowitz, yes.
4   **MS. OZGA:** Dr. Marshall?
5   **MR. MARSHALL:** Marshall, emphatically
6   yes.
7   **MS. OZGA:** Dr. Maynard?
8   **MR. MAYNARD:** Maynard, yes.
9   **MS. OZGA:** Dr. Murphy?
10   **MS. MURPHY:** Murphy, yes.
11   **MS. OZGA:** Dr. Olsson?
12   **MR. OLSSON:** Olsson, yes.
13   **MS. OZGA:** Dr. Walters?
14   **MR. WALTERS:** Walters, yes.
15   **MS. OZGA:** And Dr. Wicelinski?
16   **MR. WICELINSKI:** Yes, yes.
17   **MS. OZGA:** Motion passes.
18   **MR. DOYNOW:** Okay. So with that
19   motion, I will send a letter to the new Commissioner.
20   And they will bring it up to SEMSCO as information.
21   I don't believe it needs to go there for a vote. If
22   anybody has any comment on that.
23   **MR. LANGSAM:** It doesn't need to go
24   for a vote to SEMSCO unless you want SEMSCO's
25   endorsement as well, which may not be the best idea

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2   but --.
3   **UNIDENTIFIED SPEAKER:** I would agree
4   with Dr. Langsam. I think this would be an excellent
5   situation to get the SEMSCO's endorsement.
6   **MR. DOYNOW:** Okay. We'll bring it up
7   them for a vote for SEMSCO as well, and I will
8   generate a letter as well. Okay. Dr. Marshall,
9   other items that were discussed.
10   **MR. MARSHALL:** Yeah. So there was
11   another motion made and postponed till the January
12   meeting, and it was about Suboxone use in E.M.S. And
13   the general feeling of the committee was that this is
14   something that we definitely need to look into in
15   terms of providing our patients with appropriate
16   services, and it may come in handy under the new
17   E.M.S. innovations committee as they do their work on
18   treat employees and telemedicine, so the motion was
19   to add it to the state formulary.
20   But that motion, as I mentioned, was
21   postponed until the January meeting. We also will be
22   requesting some data from the state in regard to
23   ketamine utilization in the state so we can evaluate
24   safety. Also looking at pre-hospital press for use
25   across the state, and also in terms of burn patients

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2   and fluid resuscitation in the field, based on some
3   comments that we may be fluid overloading patients in
4   the field prior to arrival at a burn center.
5   And the last thing I want to mention
6   is that at the last meeting, we had talked about
7   developing disaster protocols for use in the state,
8   implementable by region when -- when a region was in
9   need of these protocols. And we will put together a
10   group and Ryan Greenberg will reach out to his
11   colleagues in other states to help see what's
12   available.
13   And we will come back to the January
14   meeting with some recommendations on moving forward
15   with disaster protocols and I would ask that anybody
16   who would like to participate, please send an email
17   to myself, Ryan, and Val, and we will get that
18   scheduled as a call in the next several weeks. And
19   we covered some old business.
20   The B.L.S. ideal study, we're still
21   waiting to hear from the commissioner to move forward
22   on that. And the new committees, the Quality Metrics
23   Committee, which meets tomorrow, and the E.M.S.
24   Innovations Committee, which is being scheduled.
25   That's my report.

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2   **MR. DOYNOW:** Okay. Thank you, Dr.
3   Marshall. Any questions for Dr. Marshall? There are
4   two other new committees. I think they were somewhat
5   mentioned, E.M.S. Innovations moving E.M.S. forward,
6   and also Quality Metrics, which will hopefully be
7   reporting back to ...
8   All right. Moving on to new business,
9   first is first responder P.C.R.s and documentation.
10   Dr. Dailey, I don't know if you want to talk about
11   this. I know there has been some significant issues
12   at Albany Med with the loss of data from P.C.R.s.
13   **MR. DAILEY:** I think this is a broad-
14   based issue. And I think that Mr. Brodie's been
15   working diligently to try to assist people with it.
16   But the primary problem is that in the Albany area,
17   we have a significant number of advanced life support
18   first response agencies that transport with basic
19   life support agencies.
20   As a result, the documentation system
21   that we are using here is linked into the hospital
22   record at the trauma center primarily. And that data
23   is being lost due to some of the changes the Bureau
24   has made in terms of how information is flowing. I
25   believe that Mr. Brodie is actively working to try to

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find solutions to this that will leave us with the ability to still have those charts to take care of patients.

However, that certainly is an ongoing significant concern, because the A.L.S. interventions for our patients that are transported in is profoundly important for their continuing care in the emergency department.

MR. DOYNOW: Thank you, Mike. Does anybody else have any comments or questions? I moved around a little bit here because we do have two presentations. Let me just talk about E.D. overcrowding and wait times. I believe the director has already spoken about their surge, basically, as surge and flex, D.O.H. initiative.

Does anybody have any suggestions that they can pass along as to how to help unload our E.M.S. providers? I know it's become a problem in some of our local hospitals, simply because there is just no room, and providers had to wait for some periods of time. But anybody have any suggestions how to perhaps resolve part of this issue?

All right. Nothing heard. If any of you have any suggestions, please pass them along to

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solution to the hospital problem. Yet, I think in some of our areas they're expecting us to be that solution by waiting for extended periods of time when we know that they are legally responsible for those patients. And again, I think we need to all be understanding and work together as a group. But I think we also need to try to take some proactive measures to prevent our system, E.M.S. system, from becoming more strained.

MR. GREENBERG: I couldn't agree more. And I would also say that, you know, our E.M.S. system has its own series of crisis moments right now. Everything from staffing to operations. And so, you know, as we look forward, especially around this room, and you know, we know that we're seeing these -- these offload times in particular pockets right now, ... demand.

But if there are other areas that have figured out best practices or things that can help this, it would be important. I also think it's important that right now we do take the opportunity on the innovation side, an ET3 and different models from there, to figure out can that help the system without putting the burden on the E.M.S., as you said

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me, and I'll pass them along on to the committee.

UNIDENTIFIED SPEAKER: Dr. Doynow --

MR. DOYNOW: I'm sorry. Go ahead.

UNIDENTIFIED SPEAKER: -- I don't necessarily have a specific recommendation. But I think this body, I think it's important, we all know the delays we're seeing in the hospitals, and I think we all sympathize, since most of us work in the hospitals and know what it's like in the emergency room. And we know what some of the bottlenecks are, especially getting patients out to nursing homes, et cetera.

But I think it's important for us and for the Bureau and the Department of Health to recognize that this, as Ryan put it, as part of it -- we're part of an ecosystem. And I'm just concerned that the hospital crisis that we're seeing is going to start being pushed further and further into the E.M.S. And we're going to see further strains on our E.M.S. system.

And I think we need to be careful that while we work as a system, we need to be careful that a hospital problem doesn't continue to become more of an E.M.S. problem. We are not necessarily the

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Doc. And I think in a positive way, so you know, is there models within ET3, are there patients that don't need to go to the hospital that can still -- that not only would help the hospital, it would help the E.M.S. system as well. And the E.M.S. providers, you know, if we can reduce the number of transports that we have to transport -- number of patients we have to transport, number of patients we have to carry down a flight of stairs who may not need to go to hospital, but can be seen via telemedicine, that, you know, hopefully, we would start to be able to add longevity to some of our providers as well, because it helps them. And so I think this is the time where especially this group, as the physicians and the leaders within the E.M.S., need to really look at some of these models and say this works, this doesn't.

And also for this group to also look at, you know, working with their local E.R.s. I know many of you are E.R. doctors, some of you, you know, working in different roles. But to figure out what -- what helps or doesn't, you know, if you come back and say, telemedicine doesn't really help because our system is using the docs and E.R. to do telemedicine

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2   and therefore it's still the same kind of problems,
3   it's just in a different way.
4   Well, then, you know, not to focus on
5   that but to hopefully have the SEMAC come out with
6   some best practices on things that are going to help
7   both from a clinical point of view, from an E.M.S.
8   point of view and an operational point of view. And
9   you know, if there is any opportunity for, you know,
10   SEMAC to look at that and come out with some best
11   practices, I think there are lots of parts, there are
12   many parts of the state that either through a lower
13   call volume or other things may not know some of
14   those best practices or see it. And you, as a group,
15   you have the opportunity to really share that and
16   move that forward and see what makes the biggest
17   impact.
18   **MR. PHILIPPY:** Dr. Doynow, if I may?
19   **MR. DOYNOW:** Sure.
20   **MR. PHILIPPY:** Mark Philippy. So one
21   of the things that the region that I represent has
22   engaged in some high-level discussions with a number
23   of stakeholders in our community, not limited to the
24   ambulance services themselves, but local government
25   hospital systems and local health department and so

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2   intercepted at the nine one one call level, rather
3   than sending an ambulance. We've heard about
4   telemedicine, and I think telemedicine is a great
5   opportunity, as has been discovered by the state
6   government looking at as ways to open that up to us
7   through the governor's Executive Orders.
8   But there's a lot to that and there
9   are a lot of pieces that how that system is going to
10   work and integrate with your local operations. What
11   are the protocols, who is going to be the ones to
12   commit those visits. So there is a lot to answer
13   there. But I think there is an opportunity that both
14   at the regional local level and also through this
15   body need to be discussed.
16   And as we move toward January, it's
17   not that far away, if we have meetings in January,
18   which I'm hopeful we will. I would encourage the
19   physicians of this body in our subcommittees to
20   please look at these closely and start to have some
21   of these in between WebEx meetings to discuss ways
22   that we can move this forward because I do fear for
23   the state of our system come January.
24   It's not that far away, but yet, we
25   have some opportunities. Alternative destinations

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2   on.
3   As we start to explore a number of
4   different options and something for the members of
5   this body to consider are probably four or five ideas
6   that some of which may be short term, some of which
7   may be longer term solutions to some of these issues.
8   They're all somewhat small starting steps, but they
9   can have, I believe, an impact over time as we start
10   to re-educate and realign our healthcare system and
11   as the director mentioned, this is a healthcare
12   system crisis. We can no longer refer to this as an
13   E.M.S. system crisis as I did back in May.
14   This is truly a healthcare system and
15   is a complete throughput, front to back system
16   problem. And some of those solutions include such
17   things as reimagining how we deal with inter facility
18   transfer work. Are there opportunities for non-
19   traditional services to do inter facility transfer
20   work to relieve that bottleneck at the back end,
21   getting those patients out of the hospital to allow
22   beds to be opened up for patients coming in.
23   Are there opportunities for
24   communities to consider things such as nurse
25   navigation systems, where those calls may be

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2   has been mentioned, but as we start to see systems
3   start to ... their closing ranks, and by that I also
4   mean their -- in some cases, closing some of those
5   alternative destinations. So whereas that may have
6   been an alternative six or eight or ten months ago,
7   those opportunities are closing.
8   However, that doesn't mean that we
9   can't engage some of our primary care practices and
10   potentially divert some of those patients there,
11   which is where I think some systems like nurse
12   navigation can be helpful. So I think there are a
13   lot of opportunities here. I do want to implore and
14   encourage our hospital partners to look at the
15   overall system.
16   We do tend to have the emergency
17   department as its primary care role in many of our
18   urban communities, find themselves being overwhelmed.
19   I've heard some stories as nurse-to-patient ratios as
20   high as ten, fifteen, twenty or even higher, whereas
21   inpatient nurse ratios may not be quite so high.
22   So balancing that load and balancing
23   those responsibilities also may be around for our
24   physicians, as they influence their hospital systems
25   and have discussions with those. Something that we

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2   in the E.M.S. end of things may not have those
3   opportunities, but you folks may so I ask that that
4   be something you consider as we go back for this
5   meeting today.
6   MR. DOYNOW: Thanks, Mark. Any other
7   comments?
8   MR. KROLL: Dr. Doynow.
9   MR. DOYNOW: Hi, Steve.
10   MR. KROLL: Hi, Steven Kroll. I think
11   most of us are probably seeing the New England
12   Journal Article canary in a coal mine that tells us
13   that this was entirely predictable, and that it's
14   going to be with us for a while. So it's probably
15   going to get worse for the hospital industry before
16   it gets better.
17   And that means it's probably going to
18   get worse for the E.M.S. industry and field before it
19   gets better. Hospital industry leaders are -- and I
20   agree with all the suggestions about things that we
21   need to try in our local communities, with hospitals
22   and stakeholders and E.M.S. community working
23   together.
24   But I think there is also a statewide
25   conversation that I'd like to encourage the SEMAC to

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2   through the next twelve months, the next twenty-four
3   months, till the pipeline perhaps reestablishes.
4   How can we extend your view to
5   incorporate us the the Medical Directors for pre-
6   hospital care in New York State, and the pre-hospital
7   care community, because they're -- they're in a no --
8   they're in a situation where they have to come up
9   with choices that they're going to have to make, and
10   I would like to see when they're thinking about those
11   choices, are us being part of that, because those
12   choices have implications for us.
13   And I think we can contribute to those
14   choices. So perhaps something that the SEMAC could
15   do is make a statement or send a letter to the
16   hospital associations, to the commissioner, to the
17   chair of the state hospital review and planning
18   Council and say, hey, will you include us in these
19   conversations?
20   MR. DOYNOW: Thanks, Steve, would you
21   like to head up the committee doing it?
22   MR. KROLL: I'm a non-voting member,
23   but I would be glad to help draft something for the
24   folks to look at.
25   MR. DOYNOW: That way we can use your

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2   be part of. Hospital industry leaders are meeting
3   regularly statewide, which is the Chief Executives,
4   the board chairs, throughout the state to talk about
5   what we're going to do, how we're going to come up
6   with ideas, what kind of policies can be put in place
7   that might assist. Because of first a quirk in how
8   we're regulated and we're regulated a little
9   differently than the hospitals, but also people's
10   perceptions.
11   Today, I think the view of the
12   hospital is about how we look at the hospital system
13   and the things that are encompassed inside the
14   hospital system. We're kind of outside of that view.
15   So while at a local level, I have no question that
16   members of the SEMAC see this as a systemic problem
17   that involves E.M.S. agencies in our community.
18   I think we ought to reach out to the
19   hospital community, whether through the regulatory
20   apparatus, like the state hospital review and
21   planning council, or whether to the hospital
22   associations, like Greater New York, and HANYS. And
23   I think the SEMAC would be a great group to do that
24   and say, hey, we know you're having these large
25   conversations about what we're going to do to get

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2   expertise so that'd be -- that'd be well appreciated.
3   I would also suggest that we do set up a WebEx maybe
4   in another month or so of all the committee members
5   just to discuss how things are going and any ideas
6   folks have as to how to resolve the problem, rather
7   than just having a few people on the committee.
8   Everybody's in agreement with that.
9   MR. GREENBERG: Steve, I think that's
10   a good idea. And I think part of that discussion,
11   and Ryan, I would think from the Bureau and the
12   Department of Health, I think there needs to be an
13   acknowledgement that -- that it's not appropriate or
14   a good utilization of resources to hold E.M.S.
15   providers with a patient in the hospital for two to
16   three hours for offload times.
17   And I think that that's part of what a
18   lot of our hospitals see as a solution. And I
19   understand they don't have beds, I understand its
20   lack of staffing, I understand all of that. But
21   looking at resource management, especially coming
22   from a rural area where we don't have that many
23   ambulances available, it creates quite the downstream
24   effect for availability for response in the nine one
25   one system to the public. And so I think that that

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2   needs to be an acknowledgement.
3   I think as we go forward that we're
4   going to need the support of the Bureau and the
5   Department of Health as we deal with the hospitals to
6   say that they support our E.M.S. agencies when we say
7   we cannot wait that long. The patient is here,
8   you're going to have to find a way or find a bed or
9   bring in some beds that we used at these mobile
10   hospitals last year that we're not using now. We're
11   going to need that support from the Bureau and I
12   think that needs to be an acknowledgement.
13   MR. GREENBERG: I think you definitely
14   have that support. I can tell you that, you know,
15   again, especially being, you know, having the search
16   and flex operation center under the Bureau of E.M.S.,
17   we do hear all -- all those things.
18   And it is incredible to me the -- the
19   -- the amount of cooperation and coordination, you
20   know, all the way up to the commissioner's office
21   and, you know, regular meetings with the Executive
22   Deputy Commissioner and our first Deputy Commissioner
23   related to items like this and trying to find what
24   can we do.
25   Although, you know, slightly

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2   crews too. Particularly as we look at a system that
3   is, you know, significantly volunteer based. And as
4   these delays come up, it's not a situation if only,
5   you know, well, I don't want to stand there, it's a
6   situation of, well, if I need to, you know, attend to
7   a family matter and I'm volunteering what I know is
8   an hour, an hour-and-a-half, of my time in order to
9   be able to do a call. And now all of a sudden, I'm
10   volunteering four hours of my time. That's a
11   significant impact.
12   So, you know, we are trying new
13   things. It's one of the executive orders that came
14   out in part to help with some of those offload times.
15   And, you know, I'm happy to sit and discuss some of
16   the other things. The one thing I would bring to you
17   from, you know, from this counsel to is, as we do
18   start to look at some of these other alternatives
19   like telemedicine and treatment in place, I do think
20   there should be, you know, some sort of guidelines
21   coming out of the SEMAC in order to how to facilitate
22   that, how to work with that within a region.
23   And I think, you know, as -- as that
24   continues on the ... program. We've seen New York
25   City very, you know, specific kind of outlines on how

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2   controversial, the executive order that's in place
3   right now that allows the E.M.S. providers to work in
4   non-traditional environments was feedback from both
5   the E.M.S. community as well as the hospital
6   community to try and help combat with some of this,
7   to say, can we, you know, bring in additional
8   resources in that triage area that would, you know,
9   possibly be a more stationed situation, to allow for
10   those E.M.S. resources that need to get back out onto
11   the road to be able to get out there.
12   And so that if it does take forty-five
13   minutes or -- or something for that bid to free up in
14   the E.R., that there's a resource there that can work
15   with the nurse and the providers and the physicians
16   to offload that patient, so the E.M.S. crew and the
17   ambulance can get back into their service area.
18   While at the same time understanding
19   that there may not be a place for them to go within
20   five minutes that we walk in the door. In some
21   hospitals, they -- they don't even let you walk in
22   the door. They say, okay, well, wait in the
23   ambulance and we'll call you in ten minutes, or call
24   back in in ten minutes.
25   And that's frustrating for the E.M.S.

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2   they want to move forward. But the other areas, I
3   think it's important to outline now so that the
4   E.M.S. providers know, well, what are my resources
5   and how do I approach that and what's the best path
6   to it.
7   MR. DOYNOW: Any other comments?
8   MR. BART: Don, it's Joe Bart, if I
9   might? Can you hear me?
10   MS. BERRY: Just to be explicit, Ryan,
11   when you say non-traditional environments, you are
12   saying that people can work in the emergency
13   department? Is that correct?
14   MR. GREENBERG: Correct. Right now,
15   through an executive order, E.M.S. providers can work
16   up to the level of their certification within a non-
17   traditional environment.
18   MS. BERRY: I just wanted to clarify.
19   Thank you.
20   MR. DOYNOW: Any other comments?
21   MR. BART: Don, it's Joe Bart. Can
22   you hear me?
23   MR. DOYNOW: Dr. Bart, go ahead.
24   MR. BART: I -- I mean, thanks,
25   everybody for ... I am applauding the efforts here of

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2   recognizing that we need to do some innovations on
3   behalf of this. But E.M.S., in general, has -- has
4   been the cargo pants wearers to all of emergency
5   medicine problems. And quite honestly, our pockets
6   are full.
7   And the burdens within the hospital
8   systems, just they can't spill out into the E.M.S.
9   community any further than they are. I -- I think
10 this might be from the Bureau and I don't think this
11 is your direction in the first place.
12   But it -- it seems like the pathway
13 perhaps for ambulance diversion has become maybe a --
14 a crutch for some emergency departments when there is
15 either staffing issues or frankly labor negotiations
16 or that they're just too busy for the day to handle
17 patients. The diversion ends up being their -- their
18 choice and their mechanism.
19   And obviously the spillover to that to
20 the E.M.S. community and what that means to us, I
21 don't have to explain to anybody on this call, but I
22 was wondering, is there an easy answer to that for
23 the Bureau perhaps of who makes those decisions and
24 are they just more frequent, or are we just now privy
25 to the emails a little more commonly?

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2   diversion.
3   So I -- I do think that it's helped to
4   facilitate more communication and to make sure that
5   the leadership of the hospital is aware of what's
6   going on diversion to hopefully that they can work
7   towards reducing their diversion.
8   Again, in some areas, we've seen
9   tremendous collaboration and cooperation in trying to
10 ensure that not all hospitals are on diversion at --
11 at the same time and what would happen, should that
12 happen. We've, you know, gotten to that point as
13 well, including, you know, having the commissioner on
14 the phone to discuss what would happen if we got
15 there.
16   And so -- but I -- I definitely think
17 that you're noticing it more now because we are
18 sending out statewide notifications. And part of the
19 reason why we send out statewide notifications is
20 just not sure where, you know, where that line is, in
21 which direction someone may go.
22   And so it is, you know, more
23 reasonable for us to send out the statewide
24 notifications than to send out, you know, just to a
25 given region where the region next door could still

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2   MR. GREENBERG: I think it's a little
3   bit of a combination of both. I -- I think it is
4   currently right now in the current dynamic, it's a
5   little bit more frequent than what we've seen before.
6   But if you talk to some people in some regions, it's
7   actually less than it is before.
8   And that's in part because of search
9   and flex and the department health where we have
10 turned and said you need to, you know, present to us
11 why you're going on diversion. We look at NEDOCS
12 scores. We make sure that the leadership of the
13 organization is aware of it.
14   We were seeing, you know, frequent
15 situations before where an E.R. would go on
16 diversion. And when we contacted the hospital to
17 find out why you're going on diversion so often that
18 are -- and there're things thing that are -- that --
19 that we can help with and -- and the return would be
20 like, well, what do you mean we're on diversion.
21   And so senior leadership wasn't aware
22 of some of those diversions within the institution
23 that the -- the E.R. for whatever reason, maybe as a
24 charge nurse, or whoever was in charge of that ...
25 we're at capacity, you know, we -- we need to go on

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2   be transporting to, you know, a regional trauma
3   center that's bigger than, say, the E.M.S. region
4   that they're going to.
5   MS. EISENHAUER: Excuse me for one
6   moment, this is Amy Eisenhauer. I just want to
7   remind everybody, please state your name before you
8   speak. The court reporter can't always see
9   particularly if you are attending virtually, and they
10 do need it for the record. Thank you.
11   MR. DOYNOW: Any other comments?
12   MR. COLE: This is Steve Cole. Just
13 to follow up with Ryan, and what you just said is --
14 is alarming. If hospital C.E.O.s don't know that
15 their E.R.s are on diversion, that means that the
16 people that are in command of the largest piece of
17 our health care system aren't paying attention to our
18 existence.
19   So even though those of you that are
20 the heads of pre-hospital medicine for your hospital,
21 or who may be the head of an emergency department, if
22 our situation only rises to that level, we're in a
23 very bad place.
24   And I think that reinforces why we
25 need the top-level leaders in the hospital industry

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2 to see their envelope go out past the doors all the
3 way to where 911 is called.
4   **MR. GREENBERG:** And I will say with --
5 you know, with this, you know, with the hospital
6 diversions and the requirements that we've had --
7 and -- and -- and you can look on four zero five one
8 nine which is the hospital diversion regulations on
9 what needs to happen and -- and what we collect
10 related to that, making sure that leadership of that
11 institution is aware of it, and what plans are doing
12 to mitigate it and work with it.
13   There's only so much, you know, it's
14 sometimes the things that can be done, but you know,
15 those are all things that are -- that are moving that
16 forward.
17   **MR. DOYNOW:** Any other comments?
18   **MR. WASHKO:** Yeah, hi, this is
19 Jonathan Washko. I agree that everything that's been
20 said so far, I think are good ways to mitigate. But
21 ultimately, it's going to take a combination of
22 everything we talked about. We need to pre can't,
23 you know, and -- and do treat in place and have
24 alternative destinations.
25   We have to have the ability to load

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2 entire healthcare system.
3   We've started that initiative down in
4 New York City because of many issues with E.M.S.
5 mostly dealing with unavailable ambulances to get
6 patients out of the hospital on the discharge side,
7 which are now backing up patients in the emergency
8 room, which are now backing up into longer hospital
9 drop times.
10   So you know, we're working to solve
11 some of those problems and we're doing that through a
12 regional approach where we're all looking to try to
13 solve the problem as a healthcare system, not just as
14 an emergency room and separate E.M.S. agencies.
15   We'd be happy to join any committee or
16 group that wants to work on this Steve, if you're
17 going to be working on something, I'm happy to help
18 you, you know, to try to figure out ways to come up
19 with some solutions to this. Thank you.
20   **MR. DOYNOW:** Thank you.
21   **MR. GREENBERG:** Just one more thing to
22 bring up for everybody here. Some of the regions
23 have a program where they're using a software called
24 E.M. resource, which helps them manage diversion and
25 at least, so that the E.M.S. providers and the

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2 balance, you know, in a -- in a regionally
3 coordinated way. And then we have to have a
4 diversion management system and regional diversion
5 management system, so that everyone knows when
6 everyone else is on diversion and, you know, so that
7 -- so things can be coordinated amongst all the
8 different entities.
9   Now there's potential where you need
10 to be looking at load balancing for some of these
11 facilities if they're at a point where they can no
12 longer, you know, get patients in. Because
13 ultimately it will back up into the 911 system.
14   I mean, Canada's are great case study
15 of where we don't want to go. If you're not familiar
16 with what goes on out there, they have ambulances
17 that can wait twenty-four hours before offloading a
18 patient and that's been going on for years.
19   And I don't think we want to end up
20 there and they've put many of these things in place
21 and -- and are still suffering from that. So I think
22 -- and I also agree that you've got to engage your
23 medical leadership at the hospitals, at the -- and
24 probably, you know, not just at the E.M.S. agency in
25 the single hospital entity approach, but with the

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2 dispatch centers can see when the facility is on
3 diversion, off diversion.
4   The Bureau of E.M.S. and trauma system
5 says -- made a considerable investment in some
6 technology. And actually, we are bringing -- we'll
7 be bringing on statewide E.M.S. resource as well as
8 some other technology, which is -- comes from a
9 software platform called Jabbari to help with system
10 awareness, diversions and to be able to track it, so
11 we can see trending and histories and things of that
12 nature.
13   So that is another step that we're
14 trying to do moving forward, so that you won't just
15 be receiving a, you know, another email with another
16 P.D.F. that, you know, has a saying, this is what's
17 on divert and why they're on divert.
18   So that is one of the things that's
19 happening. In addition, I think it's important, and
20 hopefully we'll have more information at this next
21 meeting, that if there's lots of conversations
22 related to data, and how do we get more data back out
23 to our committees and to our agencies and such -- and
24 such.
25   And so we did -- we are now working

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2   with an analytic platform that we're working on
3   getting the data into that platform, and then
4   hopefully the goal is, is that that information would
5   then be able to be shared with our council members,
6   with our committees to be able to -- to work on
7   whether it be system performance things, offload
8   times, as well as clinical performance and metrics
9   from that side, both in the trauma and the E.M.S.
10 side.
11   And so again, we -- we hope to have
12 that platform at least to some scale up and
13 operational by the January meeting where we'll be
14 able to report out and show some of the work that
15 they can do.
16   MR. DOYNOW: Okay. Thank you. Any
17 other comments?
18   MR. DAILEY: Ryan, just in the -- for
19 the present time, who gets that distribution of
20 diversion notices? It seems like a lot of the
21 medical directors and people on this committee don't
22 get those. Do you know how those go out? Where they
23 go to? Or are they posted online anywhere like
24 updated forms that people can just go and check and
25 see what the status is?

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2   diversions from a state and from search and flex are
3   done via a P.D.F. where we confirm it and then send
4   it out.
5   MR. DOYNOW: Ryan, when will that be
6   up and running?
7   MR. GREENBERG: The goal is by the Jan
8   -- you know, by January. So for first -- first
9   quarter next year, we're already working with the
10 software platform. It's been purchased and
11 operational. It could be much sooner. But like I
12 said the goal, I think realistic, is first quarter
13 next year.
14   MR. DOYNOW: Okay. Any other
15 comments? I appreciate everybody's thoughts and
16 hopefully together we'll -- we'll be able to make a
17 change or -- all right. Two more things to get to
18 before we get to our presentations.
19   Last time we met -- the state brought
20 forward the bullet policy and it was decided to table
21 that until this meeting. After Dr. David, Dr. Cooper
22 and Dr. -- Dr. Alexandrou had time to look at ethics
23 that were involved. Any of the three, do you have
24 any comments to make on that?
25   MR. CUSHMAN: Cushman, I can kind of

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2   MR. GREENBERG: Sure. So currently,
3   right now, every time there's a diversion that goes
4   out, there's a distribution list. But in that
5   distribution list also includes all of the program
6   agencies who are supposed to distribute it locally
7   beyond that. I believe it's also the E.M.S.
8   coordinators and things.
9   And -- and we can add to that
10 distribution list, and we're all for sharing that
11 information. But the bulk of it is shared through
12 the program agencies that should be distributing it
13 to the appropriate parties in the region.
14   MR. DAILEY: And is there an ongoing
15 list of what hospitals like statewide are on
16 diversion, or something that you can easily access on
17 the website?
18   MR. GREENBERG: There's not. That's
19 the goal of E.M.S. resource, --not the goal. That is
20 the -- will be the function of E.M.S. resource or E -
21 - sorry, E.M. resource is to be able to, you'd be in
22 one central place, you'd be able to see everything in
23 the state or you narrowed it down into your region to
24 be able to immediately see it at a local level.
25   Currently, right now, literally

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2   speak to that. All right. Jack and I had a meeting.
3   It was just the two of us. We talked through some
4   concepts. They were emailed out and there's been no
5   action since. Given that he's left the state, I
6   think we have to find a different band to get
7   together to address that issue.
8   MR. DOYNOW: Okay. We can maybe get a
9   WebEx together to do that. I would -- would hate to
10 table it to the next meeting, not sure that anything
11 would happen at that point. Would you want to end up
12 setting something up or how would you want to do
13 that?
14   MR. CUSHMAN: I guess that means that
15 I'm now the chair of -- based on succession of
16 someone leaving. So I'll connect with you offline.
17 This -- this is stuff that quite frankly should be
18 handled offline to the Bureau in the -- in the
19 stadium as medical director, so.
20   MR. DOYNOW: Okay. Thank you, Dr.
21 Cushman. We'll -- we'll talk about it. Let's see
22 the project we talked about under med standards. The
23 only last thing to bring up before we get to our
24 presentations is something Dr. Cooper brought up and
25 I don't know if he wants to make a motion

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2   specifically and recommending to the commissioner
3   that our E.M.S. providers be vaccinated.
4   Dr. Cooper, would you want to do that?
5   **MR. COOPER:** I would -- I -- I would
6   do this, Dr. Doynow, me as an individual. I -- but I
7   do think it's an issue worthy of discussion. I do
8   not have leave from the E.M.S. the advisory committee
9   to do any more than bring this as an informational
10   item. They did not vote explicitly to ask that SEMAC
11   and SEMSCO join with us.
12   But for purposes of discussion, I will
13   make the motion that the -- the SEMAC strongly
14   recommend that the commissioner advice all E.M.S.
15   personnel to become vaccinated against SARS-CoV-2,
16   the virus that causes COVID-19. Thank you.
17   **MR. DOYNOW:** Thank you, Dr. Cooper.
18   Any second on that?
19   **MS. BERRY:** Second.
20   **MR. DOYNOW:** Who was that?
21   **MS. BERRY:** Cherisse Berry, sorry.
22   **MR. DOYNOW:** Okay. Thank you. Do we
23   have any discussion on that motion?
24   **MR. WALTERS:** Dr. Doynow, I --
25   Walters, I have a comment. I -- first of all, I'll

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2   just say that, you know, while I'm supportive of the
3   vaccine, I think we need to be careful about
4   mandates. I think especially given the discussions
5   that we've just had. I know we're not mandating it,
6   but I think that a statement like that from this body
7   could then be used as fuel for a vaccine mandate for
8   E.M.S. providers.
9   And I think that given the discussion
10   we just had on our resources, on the crisis, our
11   hospitals, and our E.M.S. providers are in knowing
12   the, you know, strain they're already under, I think
13   that we want to be careful in something like that
14   that could then be used as a mandate or support for a
15   mandate which would just, you know, add to the crisis
16   that we're seeing.
17   I think when you start to look at
18   what's happened in our nursing homes in the state
19   after a vaccine mandate. When you look at some of
20   the other cities, police departments and -- and other
21   workers across the country who are facing these man -
22   - these mandates and that -- and the shortages
23   they're seeing, I think we'd be -- we have to be very
24   careful from this body to come out with a statement
25   like that.

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2   **MR. DOYNOW:** Thank you, Dr. Walters.
3   Any other comments?
4   **MR. COOPER:** Dr. Doynow, if I might --
5   if I might just respond to that. The E.M.S.
6   committee did extensively discuss that very issue.
7   We were particularly focused on the potential impact
8   on voluntary E.M.S. was that are -- are having enough
9   trouble recruiting members to serve their
10   communities.
11   It was for that reason, very reason,
12   in fact, the E.M.S. committee did not recommend that
13   E.M.S. ever be mandated to accept vaccination. But
14   indeed, instead, based upon the scientific evidence
15   that was available which all of us, I -- I -- I'm
16   sure are intimately familiar with, you know, that --
17   that -- that the vaccine should be part of the -- the
18   plan for any healthcare provider that interacts on a
19   regular basis with the public.
20   So this issue was considered and
21   discussed at length, the very reason that we stopped
22   short of recommending a mandate, recommend or -- that
23   recommended only a strong recommendation to the
24   commission to the E.M.S. personnel of our state.
25   Thank you.

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2   **MR. DOYNOW:** Thank you, Dr. Cooper.
3   Any the other comments, Dr. Walters?
4   **MR. WALTERS:** It's Walters again. And
5   Dr. Cooper, I -- I understand the -- the distinction
6   and I -- I respect that. I still think that
7   something strong statement from this body then can be
8   used as fuel for someone to -- to employ a mandate in
9   the future. That's all that I'm saying.
10   **MR. DOYNOW:** Thank you. Any other
11   comments? Any other comments before we vote?
12   **MR. BART:** Could you repeat and
13   clearly state the -- the motion here?
14   **MR. DOYNOW:** Dr. Bart, go ahead.
15   **MR. BART:** I don't -- I don't think
16   I've understood the motion. Just wondering if we
17   could repeat the motion to understand if we're voting
18   on something.
19   **MR. DOYNOW:** Val, can you repeat it
20   back, or do you need Dr. Cooper to -- Dr. Cooper, can
21   you repeat it slowly and so Val can write it?
22   **MR. COOPER:** The motion is to
23   recommend the Commissioner of Health that he later --
24   she strongly recommend that all E.M.S. providers in
25   the state of New York be vaccinated against SARS-CoV-

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 2    2, the virus that causes COVID-19.
 3              MR. DOYNOW:  Any questions on that?
 4              MR. COOPER:  Dr. Doynow, before we
 5    vote on this, I would just like to, you know, go on
 6    record in saying that a -- a vote not to support this
 7    motion, you know, could be seen as an equally
 8    negative like that SEMAC does not believe that E.M.S.
 9    providers, you know, should be vaccinated.
10              If it is the sense of SEMAC that --
11    that this motion would go down to the feet, we're
12    only -- and we're speaking again as a strong
13    recommendation that I would withdraw that motion
14    because the last thing we want to do is -- is give
15    any sense that the emergency medicine leadership in
16    New York State does not believe in -- in vaccinations
17    for emergency medical providers, whether they are in
18    hospital emergency medicine physician, and nurses, or
19    pre-hospital, emergency medical personnel.
20              MR. DOYNOW:  So Dr. Cooper, are you
21    rescinding your motion or -- or not?
22              MR. COOPER:  Well, honestly, I would
23    like to hear more discussion as to how others feel.
24    If others are -- are -- are also against this motion,
25    then I -- then I will definitely withdraw it.  I
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 2    don't want on record, on the SEMAC record, a, you
 3    know, we had motion to strongly recommend vaccines,
 4    you know, and it went down to the feet.
 5              I think that -- that could be
 6    amazingly counterproductive to, you know -- you know,
 7    the issue at hand.
 8              MR. DOYNOW:  Okay.  Thank you.  I'm
 9    not sure how we can get more of a feel of what the
10    committee is going to vote without voting.
11              Mr. LANGSAM:  You don't have a second.
12    You don't have a second yet.  So there's no motion on
13    the floor.
14              MR. DOYNOW:  I believe we did have a
15    second.
16              MS. BERRY:  I second it.  Cherisse
17    Berry.  I second it.  I -- and -- and if we can bring
18    it up for discussion, I, you know, we're all
19    healthcare professionals who believe in science, and
20    we've been -- we have experienced this pandemic over
21    the last eighteen months.  I just can't imagine that
22    we would not be supportive of recommending that
23    E.M.S. providers be vaccinated.  Yeah, this is not
24    about politics.  This is about public health.
25              MR. DOYNOW:  Any other discussion?
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 2              MR. GOMEZ:  This is Dr. Gomez.
 3              MR. DOYNOW:  Well, go ahead.
 4              MR. GOMEZ:  The Southern Tier region,
 5    I -- I would support what Dr. Berry said.  I think we
 6    need to be very proactive in -- in stating how
 7    important we think this is for our E.M.S. providers.
 8              MR. WICELINSKI:  This is Dr.
 9    Wicelinski, also from the Southern Tier, just a
10    little bit more West.  I would also speak in support.
11    Just as we're seeing a surge right now of people with
12    potentially preventable illness.  So I would speak in
13    support of it as well.
14              MR. BERKOWITZ:  It's Dr. Berkowitz.
15    And I am also very supportive.  I've had a lot of
16    tough conversations with our crews, but that doesn't
17    mean that this isn't important.  This is a -- that
18    actually means, it's even that much more important.
19              MR. PHILIPPY:  Dr. Doynow?
20              MR. DOYNOW:  Yes, go ahead.
21              MR. PHILIPPY:  Mark Philippy.  So one
22    of the discussions that we did have during the
23    E.M.S.C. discussion was the idea that many of our
24    health care providers, particularly in the E.M.S.
25    field, may not feel that they have sufficient
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 2    information to make the informed decisions there
 3    we're asking them to make.
 4              And that regardless of the hot button
 5    item that we're talking about here, I think that part
 6    of any move by this body to make such an
 7    encouragement should be accompanied by directions,
 8    the proper educational resources, so people can make
 9    informed decisions about this.
10              There was a -- a cite that was shared
11    during the M.S.C. and perhaps Chief Eisenhauer would
12    have access to that.  There was a, I believe, a
13    Southern Tier informational session that was held.
14    Things like that as we push this forward, as the
15    physicians in this group push this forward should it
16    happen.  I think it needs to be accompanied by an
17    educational component.
18              MR. COOPER:  Dr. Doynow, I want to
19    state for the record that the letter of tran -- of
20    transmittal to the commissioner gets called for
21    education on this -- on this issue.
22              MS. EISENHAUER:  This is Amy
23    Eisenhauer.  Just to speak to Mark's point and Dr.
24    Cooper's comment.  So Southern Tier Health Care
25    Services had a regional event with one of their
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2   medical directors from their local hospital, just
3   having an informal WebEx conversation with providers.
4   So basic information and then
5   conversation answering questions. Some of those
6   questions had been submitted in advance. In case,
7   you know, there was necessity to find specific
8   scientific resources. But essentially, it was
9   education and conversation in allaying any concerns
10   about vaccines, not just COVID-19.
11   And people were free to bring whatever
12   questions they might have without judgement.
13   **MR. DOYNOW:** Okay. Thank you.
14   **MR. DAILEY:** If I may. Sorry, it's
15   Dailey. So I'm very troubled by this. First, I
16   agree we should follow the science. But at the same
17   time as following the science, E.M.S. has never been
18   included in any of the vaccine mandates from the --
19   from the department before.
20   In particular, we've asked for E.M.S.
21   to be included in the flu mandate before, a flu
22   vaccine mandate before. And the department didn't do
23   that. I've had a significant number of conversations
24   with Law Enforcement and fire members of the E.M.S.
25   community over the course of the last year since we

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2   got the access to the vaccine.
3   And as we've seen in the general
4   population, there's a dichotomy between the people
5   who will or will not get the -- the vaccination. I
6   would caution us while I support people getting the
7   vaccine, that at this point, there is an extremely
8   almost violent opposition in some elements of
9   society.
10   And we have large numbers of people
11   that participate in public safety who may support,
12   who may not be supportive of -- of a vaccine. And I
13   think right now we are in a tenuous enough staffing
14   situation that if we were to lose a significant
15   proportion of our responders, that may further damage
16   an extremely difficult situation that we already are
17   living in.
18   If the religious mandate is upheld, I
19   believe the current number is approximately fifteen
20   hundred healthcare professionals will be lost in the
21   greater Capital District of New York. I can only
22   imagine what that number would be across the rest of
23   the state. And I would anticipate something similar
24   happening with the E.M.S. I'm not sure we can afford
25   that.

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2   Although I do certainly support the
3   science behind the vaccination. I'm concerned about
4   the humans that are involved.
5   **MR. DOYNOW:** Thank you, Dr. Dailey.
6   Any other comments?
7   **MR. RABRICH:** Dr. Doynow, I just want
8   to clarify. It's Rabrich. Point of clarification.
9   I don't believe this motion is calling for a mandate.
10   So I understand that the downstream consequences are
11   that it could result in such an effort, but it's not
12   what we're discussing now, I belief.
13   **MR. DOYNOW:** That is correct. It's a
14   recommendation, not a mandate.
15   **MR. COOPER:** Let me -- Dr. Doynow,
16   this is Dr. Cooper. Let me just say that -- that,
17   you know that, you know, SEMAC is in a very strong
18   position to stand on science in strongly making this
19   recommendation.
20   However, the commission is under no --
21   no, you know, you know -- shall we say no obligation
22   to follow its recommendation. It's -- the
23   commissioner feels that, you know, as Dr. Dailey
24   does, that, you know, that -- that this could
25   potentially be the two that are upheld for our pre-

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2   hospital colleagues to follow, I'm sure the
3   commissioner will not -- not adopt the
4   recommendation.
5   But I think as -- as the E.M.S.
6   medical leadership of New York State, I personally
7   believe that -- that based on the science, I -- I
8   think it would be almost -- almost a ... on our part
9   not to -- not to make this recommendation to our --
10   to our own colleagues. Thank you.
11   **MR. DAILEY:** Dr. Cooper, if I may. So
12   there's an alternative that's being used in some
13   spaces, which is vaccination or regular testing. Now
14   regular testing is clearly expensive. But making
15   sure that we're keeping our workforce safe, both
16   amongst each other and for the patients they serve, I
17   think is important.
18   So that may potentially be something
19   to add into a recommendation letter. But I agree
20   with comments from earlier that anything coming from
21   this body will likely be interpreted as suggesting a
22   mandate.
23   **MR. DOYNOW:** There's no --.
24   **MR. DAILEY:** I'll add -- I'll add to
25   that a comment that came across to me and I just put

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in the chat, which is, if we are going to suggest
COVID vaccination, we should certainly include
influenza vaccination.

    MR. KROLL: Dr. Doynow, this is Steve
Kroll.

    MR. DOYNOW: Go ahead, Steve.

    MR. KROLL: I want to just make an
observation. We have a governor who supports a
mandate for healthcare workers and has talked about
expansion of mandates. The American Medical
Association and the Medical Society of State of New
York have come out in support of a mandate for health
care workers.

    The -- the American Hospital
Association and the Healthcare Association of New
York State have come out in support of the mandate
for health care workers. So I -- I point that out
because we are stepping into territory where the
health care system or at least the establishment in
the health care system has clearly come out
supportive of a mandate for whatever the reasons
they've chosen, and not said, we're going to put the
-- keeping our staff robust first.

    So whatever this body does, you are --

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duty? Or are we perhaps just kind of wandering over
into some place that's been clearly stated by the
C.D.C. and the Department of Health and everybody
else on behalf of what individuals should be doing?
Do we need to send this letter?

    MR. DOYNOW: It is because ...

    MR. LANGSAM: I think we should. And
I think we should make ourselves available as a
source of information to the E.M.S. communities that
we direct.

    MR. DOYNOW: Dr. Donna --.

    MR. LANGSAM: All right, Dr. Olsson, I
think was there.

    MR. OLSSON: Yeah, please. Thank you.
I understand the concept of this, I believe. I've
always had trouble not -- I've always had trouble
understanding why healthcare professionals don't get
vaccinated? I mean, E.M.S. providers see this every
day. And they see the deaths that are related to it.
As Mr. Kroll pointed out, there have been mandates,
there's been individuals going on and on and on about
how we have to do this.

    I'm not convinced that our stepping
into this, as Dr. Barton mentioned, is the right

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that statement enters into that political context.
And I just thought that was worth pointing out.

    MR. BART: It's an excellent thing to
point out here in -- in -- in let me just call it
out that this -- because this is such a hot button
topic and to say it's not political, it's not going
to be interpreted that way where this body and the
subcommittee of these bodies are talking about
E.M.S., the medicine and the protocols we deliver.

    Are we wandering into this territory
providing this recommendation because we feel
necessary as physicians, and perhaps we've lost the
battle of having that conversation publicly? Because
as an advocate for my patients, I'm a hundred percent
for this. As an advocate on behalf of E.M.S.
professionals, as individuals, we may be overstepping
our bounds here.

    Would we like to include a letter that
says nobody should smoke anymore? Because I -- I
think as we talk about the risk for healthcare
providers, there's larger risk for E.M.S. providers
as individuals as well. Are we making
recommendations on behalf of Emergency Medical
Services and the protocols as a committee, as our

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idea. We don't know what is going to happen
politically with this, as much as we would like to
think this does not -- does not have the potential
for -- potential for political football being
dropped, it can. And I think that when we venture
out into immunizations and things that we think are a
good idea about smoking, lose weight, et cetera, we
have to tread very carefully. And I just think we
need a lot of caution on this. So thank you.

    MR. DOYNOW: Any other comments? So
it would appear we have perhaps three options here,
vote on the initial motion by Dr. Cooper, amend that
motion to include -- recommend vaccination and/or
frequent testing, or Dr. Cooper removes the motion.
Since it's Dr. Cooper's motion I will leave it up to
him as to where he'd like to go.

    MR WALTERS: Dr. Don Doynow -- sorry,
it's Walters. I think there's another option here,
too. I mean, just hearing the discussion, I think a
lot of us are supportive of vaccines and have had
that discussion with our providers. I think we're
also being realistic in looking at the implications
on public health and the delivery of emergency
medicine in the field or in the prehospital arena.

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2   And I think that's what I hear, you know, Dr. Dailey
3   and others saying, and that's my concern as well.
4   I think the other option is, we -- if
5   we felt strongly that we should encourage providers
6   or put out a statement to get vaccinated, we could
7   put out a statement that says, we believe it's safe,
8   effective and encourage E.M.S. providers to be
9   vaccinated. However, we are not supportive of
10 vaccine mandates for E.M.S. providers at this time.
11 And that's another option.
12   Now to Dr. Bart and Dr. Olsson's
13 point, that we're getting into a political discussion
14 -- and I don't know if we want to take that stance.
15 But I think some of the hesitancy of -- of this
16 conversation is based on the misconstruing of
17 statements to be used as ammunition for a mandate in
18 the future. And I think that that would -- would
19 alleviate that concern.
20   MR. DOYNOW: Thank you, Dr. Walters.
21   MR. COOPER: Dr. Doynow, this is --
22 this is Dr. Cooper again. Since you have asked me to
23 choose which of the actions I would, you know, rather
24 suggest, I think the -- I think Dr. Walters'
25 suggestion is -- is -- is a good one. It's -- it's -

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1
2   - it misses as much in how the issue is phrased as in
3   -- as in its content. And by -- by adding, you know,
4   the language to the -- to the form of emotion
5   indicating that we are not recommending a mandate at
6   this time.
7   I think -- I think that would
8   strongly, you know, aid the -- the concept. I might
9   also add that given the diversity of opinion on this
10 subject, I'd also be open to withdrawing the motion
11 in favor of a workgroup of SEMAC to consider the
12 issue and come back with a definitive recommendation
13 next time. But I -- once again, I think for us to
14 walk away from the science of the E.M.S. medical
15 leadership of New York state will send a terrible,
16 terrible message to our -- to our prehospital
17 colleagues.
18   So I guess I would favor either adding
19 language explicitly stating that we are not seeking a
20 mandate and/or forming a workgroup to phrase a motion
21 that we can all live with. In which case, if the
22 group supports the latter direction, then I withdraw
23 the original motion.
24   MR. MAYNARD: This is Dr. Maynard. I
25 would just like to put a little perspective on this

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1
2   as well. I would support Dr. Walters' amendment for
3   making the recommendation, but also recommending that
4   we're not making it a mandate, and I represent the
5   ... county region, which recently made national news
6   because one of our hospitals had to close their
7   ob/gyn department because of mass exodus due to the
8   vaccine mandate.
9   And that crippled obstetrics care in
10 an entire county of our state. And so I -- I think
11 that putting it off to a workgroup, I think it's just
12 kicking the can down the road. I think we should
13 make statements say, yes, we believe in the science
14 and want to do this, but if we were to -- to make
15 this a mandate, it could potentially cripple an
16 already extremely stressed system.
17   MR. DOYNOW: So Dr. Cooper, would you
18 like to amend your initial motion that recommends but
19 does not mandate vaccine?
20   MR. COOPER: Yes, sir, I will.
21   MR. DOYNOW: All right. So can we
22 restate it for the record so that we can vote on it?
23   MR. COOPER: Val, could you -- could
24 you read what I had previously moved, so we don't
25 make a mistake?

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1
2   MS. OZGA: Yeah, I can read what I --
3   I think I got most of it. The first motion was for
4   the Commissioner of Health to strongly recommend that
5   providers in New York State be mandated to -- to
6   mandate the vaccination against COVID SARS.
7   MR. COOPER: Okay. Let me try to
8   restate it again. Okay?
9   MS. OZGA: Okay.
10   MR. COOPER: SEMAC -- I'll speak
11 slowly now. SEMAC recommends that the Commissioner
12 of Health strongly recommend but not mandate
13 vaccination of E.M.S. personnel against SARS-CoV-2,
14 the virus that causes COVID-19. And I will further
15 add to that motion a request that in crafting the
16 letter to the commissioner the -- the notion that
17 widespread education of the safety of the vaccine be
18 made available to all E.M.S. personnel.
19   MR. DOYNOW: That's well-phrased. Any
20 comments before we vote on that?
21   MR. KROLL: This is Steve Kroll. I'm
22 going to speak strongly in opposition to this motion.
23 I'm not a voting member, but I guess I get to speak.
24 You're making a statement that can be misconstrued
25 just like making a statement around a mandate, now

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1   10-19-2021 - SEMAC - WEBEX
2   you're making a statement around it not a mandate.
3   There, you will be sending a letter to the
4   commissioner who has strongly spoken out in favor of
5   healthcare workers being mandatory vaccination with a
6   hospital system that has just gone through that over
7   the last couple of weeks saying not us.
8   Now -- now if that's your intent,
9   that's okay. But you are absolutely putting yourself
10   into a political dialogue that will -- will be
11   noticed. Again, if that's what we want to do that's
12   okay. But I am not sure that we want to be played
13   that way by either -- either position on this issue.
14   MR. LANGSAM: Just want to point out
15   that the seconder of the original motion has to
16   accept this change. Otherwise, it's still not a
17   seconded motion.
18   MS. BERRY: I accept that change. And
19   I -- I will say that our focus really should be on
20   what is in the best interest of our patients and we
21   need to keep politics out of it.
22   MR. GOMEZ: The problem I have -- this
23   is Gomez. The problem I have with that change is now
24   I've got to go to my staff -- I'm also the medical
25   director of my E.R.s. Gomez, why are you supporting

1   10-19-2021 - SEMAC - WEBEX
2   that they shouldn't have a mandate. And, you know,
3   you lost nurses, and you were supporting the mandate
4   and where E.R. staffs -- I like the original motion.
5   MR. DOYNOW: Well, one other
6   suggestion was what Dr. Cooper just said, but perhaps
7   adding recommending, testing, if not vaccinated.
8   Anybody have comments on that?
9   MR. LANGSAM: Testing is great if
10   their infrastructure is in place to do that
11   effectively.
12   MR. DOYNOW: All right. Well, we have
13   a motion on the floor, we have a seconded on the
14   floor. Is there any other comment before we vote?
15   MR. COOPER: Could you just reread
16   that one more time, Val? I'm sorry.
17   MS. OZGA: Okay, I'll give it a shot.
18   Dr. Cooper, please add, if I did not get everything,
19   I'm not the best at stenographic ... I guess. All
20   right, SEMAC recommends to the Commissioner of Health
21   to strongly recommend but not mandate that E.M.S.
22   personnel get vaccinated against the COVID SARS
23   virus.
24   MR. COOPER: Yeah, it was actually
25   again, SARS-CoV-2 the virus that causes COVID-19.

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2   But that's pretty close. And the second part to that
3   motion was that -- that the -- that the commissioner
4   provide extensive educational materials on the safety
5   of the vaccine.
6   MR. DOYNOW: All right. Any other
7   comments before we vote? All right, Val we'll need a
8   roll call vote.
9   MS. OZGA: Okay, Dr. Alexandrou?
10   MR. ALEXANDROU: No.
11   MS. OZGA: I'm sorry, that was no?
12   MR. ALEXANDROU: That's correct. No.
13   MS. OZGA: Okay. Dr. Bart?
14   MR. BART: Bart, no.
15   MS. OZGA: Bart was no?
16   MR. BART: That was, no.
17   MS. OZGA: Jonathan Berkowitz -- Dr.
18   Berkowitz? Is Dr. Berkowitz still on?
19   MR. BERKOWITZ: No.
20   MS. OZGA: These aren't --.
21   MR. DOYNOW: Dr. Berkowitz, can you
22   repeat that, please?
23   MR. BERKOWITZ: Sure. Berkowitz, no.
24   MS. OZGA: Thank you, Dr. Berkowitz.
25   Dr. Berry?

1   10-19-2021 - SEMAC - WEBEX
2   MS. BERRY: Yes.
3   MS. OZGA: Dr. Bombard?
4   MS. BOMBARD: Bombard, no.
5   MS. OZGA: Dr. Cooper?
6   MR. COOPER: Yes.
7   MS. OZGA: Dr. Cushman?
8   MR. DOYNOW: I think he left.
9   MS. OZGA: Dr. Dailey?
10   MR. DAILEY: Dailey, no.
11   MS. OZGA: Dr. Doynow?
12   MR. DOYNOW: Yes.
13   MS. OZGA: Dr. Gomez?
14   MR. GOMEZ: Yes.
15   MS. OZGA: Dr. Kugler?
16   MR. KUGLER: Yes.
17   MS. OZGA: Dr. Lynch?
18   MR. LYNCH: No.
19   MS. OZGA: Dr. Markowitz?
20   MR. MARKOWITZ: No.
21   MS. OZGA: Dr. Marshall.
22   MR. DOYNOW: I believe -- I believe he
23   left.
24   MS. OZGA: He left. Okay. Dr.
25   Maynard?

1   10-19-2021 - SEMAC - WEBEX
2   **MR. MAYNARD:** Maynard, yes.
3   **MS. OZGA:** Dr. Murphy? I think she
4   left also. Dr. Olsson?
5   **MR. OLSSON:** Olsson, no.
6   **MS. OZGA:** Dr. Pigott is -- he left?
7   Is Dr. Pigott on? No? Dr. Walters?
8   **MR. WALTERS:** Walters, yes.
9   **MS. OZGA:** And Dr. Wiscelinski?
10   **MR. WISCELINSKI:** Wiscelinski, yes.
11   **MR. DOYNOW:** Val, do we still have a
12   quorum with those folks?
13   **MS. OZGA:** Yeah, I'm just checking
14   now. Yes, we still have quorum. I'm just double
15   checking my -- the votes. And we have a tie
16   according to my records. Let me just double check
17   one more time.
18   **MS. LANGSAM:** First of all, if a
19   motion has a tie, it didn't pass, because you vote
20   affirmatively. Secondly, since I'm not officially a
21   parliamentarian, I suggest you consult your lawyer.
22   But according to the New York State Open Meeting Law,
23   the general construction law of New York state, you
24   need not just a simple majority to pass a motion. But
25   you need a majority of the whole, which means the

1   10-19-2021 - SEMAC - WEBEX
2   number of members that are -- the number of REMAC
3   members, the majority of them whether they're here or
4   not. So I don't think the motion passes either way
5   you look at it.
6   **MR. DOYNOW:** Okay, and then we'll
7   accept that as it did not pass. Does anybody want to
8   make another motion at this time or table this until
9   the next meeting? ... and not bring it up again?
10   **MR. COOPER:** Dr. Doynow, this is Dr.
11   Cooper. I just want to say that I believe that --
12   that once bylaws of an organization have been
13   accepted by the -- by the legal counsel for the
14   department that -- that -- that is what stands. The
15   -- so I'm not sure Dr. Langsam is entirely correct
16   about this. I don't recall exactly what the bylaws
17   say. But certainly if it does say a majority of the
18   whole number, then it is a majority of the whole
19   number.
20   I don't recall that it does. But
21   that's something for the future in any motion that --
22   that we should -- you know, that we should consider.
23   I'm not going to make any other motion at this time.
24   The E.M.S.C. committee felt strongly about this
25   because of the -- of the risk to children and

1   10-19-2021 - SEMAC - WEBEX
2   adolescents, who are again, among the highest number
3   of unvaccinated patients. I'm -- I'm -- I will halt
4   my -- my comments at this time. Thank you.
5   **MR. DOYNOW:** Okay. Thank you, Dr.
6   Cooper. What I would recommend is that we suggest
7   the Commissioner make available education for E.M.S.
8   providers about the current vaccinations and perhaps
9   that will encourage folks to get vaccinated who
10   otherwise had concerns. All right, let's move on
11   because we have kept our two presenters here a long
12   time and we're actually running over. Suffolk
13   County, would you like to present your data on the
14   R.S.I.? There you go.
15   **MR. WINSLOW:** Okay, that's better.
16   All right. Thank you, Dr. Doynow. I was asked to
17   give a presentation on our R.S.I. program in Suffolk
18   County. I am going to put my email in the chat,
19   because I did not submit my slides previously to have
20   them vetted, so I'm not allowed to show my
21   presentation. I have a fourteen slide R.S.I.
22   presentation on PowerPoint with the actual protocol
23   and some of the information here. If you want it,
24   please send me an email and I will email it to
25   whoever would like it.

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2   **MR. DAILEY:** I'm sorry, forgive me for
3   interrupting. It's Dailey. So you have a
4   presentation with your data on it so we can see it.
5   And all of the participants will be able to see it,
6   will be able to review it and record it, but you
7   can't present it because those slides have not been
8   vetted?
9   **MR. GREENBERG:** Correct. They weren't
10   submitted prior to.
11   **MR. DAILEY:** May we table this
12   presentation until the slides have been vetted, so we
13   can see this presented appropriately so we can really
14   review what this person is attempting to do?
15   **MR. GREENBERG:** That's up to ...
16   **MR. DOYNOW:** Yeah, I'll leave that up
17   to our presenter if he wants to come back in January,
18   or no.
19   **MR. WINSLOW:** Well, I'd be happy to.
20   I would like to just give you the information that
21   was requested as we are the largest R.S.I. program in
22   the state, in case other regions are interested in
23   adopting it. And as I said, I'll be happy to share
24   this with anyone that wants to send me an email. And
25   I'll email you the presentation I was going to give.

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2   I also would request to the state that I be vetted as
3   a member of SEMAC.
4   My application has been with the state
5   since May of last year. And I'm not a vetted member
6   of SEMAC, so currently, Suffolk County does not have
7   a vote on the committee. But if you would like to
8   hear the presentation, I leave that at chair's
9   discretion. I'd be happy to share the ...
10   **UNIDENTIFIED SPEAKER:** Dr. Greenberg -
11   - I'm sorry, can I just ask a question about -- if
12   he's presenting his data and protocols, what is there
13   to vet in these slides? Are we vetting his research
14   or his data?
15   **MR. GREENBERG:** All the materials that
16   are presented in an open meeting go through vetting
17   process. So it's not that it would be changing
18   things like that but it has to go through the vetting
19   process, that's the process. That's why we also send
20   out the information prior to anybody who wants to
21   present during materials that has to go forward and
22   it goes through the process.
23   **UNIDENTIFIED SPEAKER:** But you put
24   them on the agenda, correct?
25   **MR. GREENBERG:** He is on the agenda.

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1   10-19-2021 - SEMAC - WEBEX
2   We did not know that there was a PowerPoint to it.
3   So there are many things that go on an agenda to have
4   it to conversation. If there's a presentation that
5   goes with it, the communications that go out have to
6   be associated with it.
7   **MR. BART:** Let's have a conversation.
8   He's come a long way.
9   **MR. WINSLOW:** I can just give a five-
10   minute presentation verbally. And then if anyone
11   wants it, they're welcome to email me and I'll email
12   them the presentation. If you would like at a future
13   meeting to have it formally vetted and represented,
14   I'll be happy to do that again.
15   **MR. DOYNOW:** I'd like you to go ahead.
16   I mean, you've been here a long time --
17   **MR. WINSLOW:** Thanks.
18   **MR. DOYNOW:** -- so. And if anybody
19   wants the -- the presentation, if you want to offline
20   give your email address, not sure you want to do
21   that.
22   **MR. WINSLOW:** I put it in the chat,
23   but yes.
24   **MR. DOYNOW:** Okay.
25   **MR. WINSLOW:** My email is

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1   10-19-2021 - SEMAC - WEBEX
2   jason.winslow@suffolkcountynewyork.gov. I'm the
3   regional E.M.S. system medical director of Suffolk
4   County. I'm also the director of the program agency
5   for Suffolk County and the Director of Public Health
6   and Emergency Preparedness for the Department of
7   Health for Suffolk County. So we've -- we've had a
8   ten-year anniversary. We started as a pilot program
9   with our assign Suffolk in 2011 with a very small
10   group of three agencies and three involved agency
11   medical directors and fire paramedics.
12   It began as a two A.L.S. provider
13   skill, one R.S.I. medic credential then another
14   A.L.S. provider either a paramedic or a C.C. to
15   assist. Now, after years of progress as a standalone
16   R.S.I. paramedic understanding orders that can
17   provide as a sole provider of this skill. We began
18   with just etomidate and succinylcholine as the only
19   medication choices. Now we've added ketamine and
20   rocuronium as alternative choices.
21   Also, we have added the use if they
22   wish to train and equip and purchase the automatic
23   transport ventilator. A lot of providers like that
24   after they are assigned someone to put them on A.T.V.
25   to save your hands. We have now over a hundred and

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2   fifty credentialed R.S.I. paramedics in twenty-six
3   different R.S.I. agencies. For everyone who may not
4   know, Suffolk County is a very large system with a
5   hundred and fifty-five thousand annual calls, a
6   hundred and four E.M.S. agencies and fire departments
7   that participated in nine one one.
8   And we have a total of seven hundred
9   and twenty credentialed paramedics. So it's about
10   twenty-five percent of the system. R.S.I. agencies
11   are approved by our Suffolk County REMAC, so the
12   agencies are approved by REMAC. We have an R.S.I.
13   subcommittee which is a subcommittee of REMAC that
14   involves physician and non-physician members. A
15   provider that wishes to be credentialed as R.S.I. in
16   the county is credentialed by the subcommittee.
17   We have a very involved paramedical
18   flight program from Stony Brook University Hospital
19   and we have merged ground and air R.S.I. We sit on
20   the same committee and we have the same procedure.
21   Today we've had more than five hundred total
22   performances of R.S.I. in ten years. Now we average
23   between eighty and ninety cases per year. Up in
24   2021, we've already had fifty-five cases. In 2020,
25   there were ninety total cases, sixty-eight by ground,

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27 (Pages 105 to 108)

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2   twenty-two by air.
3   There are eighty-two endotracheal
4   placement successes of the procedure, seven
5   supraglottic airway placements and only one patient
6   was an unsuccessful procedure who had to be bagged.
7   This was a patient who had a completely impacted
8   airway full of meat that even emergency physicians at
9   the hospital weren't able to integrate this patient.
10   That gives you an overall success rate of ninety-nine
11   percent, with ninety-one percent being endotracheal
12   placement.
13   We use sixty percent of the time
14   etomidate and forty percent of the time ketamine as
15   the induction agent. Succinylcholine is used ninety
16   percent of the time and rocuronium ten percent of the
17   time as the paramedic choice. We have a very robust
18   five step process for quality improvement.
19   I don't want to get into every detail,
20   but the two main keys are, one, they post call
21   notification to medical control the flag to call in
22   the system and two, there's an audit form that we ask
23   each R.S.I. medic to have the physician at the
24   receiving facility visually verify or listen to the
25   breath sounds, in some way document where the tube

1   10-19-2021 - SEMAC - WEBEX
2   was and then sign the form. The other thing that's a
3   success of the program is each R.S.I. medic has
4   seventy-two hours to call their agency medical
5   director to discuss the call in real time in case
6   there are any issues or any teachable moments.
7   All R.S.I. cases are formally peer-
8   reviewed at the agency level and then secondarily
9   peer-reviewed by Suffolk County E.M.S. And just a
10   note on pediatrics, there have only been two
11   incidences of pediatric R.S.I. in Suffolk County in
12   the last five years, none in the last two. It is
13   made a medical control option as the paramedics in
14   the system feel that having an online physician
15   consultant while they do this, especially with
16   pediatric medication choices and dosage is important.
17   I will also mention that our protocol
18   is slightly different than the New York State
19   collaborative protocol in just two main areas. And I
20   recommend that the SEMAC consider this considering we
21   have ten years of data one piece. We don't require a
22   G.C.S. less than eight to perform the R.S.I. I
23   audited the last twenty-five charts of successful
24   R.S.I. and forty-four percent of them were G.C.S.
25   greater than eight patients.

1   10-19-2021 - SEMAC - WEBEX
2   You have someone who's about to go
3   down, but they're still, you know, somewhere in that
4   twelve, thirteen, fourteen range. We also only allow
5   for two attempts of endotracheal at -- attempting to
6   place an airway before stating that we place a
7   supraglottic airway. The collaborator protocol says
8   three attempts and then consider insertion of an
9   alternate airway device. Those are really the two
10   main differences that I saw and I would recommend you
11   consider that.
12   That's the end of my presentation. I
13   appreciate you letting me speak to you. And like I
14   said before, if anyone liked the entire presentation,
15   I'll be happy to share it with you.
16   MR. DOYNOW: Well, thank you very
17   much. Thank for your patience. And we'll certainly
18   look into what the holdup is with your application.
19   MR. WINSLOW: Thank you.
20   MR. DOYNOW: Not a problem. We have
21   one more presentation for a MURU app. Mr. Bart, if
22   you're still here.
23   MR. BART: Could I ask a couple quick
24   questions about Suffolk County?
25   MR. DOYNOW: Sure.

1   10-19-2021 - SEMAC - WEBEX
2   MR. BART: Do you -- do you
3   differentiate between D.L. and V.L.? Do you collect
4   data on first pass ...?
5   MR. WINSLOW: So ninety percent of
6   them are video.
7   MR. BART: And you have first pass
8   rates?
9   MR. WINSLOW: Ninety.
10   MR. BART: And then how about
11   desaturation and hypotension?
12   MR. WINSLOW: We don't collect that
13   data because they're actually giving us the entire
14   chart when we see the -- we can actually see the
15   waveform capnography as well as the pulse ox the
16   entire call.
17   MR. BART: Okay, thank you.
18   MR. WINSLOW: Yeah.
19   MR. DOYNOW: Any other questions
20   before we move on? Okay, let's do our last
21   presentation on MURU.
22   MR. BLOCK: Hi, thanks for having me.
23   I'm Steven Block, I'm the C.E.O. of Euro. I
24   appreciate everyone coming up. I'm just here to
25   answer questions on how the rollout's been going and

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1   10-19-2021 - SEMAC - WEBEX
2 you know anything -- questions you have about the
3 products. Quick update from where we are now. We're
4 at about seventy-five hundred users across the state.
5 We mean every one of them is activated is accessing
6 the app ninety-five percent of them accessing the app
7 at least once a month.
8   And we find that organizations at this
9 point are mainly doing it in batches, so we'll see
10 very small signups and then all of a sudden, a huge
11 spike in signups when we see other agencies join. A
12 few other small pieces that I'm sure this committee
13 would be interested in. It has been an even split
14 between B.L.S. and A.L.S. I know that the dosing
15 calc on the A.L.S. side is something that a lot of
16 A.L.S. providers love.
17   But we're seeing a lot of B.L.S.
18 providers use it to find the correct protocol quickly
19 in a specific situation. And so we've been seeing
20 the same amount of use, obviously, different ways,
21 but the same amount of use between B.L.S. and A.L.S,
22 and kind of seeing that grow across the state. With
23 that, we're doing some other rollouts to just keep
24 getting a go, to just keep growing just as much
25 education we can get around the area. And yeah, I'm

1   10-19-2021 - SEMAC - WEBEX
2 until we create a different feature that allows you
3 to rapidly switch between them.
4   MR. DOYNOW: Are there any other
5 questions?
6   MR. PHILIPPY: Mr. Block, I'm Mark
7 Philippi. Thanks for coming and speaking with us
8 again today. Back in May, when we had met and had
9 these initial discussions, there was two things that
10 we had discussed at that time. One was the
11 capability of the MURU app to do some research and
12 data collection and -- and to report back potentially
13 or how the application was being used. Has there
14 been any effort to get that information out?
15   Who is using it if anyone? And is
16 there a way potentially we could see some of those
17 results so we can see what the activity is on that?
18 And then the –- well I'll let you answer that first
19 one. Thank you.
20   MR. BLOCK: So Steven Block again. So
21 the answer is we are building it out but we have been
22 dedicating an enormous amount of resources right now
23 to be correct aggregation and correlation of all data
24 across the state. I can go into the details, but
25 it's everything from agencies to everything else.

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2 happy to answer any questions anyone has.
3   MR. DOYNOW: Does anybody have any
4 questions for Mr. Block?
5   MS. BOMBARD: How can medical control
6 physicians access the app?
7   MR. BLOCK: I'm sorry, who is this?
8   MS. BOMBARD: Dr. Bombard.
9   MR. BLOCK: Okay. Hi, yeah, so one of
10 our big requests ... has been about medical control
11 physicians not only accessing it, but being able to
12 access it in different ways, right. So for their
13 ability to switch between paramedic and E.M.T.,
14 A.M.T., so they can not only find the protocol, but
15 look at it as if they are a provider in that specific
16 set of ... We are building out a feature for that
17 now.
18   What we are doing both for the
19 schoolhouses and all medical control facilities this
20 month, is they will all have their own agencies that
21 they can log into. And then what we'll do since we
22 don't need to ... because the search data that
23 they're using isn't that important. Those agencies
24 can then issue usernames and passwords to every
25 individual so they can do it in all different states

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2 You will absolutely have access to that data. There
3 is nothing holding that back except our ability to
4 commit enough resources to it.
5   But we are collecting data on --
6 without violating any individual user's interest on
7 search terms, the certification level that the
8 provider is. As soon as we have the resources to
9 make a portal for you guys to easily view that, it is
10 one of our top priorities once we finished the
11 rollout successful.
12   MR. PHILIPPY: Thank you. And the
13 second question, as we had discussed back then, the
14 members of the SEMAC had expressed some interesting
15 concern about pricing models and the paywalls such as
16 that. Has there been any further discussion on what
17 features may be continued under the current agreement
18 with the state, or what may continue at some point
19 after the -- the -- the freeware goes away for that
20 section on what those costs may be?
21   MR. BLOCK: Sure. We have kept the
22 entire app without any paywalls open for the entire
23 state due to COVID since the beginning of our launch
24 in New York. We plan to do that well through the end
25 of the year and into Q one of next year. The -- our

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2 feedback so far has been and the language we've been
3 saying is that it's probably going to be focused
4 around not the correlation of all the data in one
5 place but the ability to access that data and do
6 other work with it.
7   So you'll be able to see all your
8 protocols, hospitals, equipment, and meds in there no
9 matter what. But to be able to search using dosing
10 calculators is something that will probably be behind
11 the paywall. And that's still our intention as of
12 now. But with that, we will add faster ways to
13 scroll and find direct correct protocol. But that'll
14 be the -- that will be the breakdown. And then for
15 agency level, additional data and informatics is what
16 we'll have extra features there.
17   **MS. BOMBARD:** It's Dr. Bombard again.
18 How much will the medication calculator cost?
19   **MR. BLOCK:** Sure. The entire thing is
20 -- sorry, I forgot to answer that part of the
21 question. The entire thing is eight dollars per user
22 per month with no onboarding fee. So the agency will
23 just pay based on the size of the agency and the
24 number of providers on it. And the provider can use
25 it across multiple of their devices without any

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2 agencies.
3   And I would suggest that if -- if this
4 is something we feel is important that perhaps we
5 need to be looking at paying for this from -- at the
6 state level, whatever that would cost.
7   **MR. BLOCK:** The one thing I can, I
8 guess, share is there have been large groups of
9 organizations that have already approached us about
10 doing something along those lines within New York
11 whether it was regional or large rotational bodies or
12 people who have grants that thought it was important
13 to.
14   **MR. DOYNOW:** Any other questions?
15   **MR. PHILIPPY:** Yeah, I think you --
16 you also -- you said something about re-organizing
17 the order of protocols that you say. I just didn't
18 understand.
19   **MR. BLOCK:** Oh, we're just done with
20 these current scroll functionality within the
21 protocol section will be made better prior to any
22 search functionality being taken away from the
23 individual users. Right now, when you scroll through
24 it -- it's just alphabetically listed. In the future
25 that will be broken down by, you know, cardiac

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2 additional cost.
3   If the agency chooses not to get it
4 for the providers and the providers have to pay for
5 it for themselves, that cost is eight dollars for the
6 user for the first organization, and then a dollar
7 for every additional organization that they are part
8 of.
9   **MR. PHILIPPY:** So -- I'm sorry. So
10 it's essentially ninety-six dollars a year?
11   **MR. BLOCK:** Yeah, under a hundred
12 dollars a year. And we just give the option to allow
13 the -- if the agency passes on the ability to
14 purchase, we don't want to lock those features out
15 for the individual, so the individual has the option
16 to purchase it.
17   **MR. PHILIPPY:** So this -- I guess this
18 isn't a question for you. But I guess I'll just say
19 to this body. I think one of the things that the
20 medical directors that we had discussed was the
21 option for an online ... dosing calculator built in
22 the app. I think a requirement of a hundred dollars
23 per provider per year, whether that's paid by the
24 agency or the provider is -- is a little cost
25 prohibitive, I think for a lot of people or a lot of

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2 protocols or trauma protocols, you know, a much
3 easier way to scroll through it.
4   So we are continuing to add new
5 features to both the free version and what the paid
6 version would be.
7   **MR. WALTERS:** I think that was one of
8 the features that the users have a collaborative
9 protocol app if -- it found useful and compared to
10 the ... app was the way they were structured and
11 organized by adult pediatric, medical trauma things
12 like that. And your cardiac arrest being pulled out.
13   The other kind of criticism I hear,
14 and not to put you in the hot seat, just as a
15 discussion, is that, you know, it's incredibly wrong.
16 It's like a P.D.F. that's scanned in the ... so you
17 have to blow up and kind of -- it's difficult to read
18 the size of the font is the feedback, I'm hearing
19 from providers.
20   So is there any discussion of in the
21 future and having yet the protocols be easier to read
22 in a more mobile type format as opposed to something
23 that's tiny and has to be blown up and -- and takes
24 more time for the end user in the back of the
25 ambulance.

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2   **MR. BLOCK:** Yes, it's Steven, again.
3 The answer to your question is one most people don't
4 realize is that if you just flip the phone sideways,
5 it instantaneously blows up to the width of the
6 phone. And then you can read it very legibly. The
7 other part, because you touched on scroll and other
8 features.
9   Yes, we are continually and will
10 continue to always develop new features. In the
11 version of the application you have now, I joke is
12 the worst version that will ever get. And that's
13 true. The reason we have not -- one of the reasons
14 we've kept search open and we'll continue to keep
15 search open for now is because we realize that search
16 is the best way to find the protocol.
17   And until we have another version that
18 we are satisfied with within scrolling, like you
19 mentioned from other apps until we implement that,
20 we're not going to take away the providers' ability
21 to find a protocol as rapidly as possible. We are --
22 we do not just scan the protocols in. The P.D.F. is
23 the backup.
24   So that if any provider wants
25 information, they can always reference the original

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2 source where we pulled that content from. Right,
3 that doesn't just come from that. But it also comes
4 from hospitals where we allow providers to go
5 straight. Right, we link directly to the website
6 where that data is listed on the state. Other things
7 like that.
8   So we always keep the protocol
9 available within one click of any screen they're on.
10 So they can always check the original source
11 material. But the way we put it in is we actually
12 code in every protocol. Something a lot of providers
13 don't know or an example is if you search for the
14 word diabetes, when you open up the P.D.F. of the
15 state protocols, it says nothing found if you are on
16 the collaborative because it is written under the
17 hypo and hyperglycemia protocol.
18   And the word diabetes is not listed
19 anywhere. So when you use Muru and you search, it
20 recognizes the condition and then realizes what
21 protocols you may be talking about. So until we have
22 a better way to -- so that is how we improve
23 protocols. It's -- we have to do, you know,
24 conditions of use and figure out what someone's
25 looking for and all that.

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2   So it's far more than just the -- the
3 scanning. It's like coding the entire line by line
4 into the system.
5   **MR. DOYNOW:** Any other?
6   **MR. BLOCK:** Sorry two --.
7   **MS. SMITH:** Yeah.
8   **MR. BLOCK:** Go ahead.
9   **MS. SMITH:** Yes, this is Ann Smith. I
10 just had a quick question. So there are regional
11 protocols in there -- or excuse me, not protocol –
12 protocols, policy statements. And I know we had
13 discussed previously what is going to be your
14 mechanism to be able to update those as they change
15 regionally because there is no given, you know, date
16 or time when they'll change. It could be any time.
17   **MR. BLOCK:** Sorry, Steven again. So
18 two points, one, we enter in every protocol set, so
19 all three across the state right now. Plus every
20 region's regional advisories, as of today, you will
21 be getting an email as the program coordinators or
22 regional chairs with a direct way to vet and enter
23 all content you would like in the program going
24 forward.
25   It -- it should be emailed to -- to

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2 you by tonight as soon as I get responses from who
3 I'm sending it to. And I think I answered both
4 questions there.
5   **MR. LYNCH:** Joshua Lynch, just so I
6 understand that state would be providing the cover
7 and the cost for the basic application. And the
8 calculator has a certain cost to it per month
9 indefinitely. Can you -- I guess I'm just having a
10 hard time understanding what type of support would
11 justify that cost on a monthly basis indefinitely for
12 many, many users that would require the calculator,
13 like what -- what support or what continual updates
14 would go into the calculator that would justify such
15 a cost across the state indefinitely?
16   **MR. BLOCK:** So thanks for the
17 question.
18   **MR. LYNCH:** We are not -- the current
19 product is not the final product, just like your --
20 any other of the apps you have on your phone whether
21 that's a social media product or another work
22 product. There are constantly new features added.
23 The line is not for the calculator, although that is
24 the obvious biggest impact that we've released to
25 date.

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2   And we're working on a ton of other
3 new features. And this includes support and
4 everything else that we go along with its analytics
5 and compliance and everything else that we're
6 planning to roll out and release going forward. So
7 we have taken on a significant cost burden, to make
8 sure that we can get this out to everyone.
9   And the state has been amazing, you
10 know, working on making sure everyone has access.
11 But the calculators not anywhere near the end goal
12 that we're providing, whether it's a different way to
13 do the protocols, forums, notification compliance,
14 inboxes. There is a lot of other features coming out
15 to help you as a body and the region's connect
16 directly with those providers and hospitals connect
17 directly with those providers. I'll plan to keep
18 building those in as we go.
19   **MR. WALTERS:** Thanks. So the eight
20 dollars a month per user across the entire state get
21 to the calculator today, but future functionality
22 that is yet to be determined?
23   **MR. BLOCK:** That is yet to be
24 announced, yes. But yeah, it's --and it's including
25 -- there is other functions, right, the ability to

2 call it those signs directly, the ability to enter
3 any condition. And be able to find the exact
4 protocol within a second even if that's slang or
5 vernacular or something that is actually far more
6 complex than the calculator built.
7   And something that we see is the
8 reason why most providers are on it so much.
9   **MR. WALTERS:** So I think that those --
10 those future features could be potentially very
11 useful. But I guess my question is, what happens if
12 people say, I'm not going to pay a hundred dollars
13 per provider per year for this. And when you don't
14 get that revenue, then are those features not going
15 to be available in the future?
16   **MR. BLOCK:** So we are charging for
17 some parts of our product, beyond our agreement with
18 the state. We are continually building out what we
19 consider, you know, a really new way to interact with
20 protocols. And so we're testing a bunch of different
21 features to make sure that we can justify the price
22 and the cost.
23   And so I don't know what happens if
24 every feature released in the future doesn't work or
25 no one particularly likes them. But it seems that

2 we're having a good track record so far of providing
3 features people love. So a lot of people have said
4 that they were -- are happy to pay back costs, even
5 large-scale organizations so far just to increase
6 compliance across the organization for protocol work,
7 so.
8   **MR. WALTERS:** I guess my question
9 wasn't about what the features are and if they'll be
10 useful. I think they will be it was -- what if
11 people don't pay that cost. Are you still going to
12 be able to develop those features?
13   **MR. BLOCK:** Yes, from our revenue
14 projections we continue to see that we'll be able to
15 continue to add new features. Based on what we're
16 projecting is the total number of users across the
17 state that's going to buy it. In addition, there
18 will be other new clients outside of New York.
19   And no matter what the feature is
20 that's built, it gets delivered to all providers
21 unless it's, you know, something military specific or
22 something like that.
23   **MS. BOMBARD:** Instructor ... my
24 question is actually for Ryan. I'm not sure how we
25 started the partnership with Muru as a state entity.

2 But my question is, particularly in the climate that
3 we're living in, in regard to ketamine and the
4 controversy regarding dosing of ketamine.
5   And all of our other medications that
6 are probably way more important than ketamine, how
7 are we as a state able to go forward with an app that
8 does not have a calculator at its baseline. So I
9 guess I'm turning this a bit of -- a bit on its ear.
10 I think that our responsibility as a state is to pay
11 for that calculator.
12   It -- there may be other parts of this
13 app that we do not pay for. But I think at the very
14 least, if we're going to have a protocol app, it has
15 to have a dosage calculator in it. This is a huge
16 liability problem right. We all know this. And --
17 and above and beyond that this is a huge patient care
18 problem.
19   There is no excuse for us having an
20 app that does not add its baseline entity have a
21 calculator. That should not be an add on function.
22 And we should endorse that as a state and we should
23 pay for it.
24   **MR. WALTERS:** I would agree with that,
25 I think and -- and Ryan, I have no idea. We decided

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2   which app to go with and -- and no idea how much the
3   state is paying. But I think to report -- to -- to
4   decide on utilizing an app, but then it's going to
5   cost providers a hundred dollars a year for a basic
6   feature that we think is important for calculations
7   and for the safety of our patients.
8   It seems like we've -- we've, you
9   know, put this mandate -- unfunded mandate, right,
10   that's a term we always use, we essentially did that
11   by saying, here's the app. This is the only app you
12   can use. And now it's going to cost you a hundred
13   dollars a year, I think that that's, again for cause
14   prohibitive for agencies.
15   And I would agree with Dr. Bombard
16   that -- that if we're going down this road and we
17   agree it is the best thing for our patients, then I
18   think that we should, as a state, pay for this
19   calculator and this feature for all providers.
20   MR. GREENBERG: So I can tell you that
21   part of determination on -- on which route to go from
22   the former collaborative to -- to this one, was
23   looking at app development and long term
24   sustainability to program and part of the problem
25   that we had with the -- not problem we had, but you

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2   happy to look at other things, happy to look at, you
3   know, and -- and take this feedback. And -- and it's
4   critical. And I will say many of the concerns that
5   you brought up is also echoed with the program
6   agencies that brought back. And I believe the
7   program agencies have brought back what the
8   individual providers and those that are out in the
9   field are saying.
10   MR. DOYNOW: Any other comments?
11   MR. CUSHMAN: Jeremy Cushman, Steve,
12   we -- we had met, I think it was back in June. And
13   you had indicated that the program agencies would
14   soon have access to do those policies and so forth.
15   I want to confirm a date and time that the program
16   agencies will be able to upload and control the
17   policies and regional protocols that they have. When
18   will that be?
19   MR. BLOCK: Sure, Steven again.
20   Today, you are -- you should be getting an email
21   today from every program agency asking for a point of
22   contact, that will be -- have the authority to upload
23   and vet the application. There is a platform already
24   built for it. And it's going out as soon as I get
25   those email contacts back from the bureau.

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2   know, part of the -- some of the issues that came up
3   with the collaborative app was sustainability
4   development having a company that's actually focused
5   on maintaining the app opposed to where we ended up
6   with frustrations in sometimes not being able to
7   update the app as quickly as.
8   Whether it be protocols updated, or
9   just updates that need to happen because technology
10   and app development. And so that was part of that
11   decision factor in, you know, when -- when we looked
12   at the three proposals that came in that evaluated
13   this one. We actually had a meeting right before
14   this with the program agencies and got a lot of their
15   feedback, who of course, our program agencies are an
16   extremely valuable resource to hear, you know, kind
17   of what's going on in the field.
18   And are taking a look at things from
19   their side as well, not the program agencies, but
20   each of the regions determine what is the best, you
21   know, long term scenario for the state and for the
22   protocols. Keeping in mind prior to this, the only
23   thing that was available from the state was a P.D.F.
24   on our website.
25   So that's what we've moved from. So

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2   It's already set and ready to go
3   today. And we will -- we've been vetting all the
4   sites and making sure everything was aligned with
5   your website. And so we are -- if there is any
6   issues, we will address them immediately.
7   MR. CUSHMAN: Okay. Again, I don't
8   understand the accountability part between MURU the
9   state and our region who as -- as my colleague Dr.
10   Bombard indicated that, you know, we -- we have an
11   obligation to make sure that accurate information is
12   posted on that site that is being purchased and
13   maintained in some extent by the bureau.
14   And ultimately, the program agency and
15   the REMAC statutory responsibility to promulgate
16   accurate protocols. So given that it's seven months
17   since we had that conversation, I just -- we -- we
18   just need to make sure that there is some
19   accountability of this process given our
20   responsibility under statute to promulgate those --
21   those protocols. And only having one exclusive sole
22   source opportunity to do so.
23   MR. DOYNOW: Any other comments before
24   we close?
25   MR. PHILIPPY: Mark -- yeah, sorry,

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briefly, Mark Philippy. One of the things that had
come up in some -- prior discussions also was some of
the information that had been drawn down from the
state website. So -- so what pro-form, I'm sure as
you were drawing information into the app, as I spoke
with a number of physician colleagues in the system
have said that some of that information is not
entirely accurate or even useful.

So for example, hospital capabilities
I know is one hot button item. At that level that
information is I remember -– understand from speaking
with you in the past is coming from the state
website. How do we curate that information? So
that's not program agency, that's not Regional
Medical Director, but some of that information is at
best misleading and potentially harmful.

MR. BLOCK: So I -- so I totally --
it's Steven Block, again. I'm -- I totally agree
with you, right. This is a -- this is a massive
undertaking to have all this data from all these site
load or locations coming into one thing which is a
phenomenal resource to the provider. But only if we
can properly do it.

The short answer is within the thing

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that we've been -- within the product we're sending
out today to all the program agencies includes a list
of every hospital within your region with a detailed
list. And if there is any errors in there, we log
them and immediately send them to the state.

Obviously, different hospital data
will be able to be put in right was controlled by the
state or the region or the local -- or the local
hospital itself. And so we need to work through
that. The real answer is -- is that it's been --
it's a real process that we're going to have to
continue to strengthen the partnership with in order
to make sure that every -- every resource that can
help keep it all calm, you know, up to date and
working is really hard.

I will say one additional piece of
that as an example, is the program agencies or
regions that border other states, right, with their
requests to get hospitals from just outside the
state, right. That's a process we have to discuss
with the bureau now on how do we put those hospitals
in without and also get some sort of indication from
this board or the bureau, whoever is making the
determination of what capabilities we should be

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assigning to those hospitals, right.

And so all these -- these little
pieces are also there. The last piece of this that I
should mention is there is a live chat in the app
which allows people to ask questions directly back to
MURU. Usually it's about how to handle use of the
app. But we will be putting summaries and feeding
that information back if it's anything other than how
to technically use the app, back to the program
agencies and back to the state.

And that's all explained in the on
boarding that we've included. So that way you will
be able to get that information sent back to you
whether or not we collected, whether or not just
stumbled upon to us rather than going straight to
you.

MR. PHILIPPY: Thank you, Steven, it -
- as a follow up for the director, who at the bureau
will be curator. Is that going to be you someone in
the office, some direct person that -- that we can
discuss or I -- I just -- I guess for the -- for the
physicians here but also for the providers, is there
a point of contact?

MR. GREENBERG: So coming out from the

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meeting prior to this, I would say that currently
right now it's going to be myself and Smith and we'll
coordinate with Steven Block. And Dr. Cushman to
your side you know, in -- in the soul app, this is
the app that the state has chosen to go with.

But it's not a soul app, if a region
chose to have their own or something different. This
is the same way the collaborative had theirs we
wouldn't stop anything else. This is the choice that
we took as a statewide initiative in order to have
all the protocols in all the different regions and
everything in it.

MR. DOYNOW: Any other comments?
Okay. I thank you all for being here. I apologize
that we ran over here a considerable amount of time.
I do not have the January dates yet for our next
meeting. When we have them, the state will let us
know. And hope to see everybody at vital signs. Can
I have a motion to adjourn? So moved.

MR. GREENBERG: Wait a second.

MR. DOYNOW: All right, everybody in
favor?

MR. GREENBERG: I'm sure.

MR. DOYNOW: Right, have a good

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 2   evening.
 3              (Off the record, 5:00 p.m.)
 4              (The proceeding concluded.)
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 2   STATE OF NEW YORK
     I, BECKY FOSTER, do hereby certify that the foregoing was
 3
     reported by me, in the cause, at the time and place, as
 4
     stated in the caption hereto, at Page hereof;  that the
 5
     foregoing typewritten transcription consisting of pages 1
 6
     through 138, is a true record of all proceedings had at
 7
     the hearing.
 8
           IN WITNESS WHEREOF, I have hereunto subscribed
 9
     my name, this the 9th day of November, 2021.
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     BECKY FOSTER
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