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NEW YORK STATE
DEPARTMENT OF HEALTH
BUREAU OF EMS

SEMAC MEETING

DATE: January 4, 2022

TIME: 12:02 p.m. to 3:08 p.m.

CHAIR: DON DOWNOW

VENUE: WebEx

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APPEARANCES:
VALERIE OZGA
NIKOLAOS ALEXANDROU
JOE BART
JONATHAN BERKOWITZ
JEREMY CUSHMAN
MICHAEL DAILEY
JOHN DETRAGLIA
DAVID KUGLER
YEDIDYAH LANGSAM
JOSHUA LYNCH
DAVID MARKOWITZ
LEWIS MARSHALL
PAMELA MURPHY
DAN OLSSON
MATTHEW TALBOTT
BRIAN WALTERS
ROBERT WICELINSKI
OREN BARZILAY
MARK PHILIPPY
MARYANNE PORTORO
MIKE MCEVOY
STEVEN KROLL
RYAN GREENBERG
AMY EISENHAUER
ARTHUR COOPER
TIFF BOMBARD
JEFF RABRICH
JASON ALLEN WINSLOW
JONATHAN WASHKO
GREGORY YOUNG
AIDAN O'CONNOR
BRIAN CLEMENCY
PATTY BASHAW
PETER BRODIE
ALAN BELL
ALAN LEWIS
ALEXANDER
KOCZOR
ALICIA BROADBENT
ANDREW KNOELL
A. SMITH
BEN SENSENBACH

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BILL HUGHES
BILL LIDDLE
BRETT ROBERTS
BRIAN LEVINSKY
BRIAN WIEDMAN
CARL GANDOLFO
CARLA SIMPSON
CAROL BRANDT
CECILY SWIMBURNE
CHARLOTTE CRAWFORD
DAMON WEST
DANA JONAS
DANIEL CLAYTON
DAVID BUTLER
DAVID COLE
DAVID SIMMONS
DEAN ROMANO
DAVID VIOLANTE
DEAN ROMANO
DONALD HUDSON
EDWARD MAGER
GENE MYERS
GREGORY GILL
HOWARD HUTH
JAMES DOWNEY
JAMES O'MELIA
JASON ALLEN WINSLOW
JASON HAAG
JEAN TAYLOR
JEFF CALL
JILL BRAUNER
JOHN MACMILLAN
JOSEPH TINKLEPAUGH
KAREN BRODERICK
MARK FORREST
MELISSA LOCKWOOD
MICHAEL BENENANTI
MICHAEL BENNETTE
MICHELE FORNESS
NICK ECKERT
NICKOL O'TOOLE
PETER CHIAVETTA
RICHARD BRANDT
RICAHRD PARRISH

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ROBERT KUHN
ROBERT MARSHAL
ROBERT MCCARTIN
RON HASSON
RYAN BAILEY
SCOTT BOWMAN
SCOTT LANPHIER
SHANNON BENSAL
STEPHEN CADY
STEVE ANDERSON
STEVEN BLOCKER
STEVEN MEEHAN
STORM TREANOR
SUSIE SURPRENANT
TERESA HAMILTON
TERRY THOMPSON
THOMAS PASQUARELLI
TIM MIRABILE
TRISH HANSEN
VICTOR JONES
VINCENT OUIMETTE
WENDY JACOBSON
WILLIAM MICHAEL MASTERTON

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(The meeting commenced at 12:02 p.m.)

CHAIR DOYNOW: -- to SEMAC and a nice cold windy day out there. Just remember it is difficult to tell who is speaking. So if you are going to talk, please state your name for the transcriptionist. And also, when you're done let us know that you're finished speaking. It will work quite well with med standards and hopefully it will work well with us.

Hoping our next meeting will be in person. I was hoping this one was going to be but obviously that -- that did not happen. Also, Val, if you can move Lou to the panelists, he's not there, he just send me a text about it. Okay. Let's move on. Can we have a roll call please, Val?

MS. OZGA: Yes. Good afternoon, everyone. Okay. Dr. Alexandrou. Dr. Alexandrou?

MR. ALEXANDROU: Yes, I'm here. I'm sorry.

MS. OZGA: Okay, that's fine. Dr. Bart?

MR. BART: Bart here. I'm here.

MS. OZGA: Okay. Thank you.

MR. BART: Got it.

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MS. OZGA: Dr. Berkowitz?

MR. BERKOWITZ: Berkowitz present.

MS. OZGA: Dr. Cherisse Berry (phonetic spelling). I believe she said she was not going to be able to attend today. Dr. Bombard Tiffany (phonetic spelling). Dr. Cooper. Dr. Cushman.

MR. CUSHMAN: Cushman here.

MS. OZGA: Dr. Dailey?

MR. DAILEY: Dailey here.

MS. OZGA: Dr. Detraglia?

MR. DETRAGLIA: Detraglia here.

MS. OZGA: Dr. Doynow?

CHAIR DOYNOW: Here.

MS. OZGA: Dr. Gomez. Dr. Kugler.

MR. KUGLER: Dr. Kugler is here.

MS. OZGA: Dr. Lynch.

MR. LYNCH: Lynch is here.

MS. OZGA: Dr. Markowitz.

MR. MARKOWITZ: Markowitz is here.

MS. OZGA: Dr. Maynard. Dr. Marshall.

MR. MARSHALL: Dr. Marshall here.

MS. OZGA: Dr. Murphy.

MS. MURPHY: Dr. Murphy here.

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MS. OZGA: Dr. Olsson.

MR. OLSSON: Olsson here.

MS. OZGA: Dr. Pickett. Dr. Talbott.

MR. TALBOTT: Here.

MS. OZGA: Just wanted to make note. Welcome Dr. Talbott to SEMAC. He was just currently vetted, so we're happy for him to be able to join us today.

MR. TALBOTT: Thank you, Val.

MS. OZGA: Dr. Walters.

MR. WALTERS: Walters here.

MS. OZGA: Dr. Wicelinski?

MR. WICELINSKI: Wicelinski here.

MS. OZGA: Okay. Non-voting members. Oren Barzilay.

MR. BARZILAY: Barzilay here.

MS. OZGA: Aiden O'Connor. Mark Phillippy.

MR. PHILIPPY: Mark Philippy present.

MS. OZGA: Maryanne Portoro.

MS. PORTORO: Maryanne Portoro present.

MS. OZGA: Dr. Rabrich.

MR. MCEVOY: He is present, but he

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needs to be moved into the panelist.

MS. OZGA: Okay. I'll take care of that. Mike McEvoy?

MR. MCEVOY: I am here as well, McEvoy.

MS. OZGA: Steven Kroll?

MR. KROLL: Steven Kroll is present.

MS. OZGA: And Jonathan Washko. Is Jonathan on? Okay. Let me see how many we got. One, two, three -- we have met quorum and Dr. Doynow, you can continue.

CHAIR DOYNOW: Okay. Thank you, Val. Welcome Dr. Talbott. Thank you for joining us.

MR. TALBOTT: You're welcome.

CHAIR DOYNOW: Can we have approval of the October minutes. Anybody want to make a motion to that?

MR. ALEXANDROU: I make a motion to proof.

MR. MCEVOY: McEvoy second.

CHAIR DOYNOW: So -- okay. Dr. Alexandrou and Dr. McEvoy. Is there anyone who objects or abstains. I mean, we don't want to go through the whole list. Hearing nothing, then it's

unanimously approved. Okay. Moving on. Ryan, would you like to give the bureau report. Ryan, are you there?

MR. GREENBERG: How about now?

CHAIR DOYNOW: Okay.

MR. GREENBERG: Double mute.

CHAIR DOYNOW: Not a problem.

MR. GREENBERG: Sorry everybody. Thanks for joining. And thanks for being accommodating of the last-minute time changes on everything that's going on. Going to try and keep it to a brief for Bureau Report on what's going on, obviously, a lot going on and the Department of Health right now as we continue down the next wave of this pandemic.

And from an operational point of view, we are still deployed around the state. So most of our staff is deployed in some sort of COVID activity related to things. The most recent right now is the -- we have two deployments going on, actually three. So we have one that supports the vaccine sites, there's about fifteen vaccine sites out there.

And then we have a state mobilization and a federal mobilization to support load balancing,

backup number one, and patient movement for hospital capacity that are going on. So we have forty-two ambulances in the state right now predominantly serving the Albany, Syracuse, and western part of the seat and they are spread out.

We've also moved some resources up into the Potsdam area to serve the North Country. And the other resources are moved on the day to day most -- the biggest move to that we have is that we are now moving several units down into Hudson Valley area to support that side. And we have ten units that are in New York City.

So spread out across the state, those resources are -- go out through the search operation center. And their dispatch do that and/or communications with the local county emergency E.M.S. coordinators or emergency management when there's other priorities or other needs that are there.

So if any of your areas do need assistance, you're seeing backup in your E.R.s and you think that additional resources to help move patients would help, please by all means, feel free to reach out. The other thing is the surge operations center, which also falls under the Bureau

of E.M.S. is under the direction of Deputy Director ... I believe last count we had done just under about three hundred care coordination or patient placements moving around the state.

So hospitals who need to find placement for patients there, because they're boarding in the E.R., or other problems that are happening, that would happen through that communication or through surge operation center. So a lot going on from -- from those components.

Some quick updates, in the operation side of things, again, the bulk of our staff are currently deployed. And so that is what's happening on the operation side. We do continue, obviously on the investigation side and the other components of that. In addition, on the E.M.S. for children side, the survey starts, so E.M.S. for children survey starts -- begins on January 5th, and only takes about five to ten minutes to complete.

If you can encourage your agencies to please complete it, again, it opens on January 5th, and I believe -- I believe there'll be a brief presentation by Amy on that one, like literally ... And then our E.M.S. for children's meeting -- council

meeting is next week on Tuesday, January 11th. That'll be held at one o'clock and it's virtually for anybody who would like to attend.

And the data and -- data and informatics side, thanks to the hundreds of agencies who have enrolled in the C.M.E. program and started to document electronically. I have a picture from when I first started as the director of where we were, and it was basically like, half the state was electronic, half the state wasn't.

We've really managed to turn the entire state or predominantly the entire state electronic and for the areas that aren't they're still charting on paper, the paper portal has given us more real live time data than we've ever had before where normally it would take upwards of a year to get into a system.

So that's been really exciting on that part. And just a reminder, you know, on this program, those agencies who want in the C.M.E. program who are still on paper, please reach out to Deputy Chief Brody, if you're into -- you can understand kind of how to get to electronic to in order to stay in the system. We do offer a free

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platform at the state.

We're learning more and more about the platform every day and -- and working to improve it. Vital signs, so really excited that we're able to have vital signs, very successful. We had about five hundred and thirty people in person. We normally have about twelve hundred.

But our goal for this year was to stay about at that fifty percent mark. And ... we can do spacing and everything else. And then we -- for the first time this year, we had a virtual component. And we had about three -- just under three hundred people on the virtual component, so really happy, really successful on that one. Excited with it and Saratoga turned out to be a great place to have it.

Next year, we'll be hybrid as well. Will be October 26, to the 30th and it'll be in Albany. So for those of you who can join will be in Albany next year. For those of you who are downstate, just reminder, Albany is only two hours and fifteen minutes away from the city as when I asked most of my friends are like, well, it's like four or five hours up, isn't it? So it's not.

Corporate presenters is now open. So

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please submit your presentations for your corporate presenters, if you -- any of you would love to have more physicians presenting, we have some great physician speakers in the last one. And I would love to see more of that. And then stay tuned for more stuff coming out from the E.M.S. Council Awards for the awards next year.

This year's Memorial, the E.M.S. Memorial will be on May 17th, 2022. And there are nine ... that will be going on to the memorial this year, so May 17th, 2022. And we'll be talking a little bit about the expansion of that wall as well.

I think a little -- either a little later in this meeting, if not at the SEMSCO meeting as we are out of space on our current wall. And we have a couple of things that are on there that we'll be discussing with the SEMSCO and I believe later in this meeting as well, we'll talk about that one based on time.

Last but not least, I wanted to share with everybody here a little bit of statistics and some numbers. You know, as we look at this pandemic, and we look at a number of things going on, we've seen E.M.S. providers working in -- in different

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environments. We were calling in the med standards meeting the non-traditional environments, and maybe that's not the best term, we're going to find a better term for that.

But we have through executive orders, they've been working in non-traditional environments, they have been working in different places. And it's been very, you know, interesting to see the different hospitals and you see Albany med posting and different hospitals around that have taken advantage of -- of this opportunity that normally isn't there.

And so, you know, within the Department of Health and the Bureau of E.M.S., we've been also working on a scope of practice documents with ... everybody from med standards, I'm giving some input on that one, to be able to help people in these different when they work in different environments, or they're working in a, you know, hospital home program or fill in the blank, whatever these other programs might be.

And so we're really excited to see what E.M.S. providers are doing and the different ways that they're going to be paramedicine possible at home, working in E.R. And we understand it's a

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controversial topic. It's a controversial topic, because the counselor say we don't have enough providers in the state to work in a facility or to work in a E.M.S. agency.

How do we take more providers and put them into -- into these non-traditional environments. And so when we look at that, when we look at the non-traditional environments, we also have to think about the entire E.M.S. population or E.M.S. pool and certified providers. One of the things we're doing is trying to certify more providers.

So in January in the next week or so you'll hear about a pilot program that we're doing where we're going to try and train an extra three hundred providers and an academy style class throughout the state, so we're going to run probably close to between twenty and twenty-four programs.

And actually half of those programs will be for anybody who wants to any citizen who wants to become an E.M.T., and do it completely for free. And the other half of the program is to train between three and four hundred National Guard members to become E.M.T.s. So we're excited because those National Guard members, again, you know, one weekend,

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a month, two weeks a year also be able to take this and use it both as a guard, but also outside of guard and add more providers into the field.

So thank you to all the co-sponsors who were, you know, helping us with this one, it's a big lift. We're going to do all the training and six-week gap. And the six weeks will be from the last week of January, for the most part, to the second week in March. And again, the goal is to train about six hundred providers, half of which will be civilians, half of which are National Guard members.

The National Guard members will actually also be used to help out in hospitals and nursing homes and different component like that. The civilians predominantly for -- for E.M.S. hopefully people who want to take on the E.M.S. as a career.

But some of the data that I also want to share with you is where we are today in number of providers that we have, and number of providers who are practicing. And the way that we looked at this was how many providers actually show up on a P.C.R. and so we went in and Texas did a report on this.

We saw the report and said, wow,

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that's really interesting. Let's -- let's do it we can find out when something similar. And so we went into report and we looked at how many certified providers we have, or how many providers show up on at least one P.C.R. in the given years.

So we don't know how much they provided -- how much care they provided, but they provided care on a P.C.R. And so when we looked at 2018 -- sorry, when we looked at 2019, we were at about eighty thousand providers who are certified. Some of those are duplicates, because if you hold the C.F.R. and as an E.M.T., or paramedic, we do see that.

But there were about eighty thousand providers, we take out the -- the C.F.R.s. and we only had about thirty-six thousand provider, so we're actually on a P.C.R. So in 2019, out of eighty thousand providers were only about thirty-six thousand that were on a P.C.R.

Fast forward to 2021 were just under seventy thousand, we're down to about sixty-seven thousand providers who are certified, take out those C.F.R.s. And the reason we take those out is because they don't always turn on P.C.R. they may be, you

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know, working on a first response agency, not everybody is accounted for.

So again, take out those C.F.R.s out of the sixty-seven thousand and take out C.F.R.s we're down to about sixty thousand. And thirty thousand of those were on a P.C.R. So that means that, you know, pretty much about half of our E.M.S. -- certified E.M.S. providers aren't providing care in the E.M.S. agency or on a P.C.R.

And so the question is, where are they? And we don't have that answer right now. But I -- you know, bring that here to this committee, I'll bring that to the SEMSCO as well to start asking that question.

And then also to start asking the question of the controversial question of working in what we're calling at least today non-traditional environments, is it -- is it a good thing? Can we take that other fifty percent, those thirty thousand providers who aren't working on ambulance for whatever reason, it might be.

And are they, you know, something more in the healthcare environment that can help us in our ecosystem, that can help us you know, in maybe E.M.S.

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offload times or other, you know, physicians that maybe is not an ambulance, but still benefits the system that can help us with community paramedicine or something else.

So I just wanted to, you know, kind of leave with that thought and let people think about that, you know, a little bit. And like I said, please, you know, stay tuned for the classes that are coming up around the state. Please encourage, you know, people in your agency who have the ability to take a full-time E.M.T. class for four or five weeks, Monday through Friday often to become a certified provider, excellent opportunity.

And this pilot class is a little bit different than our normal training model because we will pay for everything. We're paying for textbooks. We're paying for the online fees. We're paying for the course itself. Equipment it's a hundred percent paid for through this pilot program.

So that's all I got. Happy to take any comments or questions and really appreciate your great support. Thanks for everything you're doing during the pandemic. If you have any more questions about the deployments that are happening throughout

the state, and some more that are coming in, please feel free to reach out to me offline.

MR. MARSHALL: I have a question for Ryan.

MR. GREENBERG: Hi.

MR. MARSHALL: Hi. This is Dr. Marshall. So really appreciate all the work that department has been doing during the pandemic, but whatever happened to the State Emergency Management Office and those resources years ago, they were doing a lot of this preparation.

MR. GREENBERG: You mean the Office of Emergency Management within digital?

MR. MARSHALL: Yeah.

MR. GREENBERG: We do a lot of planning with them. So I mean, I think just impart with the pandemic, everybody is, you know, take on more additional roles, but I mean, my -- my counterpart in the Office of Emergency Management, I am literally on the phone calls with almost daily and regular emails throughout the day in order to facilitate the ... deployment and all those things that come along with it.

But the -- you know, a lot of planning

documents and things like that, that's still being done by the -- by O.E.M., by the state O.E.M. So if there is other things specific, I'm happy to answer but you know, I think there's still a lot of work they're doing, but just everybody's pulled in multiple different directions.

MR. MARSHALL: Okay, thank you.

MR. GREENBERG: Absolutely.

CHAIR DOYNOW: Thank you, Ryan. Anybody else have questions? Dr. Alexandrou?

MR. ALEXANDROU: Yeah. Hi, Ryan. Thanks for all the information. I do have a question. With the recent surge, is there any consideration of bringing back the executive order for extending the E.M.T. certification and helped improve with the certification process throughout the state?

MR. GREENBERG: The chief sponsor never put you up to that question.

MR. ALEXANDROU: No. But there are a lot of people who were asking me about that. And this is the right time, I guess.

MR. GREENBERG: Yeah. So you know, to be honest, when we put it in in the beginning, we

didn't feel that it was needed, but we want it there in the event that it was needed. And you know, up until I think, you know, a couple of weeks ago, there's the feeling on the Department of Health and the bureau was that it -- that it wasn't necessarily needed.

We are giving strong consideration to it now and what they, you know, if an extension will be put in there and how long that extension would be. So there is strong consideration going into that right now. And I think you'll know more probably within next week or so. By the way, I still think ...

MR. ALEXANDROU: No, she really did, but thanks.

MR. GREENBERG: ...

MR. ALEXANDROU: No, honestly it wasn't. But there was a lot of discussion around the region in with our E.M.T., so thanks.

MR. GREENBERG: We -- we understand the importance. And I think, you know, I think the -- the part that we're also evaluating too in it and it is it would lead to a five-year certification for a lot of providers, and what's the impact of that and

is that, you know, the pathway that we want to take and balance that with what's going on right now and trying to keep people safe and providing care and time and everything else, so absolutely being consistent.

But and -- and thank you for bringing it up, I appreciate it. And if anybody else has any comments, thoughts or feedback or opinions on this, you know, is really needed in your region, I'd be glad to hear it, whether it be in this format or -- you know, via an email.

CHAIR DOYNOW: Thank you, Ryan. Anybody else have any questions for Ryan. Okay. Nothing heard. Let's move on into subcommittee's, Education. Dr. McEvoy, do you have anything to report?

MR. MCEVOY: No, we -- we did not meet, we've been bantering around some goals and objectives for the committee on boardable and we also distributed some nice holiday reading, which I think I copied this committee on as well with the new federal educational standards that were released.

But at this point, we're postponing that to talk about later in the year.

CHAIR DOYNOW: Okay. Thank you. Let's move on to med standards. I know Dr. Marshall has a lot to bring forth to the committee.

MR. MARSHALL: Yes, lucky me. So if Amy could pull up the motions, that would be great. But I can tell you that -- actually the first one is about the E.M.S. viral pandemic triage protocol, which medical standards made some changes to and voted on ... SEMAC as a second in motion.

And well, hopefully Amy can bring that up.

MS. EISENHAUER: Dr. Marshall, I sent them to Val and Jacob is going to get presenter so she can pull them up.

MR. MARSHALL: Okay, perfect.

MS. OZGA: ...

MR. MARSHALL: So we had a lot of discussion, there were originally two changes. One was inserting a statement that the protocol is not valid until activated by -- as needed by the region appropriate REMAC and would remain in effect for fourteen days unless renewed in which case it would just expire.

We had some discussion on that in

terms of the timeframe and fourteen versus thirty days and the committee voted on fourteen days. The second one was at the end of the protocol an option if a patient doesn't have secondary underlying conditions or doesn't have ... can contact medical control for possible non-transport and treatment and place orders.

We made a change to that so it would say contact medical control or follow regional policy for possible non-transport and treat in place orders. So if we can pull up that revised protocol so people can see it.

MS. OZGA: Hang on a second, guys, something happened to my computer where I can't -- okay, hold on a second. I think I got it now. Okay. Can everybody see that?

MS. EISENHAUER: Hey, Val.

MS. OZGA: Yes.

MS. EISENHAUER: Ryan had -- Ryan had sent the E.M.S. viral pandemic triage protocol, the update. With those updates and it is in boardable as the last document with P.D.F. after it if you need to share that as well.

MS. OZGA: Okay.

CHAIR DOYNOW: Would you like this proposed motion put up or do you want the -- the modified protocol put up first?

MR. MARSHALL: So let's put up the modified protocol if we can.

MS. OZGA: So that's the document from Ryan, correct?

MR. MARSHALL: Yeah.

MR. GREENBERG: Would be the P.D.F. in your -- I put the P.D.F. in your email.

MS. OZGA: Okay. Hold on one second.

MR. MCEVOY: This is McEvoy here. I would also note that SEMAC does not have access to the medical standards folder, so we can't see it. It's not in the SEMAC folder.

MR. GREENBERG: Amy, can you go ahead and put that in the SEMAC folder as well, please?

MS. EISENHAUER: I did put it in, it's all the way at the bottom. So maybe refresh the screen. I'm in the -- I'm in the meeting and if you go into the meeting itself, all the documents for this meeting are in there. And then at the bottom, it'll say E.M.S. viral pandemic triage protocol, and then there's a redesign.

I put it in around one o'clock. So if you opened it before, then you might just need to refresh.

MR. MCEVOY: I see it now, thank you.

MS. OZGA: I'm so sorry guys, I'm having a lot of issues with my computer right now. I'm not sure why. Okay. All right. Amy, you said you put it in the SEMAC folder, correct?

MS. EISENHAUER: Yes.

MS. OZGA: Okay.

MR. PHILLIPPY: This is Mark Phillippy. I just noticed a little bit of a glitch here that might be contributing to this. If you go to the documents and there are things there that are not in the meeting tab. I think it's just a glitch in boardable. So I think what -- Amy if I get you correctly, you're in the meetings tab. And --

MS. EISENHAUER: Yeah, just like that, I'll just show you.

MR. PHILLIPPY: Yeah, there we go.

CHAIR DOYNOW: There we go.

MS. EISENHAUER: Okay.

MS. OZGA: Is this what you need?

MR. MARSHALL: Yes.

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MS. OZGA: Okay.

MR. MARSHALL: Enlarge it a little bit, please. We can start at the top and scroll down.

MS. OZGA: How's that?

MR. MARSHALL: Little more. Little more, there you go.

MS. OZGA: Okay.

MR. MARSHALL: Thank you.

MS. OZGA: You're welcome.

MR. MARSHALL: So you'll see at the top under the title, the title was changed to add adult because if you recall when we put this protocol in place the primary patients that we were concerned with were adult patients who are the ones most affected my COVID. We did have a lot of discussion about pediatric pandemic triage protocols and E.M.S.C. we'll be taking a look at that at their next meeting.

So this was made specific for adults with the understanding that our current pediatric protocols would allow for appropriate triage treatment and transport to an appropriate facility. The text in blue is what was added. This protocol is

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not valid until activated by the appropriate REMAC and will remain in effect for fourteen days at which time will expire unless renewed.

And we did have discussion about, you know, there are some regions where the REMAC has a an executive committee that makes decisions between REMAC meetings and that would be appropriate for -- for that executive committee to make that decision. And then there are regions that have a regional medical director was empowered to act between REMAC meetings.

And we felt that this language would cover both of those eventualities. Can you scroll down a little bit? Yes.

MR. DAILEY: Lou, I'm sorry, it's my fault. So I still have the significant amount of issues operationalized in fourteen days, but -- but the other question that comes in here is, is the fourteen days the ceiling or the floor? So if REMAC wants to make it thirty days, can they do that?

Or do they have to only make it less so they couldn't make it twelve days and that expired? How are we going to interpret that for purposes of this moving forward?

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MR. MARSHALL: Good question. That did not come up, but that's something we should definitely think about. If it is the ceiling then the region would have to renew it every fourteen days, I believe. If it is the floor, then region could implement it or longer period of time if they so choose.

That would be my interpretation and so others may have a different interpretation.

MR. OLSSON: Dr. Olsson. The way I read it is that we can't change the fourteen days, because that's how it's written. So we would just have to reissue it for another fourteen days. As it says it will expire unless renewed.

MR. MARSHALL: Yes.

MR. OLSSON: That's it.

MR. MARSHALL: Any other comments? I mean, we did have a lot of discussion on the fourteen days versus thirty days and you know, timeframes for different regions may be different in terms of response and -- and pandemic effects. But the committee voted for the fourteen days. As Dr. Olsson explained, it will expire unless renewed.

So it's not -- it's not onerous for a

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region to renew it. Can be done by the executive committee or the regional medical director.

MR. PHILLIPPY: Dr. Marshall.

MR. MARSHALL: Yes.

MR. PHILLIPPY: Just -- Mark Phillippy here. Just a quick comment on box for patient assessment. There is an asterisk there that referred to B.L.S. protocols for pediatric vital signs. And I know there was extensive discussion at med standards about making this adult specific, should we remove that bullet point?

MR. MARSHALL: I can't see it on the screen. So maybe when we get down to that box, we can --

MR. PHILIPPY: Sorry, didn't mean --

MR. MARSHALL: No, that's fine. That's fine. So the next change was, you notice box two, which should actually read, done appropriate P.P.E. before initiating close contact with the patient. And then the next -- what's next is I spelled it wrong. Sorry about that. Then third box is the -- identifying which patients meet those criteria.

And then in box four we took out

temperature ... one. And we left and refer to B.L.S. protocols for pediatric vital signs. And I would -- I would recommend that we take that out as -- as Mark mentioned, since we titled this adult, and then allow E.M.S.C. to come back with a corresponding protocol for pediatric patients.

And then --

MR. OLSSON: Dr. Olsson.

MR. MARSHALL: Uh-huh.

MR. OLSSON: Just -- just a quick -- personally, I would leave that in there as a reminder or just another stimulus for somebody to look at the pediatric vital signs. It's my opinion.

MR. MARSHALL: Thank you. Anybody else? Okay. If you scroll down a little more to the last box. Here, we changed it to contact medical control or follow regional policy for possible non-transport, treat and place orders. So those were the recommended changes, and they come forward as a second motion.

I'm wondering if the -- the pediatric Asterix had been taken out from a previous version, because the one that we worked on earlier today did not have that.

MR. DAILEY: So I would suggest that that it should say refer to pediatric protocol rather than refer to B.L.S. protocol for pediatric vital signs because you want them to look at the one that E.M.S.C. is going to assess that. We do have a statutory problem that E.M.S.C. actually cannot generate protocols. They have to come through this committee.

So we're not going to be able to do anything with the pediatric side of this until the April meeting, and I would still argue that fourteen days is not something that works operationally. And that that should be decided on a regional basis or we should allow regional versions of this rather than this single statewide version, which the City of New York has already issued.

MR. MARSHALL: So the motion that has been brought -- brought forward for medical standards is that we change the name to adult viral pandemic triage protocol, remove the P.P.E. box to the second box, remove temperature from box four. And add the language at the bottom for possible non-transport and treatment.

That's the -- that's the motion that's

being brought forward. There have been some suggested changes. And I guess we need our parliamentarian to tell us if those need to -- I guess they would need to be motions.

CHAIR DOYNOW: Dr. Cooper has his hand up.

MR. LANGSAM: Yes, yes, you I'll need motions -- formal motions to change that.

CHAIR DOYNOW: Dr. Cooper, you got your hand up there.

MR. COOPER: Thank you. With respect to the pediatric version of the protocol, which E.M.S.C. will address next week, with the permission of Ryan Greenberg and the department legal gurus, I do imagine that the protocol could be developed pretty quickly.

I don't imagine that there'd be any barrier on an emergency basis to the department identifying some mechanism together with Dr. Doynow and the leadership of the -- of the SEMAC to approve the protocol on an interim basis until -- until the SEMAC can meet again later in the year.

I think this is important that we have this flexibility because we all recognize that we're

in the middle of a -- of a huge surge in terms of Omicron variant of the ... agents and you know, we really -- I cannot put up the pediatric protocol implementation at least on an interim basis. And so we have to be done pretty quickly.

So I'm going to specifically in the ... right now, and the department staff to help make that happen. Thank you.

MR. LANGSAM: If I can just comment with all due respect to Dr. Cooper and I agree with everything that he's saying. I do not believe that the bylaws allow or create an executive committee to do what you're asking. So I think you need another mechanism. Or one mechanism might be to approve something right this minute temporary base -- on a temporary basis.

And just say that the group will accept whatever the -- the -- the E.M.S.C. comes up with, at least until the next meeting, that will do it and give you to do right away. But I don't think you can get an office set up a terrible precedent, you're basically giving away the power of the SEMAC essentially and, you know that in New York City, we do have an executive ... and the bylaws.

But without that, technically, it's not legal as far as I can tell.

MR. COOPER: Well, Dr. Langsam, there are other officials in the health department, namely a commissioner who's in a position to, you know, to get something like this out. And as I recall, the original viral protocol in the middle of the first wave of COVID was not issued with immediate SEMAC approval.

So whatever mechanism was operative then I imagined can be -- can be used now. What I don't think it would be appropriate would be to rush something to in the next -- in the next five minutes without -- without almost having had a chance to look it over and think at least a little before we just go ahead and lodge it.

So I will give ... Dr. Doynow and the department staff to identify a way that this can be handled. Thank you.

MR. LANGSAM: Again, there is -- there is a Department of Bureau E.M.S. wants to do what they did last time whether it was legal or not they certainly can do it. I'm not just going to advise the SEMAC that is not a legal thing to do. Again,

I'm not telling the Bureau of E.M.S. what to do.

They did it last time and nobody -- well, actually a lot of people question what they did, and they want to do it again, go right ahead.

MR. GREENBERG: Dr. Langsam, and let me --

MR. COOPER: I think legal determinations are up to the department, not up to us. Thank you.

MR. GREENBERG: Dr. Cooper and Dr. Langsam, so there wasn't a separate executive order last time that is not in place at this time so that would not be an option to this time. And the one thing that may be an option is to possibly hold an emergency meeting.

So after your meeting to hold emergency meeting, however, the issue with holding an emergency meeting is, I believe, the ability to hold a virtual meeting -- a virtual council meeting expires on the 15th of January. And so I don't know that that would be able to happen in that time period.

So Dr. Cooper, I don't -- I don't know and that it would kind of you know, going back to

this one, you know, within the patient assessment, do we leave for, you know, at the recommendation of this council, do you put something in here that includes pediatrics, including the line that was there related to, you know, pediatric vital signs?

Or is it not a protocol that is used for pediatrics, and then we try and hold, possibly an emergency session. However, the challenges that can come with that if there is no executive order to extend ...

MR. LANGSAM: The other thing is -- the other possibility is that SEMAC right now vote provisionally to approve what E.M.C.C.C. does for the period between now and the next meeting, whatever that would occur. And if the government does come up with the executive order, then we can have a virtual meeting.

I -- I also am not aware that she's planning on doing it, but maybe people will lobby her that she should do it as they did it last time. But I think you could do it now, you could vote now to authorize E.M.S.C. that SEMAC approves in advance of course, I trust Dr. Cooper to do the right thing, because that's what E.M.S.C. is.

And it'll expire by the next meeting. If, for some reason, we just decide that what they did was the wrong thing. Anyway, that's just my legal issues. That's not saying whether it's good thing or not.

MS. BOMBARD: So guys, I'm not sure why we're worrying about this as much as we are. We're talking about protocol that allows us to leave people in place, right. And I'm not sure how many of these children that the parents call E.M.S. for should be left in place to begin with, especially without consulting medical control.

So I think we have all the time in the world to do this. I don't see a giant crisis of lines and lines of E.M.S. crews being tied up on pediatric calls that are not appropriate for transport. Unless you're seeing this where you are, I am not seeing a lot of inappropriate 911 calls for pediatric patients, period.

So why don't we just wait until the next med standards meeting and attack it then as a group. I don't see a time problem here.

MR. COOPER: Dr. Bombard, I -- I do think some of the city facilities are pretty

overwhelmed with kids coming in with fever and no other symptoms. And -- you know, that would be the main issue. We don't want kids with -- with low grade fevers and no other symptoms, you know, coming in, you know, because it ties up the emergency departments.

And even if they don't have COVID it would expose them to other kids who may have it in and our ... department ninety-five plus percent of the kid, anybody symptomatic or not are testing positive to COVID. So you know, and of course, our volumes are way up. But I think that's the issue at least in the downstate -- in the downstate areas, so I'm not sure that it would be prudent -- you know, to wait.

I still think that -- that finding some way that E.M.S.C. can -- can you know, review this and get back to you and get it approved on an interim basis or shortly thereafter I think that that's probably the best ... to take.

MR. BART: This is Joe Bart. I have few comments here. I think we -- we can all agree we've spent a lot of time on this previously, and then again today through committees. I want to just

back us up to the idea of what was the intent of this in the first place. And the intent of this was because we had a whole lot of unknown when the pandemic started, we had unknown P.B.E. we had unknown presentation of illness.

We had unknown amount of people that were going to maybe be a burden to the E.M.S. system or have to be displaced from anywhere but the emergency department. A lot of those problems have just been figured out. Some of them have not, in fact, many of them have not.

But as I read the protocol now, it essentially says, if you've got any emergency medical complaint whatsoever, follow your protocol. If you have none of those contact online medical direction for decision. That to me doesn't even have any teeth to it.

So it's not as if we're dissolving something here that's an offline protocol that suggested E.M.S., aside from calling online medical direction is going to have any authority to make decisions on factoring people away from ... department or refusing their transport.

So I understand we spent a whole lot

of time on this, but I was a huge proponent when it started with all the unknowns here. But without any teeth at the end of it whatsoever, I'm not even sure I'm in favor of keeping this protocol live at all. So I'm kind of inches away from creating a motion that says that we just abandon this protocol entirely.

Because it seems like we're already figuring this out through processes that we've developed over the past twelve months, or frankly, that we have an irregular protocol now with online and offline medical direction.

MR. OLSSON: So Olsson's, quick comment. The pediatric vital signs, unless we're going to incorporate those pediatric vital signs into this adult triage are still referring the provider to a separate document. So this document with whatever wordsmithing of that one statement you want to make is still done.

And then whatever comes out of E.M.S.C. is still an additional reference. So I think we can move forward.

CHAIR DOYNOW: So this Don, can I -- can I make a suggestion here. Let's -- let's remove

the referred to B.L.S. protocols for pediatric vital signs. This essentially is an adult protocol. And the other is perhaps we can have E.M.S.C. come up with their protocol, have it emailed out to every one of the committee members.

We can then look at it, vote on it on a temporary basis until the next meeting. That can perhaps be put on to a public document from the health department, so it is out there, what the vote was. And that probably is the easiest way to do this. Ryan, can we do that?

MR. GREENBERG: I apologize, Don. Can you repeat what you -- the process you're on?

CHAIR DOYNOW: Dr. Cooper, once they come up with their protocol, it gets emailed to every SEMAC member. We vote on all ... accept it or not. And it'll be temporarily accepted until the next meeting in which case we can reevaluate it that way it gets out there quickly.

MR. GREENBERG: Yeah, I don't believe that would be an option. Again, the option could be to hold an emergency council meeting and have both the ... med standard SEMAC and SEMSCO for the specific, you know, for one item essentially meetings

and you would come together have that one meeting, vote on it and then move it through.

But without that process and based on -- you know, the current executive orders and things that that's the only way if the pediatric would be able to go ...

CHAIR DOYNOW: Okay. Yeah, that would be ...

MR. LANGSAM: ... are not permitted under -- under our current rules.

CHAIR DOYNOW: Well, then I -- I have a feeling that that is not going to occur, so I think it's either going to be it's going to wait next meeting or it's going to be what Dr. ... which is we give them temporary authority to come up with a protocol SEMSCO also agree to do that and then we will reevaluate it the next SEMAC meeting. All right. It seems to be the only way we --

MR. WALTERS: Dr. Doynow, it's Dr. Walters.

MR. BART: Now, we're creating wall breaks within wall breaks right now. Like I mean this is it -- it start to be comedic about it. But is this protocol really that thing that we really

need to dig in so deeply to find the cracks in the system to get it out there. I mean, unless there is -- unless there is an act of motion out there right now I want a motion to table this.

CHAIR DOYNOW: Okay. Well, there is a motion to accept this on there's no motion for pediatrics.

MR. BART: All right. Then I like to call the question.

CHAIR DOYNOW: Does anybody want to make a motion for the pediatric?

MR. LANGSAM: He called the question. He called the question which means you stop talking. It needs a second and it needs a two thirds votes.

MR. MCEVOY: I'll second all the question, McEvoy.

CHAIR DOYNOW: Can we have Dr. Marshall repeat what the actual motion is that we're voting on?

MR. MARSHALL: Now the -- ... you went blank.

CHAIR DOYNOW: We can't hear you.

MR. MARSHALL: I'm sorry. I'm sorry, med -- calling the question of which now there is a

motion and a second on the floor. If it passes on a two third vote means you immediately go to vote on the motion without any further discussion. That's the only thing you can do right now is vote on calling the question.

Which they -- call the question means everybody should shut up. We don't want to hear anymore and we go directly to vote on the motion that's currently in place. So that's what calling the question means.

CHAIR DOYNOW: So the motion is -- is what Dr. Marshall needs to put up to the group again and we've talked about this about a half an hour ago, what actually is the motion we're voting?

MR. LANGSAM: We're not voting on that right now. We're voting on whether we should stop talking then I'll put it up.

CHAIR DOYNOW: Okay.

MR. LANGSAM: That was made just a minute ago, let's stop talking.

CHAIR DOYNOW: Okay. I guess I understood that. So let's end up having a vote as to what to stop talking. Valerie, if you would.

MS. OZGA: Okay.

MR. LANGSAM: Two thirds voting.

MS. OZGA: Two thirds vote. Okay. Dr. Alexandrou?

MR. ALEXANDROU: I abstain. I'm not really sure what we're voting on.

MR. MARSHALL: We're -- we're voting on whether or not to call the -- call the question means that discussion stops, and we vote on the motion. And we have to vote on whether or not to call the question. If you vote in the affirmative to call the question and as Dr. Langsam said, you go to the vote.

If you vote in the negative to call the question, then you can continue discussion on the motion.

MR. ALEXANDROU: I think it sounds a little bit more clarified. Okay. So I'm in the affirmative. Yes.

MS. OZGA: Okay. Yes. Dr. Bart?

MR. BART: Bart, yes.

MS. OZGA: Dr. Berkowitz?

MR. BERKOWITZ: Berkowitz, yes.

MS. OZGA: Dr. Bombard?

MS. BOMBARD: Dr. Bombard, yes, stop

talking.

MS. OZGA: Dr. Cooper?

MR. COOPER: Was that Kugler or Cooper?

MS. OZGA: Cooper.

MR. COOPER: Me. Arthur, yes.

MS. OZGA: Dr. Cushman.

MR. CUSHMAN: Cushman, yes.

MS. OZGA: Dr. Dailey?

MR. DAILEY: Dailey, yes.

MS. OZGA: Dr. Detraglia?

MR. DETRAGLIA: Detraglia, yes.

MS. OZGA: Dr. Doynow?

CHAIR DOYNOW: Yes.

MS. OZGA: Was Dr. Gomez on, did he -- did he get on at all? Okay. Dr. Kugler?

MR. KUGLER: Kugler, yes.

MS. OZGA: Dr. Lynch?

MR. LYNCH: Lynch, yes.

MS. OZGA: Dr. Markowitz?

MR. MARKOWITZ: Markowitz, yes.

MS. OZGA: Dr. Maynard. Dr. Maynard joined us today? Dr. Marshall?

MR. MARSHALL: Dr. Marshall, yes.

MS. OZGA: Dr. Murphy?

MS. MURPHY: Murphy, yes.

MS. OZGA: Dr. Olsson?

MR. OLSSON: Olsson, yes.

MS. OZGA: Dr. Talbott?

MR. TALBOTT: Talbott, yes.

MS. OZGA: Dr. Walters?

MR. WALTERS: Walters, yes.

MS. OZGA: And Dr. Wicelinski?

MR. WICELENSKI: Yes, Wicelinski, yes.

MS. OZGA: We have eighteen in the affirmative. With -- Dr. Langsam, you said it had to be two thirds, correct?

CHAIR DOYNOW: Yes, that's what he said.

MS. OZGA: Okay. And that's the voting members that who was present today, is that correct Dr. Langsam? Where did my parliamentarian go?

MR. LANGSAM: I'm sorry. What was the question, I apologize.

MS. OZGA: Okay. So we have eighteen in the affirmative. And you said we needed to have two thirds. So is it two thirds of the voting

members who are present today?

MR. LANGSAM: No, two thirds of -- of the -- the people are present today that comes to the quorum.

MS. OZGA: Okay. So then motion passes to call the question.

CHAIR DOYNOW: Okay. Now, can we go back to the original motion, Dr. Marshall?

MR. MARSHALL: Yes.

MS. OZGA: Okay. Let me bring him in ... give me one moment.

MR. LANGSAM: No, in the middle of a meeting with the State I can't do this.

MS. OZGA: Okay. I believe this is the motion if you could just confirm it that would be great.

MS. EISENHAUER: Now the first three motions are in relation to this document.

MS. OZGA: Okay. So do I bring one motion up at a time?

MR. GREENBERG: Well, no because I think -- and Dr. Marshall, correct me if I'm wrong ... correct?

MR. MARSHALL: Yes.

`MS. OZGA: Okay. I did not hear what was ... and my apologies, he was going in and out.

MR. MARSHALL: Can you bring up motion two and three just so we can take a look at them?

MS. OZGA: Yeah.

MR. MARSHALL: Just motion one is -- is what was being drawn.

MS. OZGA: Okay. Motion two.

MR. MARSHALL: Forward.

MS. OZGA: Here is motion two.

MR. MARSHALL: Motion two was defeated.

MR. MARSHALL: Motion three.

MS. OZGA: Motion three.

MR. MARSHALL: Motion three is actually included in motion one I think because we brought forward the final document.

MR. : So the vote would be on the amended document that were shown, correct?

MR. MARSHALL: Correct.

CHAIR DOYNOW: Would include motion one and motion three.

MS. OZGA: Do I need to bring the document back up?

MR. LANGSAM: Yeah, you can bring the document back up. Thank you.

MS. OZGA: Any other questions or should I go to the roll call vote?

MR. MARSHALL: We don't see the document.

MS. OZGA: You don't?

MR. MARSHALL: So you're on -- you're on motion three, that's okay.

MS. OZGA: Hold on one moment. Do you see it now?

MR. MARSHALL: We see it now.

MS. OZGA: Okay. Sorry about that guys.

MR. MARSHALL: So the motion is, add the language in blue at the top, rearrange the boxes and so box number two as approved by medical standard was done appropriate P.P.E. that would have to be adjusted. Well actually, it's in the second sentence. And E.R. was removed from box four, and the ability to contact medical control or follow regional policy for non-transport and treatment in place.

(Off the record, 1:01 p.m.)

(The proceeding commenced)

MS. OZGA: All right. Any other questions, shall I continue my roll call?

THE CHAIR: Yes, no further discussion, right, Dr. Langsam?

MR. LANGSAM: That's correct and not want to discuss it all now.

MS. OZGA: Okay. I will do roll call. Okay. Dr. Alexandrou?

MR. ALEXANDROU: Yes.

MS. OZGA: Dr. Bart?

MR. BART: Bart, no.

MS. OZGA: Dr. Berkowitz?

MR. BERKOWITZ: Yes.

MS. OZGA: Dr. Bombard Tiffany?

MS. TIFFANY: Bombard, yes.

MS. OZGA: Dr. Cooper?

MR. COOPER: Dr. Cooper, yes.

MS. OZGA: Dr. Cushman?

MR. CUSHMAN: Cushman, no.

MS. OZGA: Dr. Dailey?

MR. DAILEY: Dailey, no.

MS. OZGA: Dr. Detraglia?

MR. DETRAGLIA: Detraglia, yes.

MS. OZGA: Dr. Doynow?

THE CHAIR: Yes.

MS. OZGA: Dr. David Kugler?

MR. KUGLER: Kugler, yes.

MS. OZGA: Dr. Lynch?

MR. LYNCH: Lynch, no.

MS. OZGA: Dr. Markowitz?

MR. MARKOWITZ: Markowitz, yes.

MS. OZGA: Dr. Marshall?

MR. MARSHALL: Dr. Marshall, yes.

MS. OZGA: Dr. Murphy?

MS. MURPHY: Dr. Murphy, no.

MS. OZGA: Dr. Olsson?

MR. OLSSON: Olsson, yes.

MS. OZGA: Dr. Talbott?

MR. TALBOTT: No.

MS. OZGA: I'm sorry. Dr. Talbott, was that no?

MR. TALBOTT: Correct. It was no.

MS. OZGA: Okay. Thank you. Dr. Walters?

MR. WALTERS: Walters, yes.

MS. OZGA: And Dr. Wicelinski?

MR. WICELINSKI: Wicelinski, no.

MS. OZGA: I'm just double checking, hold on. Okay. We have a eleven in the affirmative and six -- six noes. Dr. Langsam, does that need to be two thirds to pass?

MR. LANGSAM: No, it doesn't need two thirds but it needs to be majority of the -- all the voting members not just those who are present. I don't know how much voting members you have.

MS. OZGA: So out of the twenty-three.

MR. LANGSAM: So majority of twenty-three is -- half of twenty-three plus one.

MS. OZGA: Hold on. All right. So we only have eleven. So I would say this does not pass.

THE CHAIR: Are they all ...

MR. LANGSAM: It misses it by one vote. Okay. ... back to med standards next time, wherever the old protocol still ... and is still out there but it has not been rescinded. So the old protocol is not modified. It's still in ...

MR. MARSHALL: Shall I continue, Dr. Doynow?

MS. OZGA: Yes.

THE CHAIR: Yes.

MR. MARSHALL: The next motion comes

medical standards is motion to approve. The pediatric dose optimization for seizures and E.M.F. study. This is the studies brought forward by University of Buffalo and ... Buffalo who have been selected to participate in a phase three multicenter trial midazolam dosing procedures in pediatric patients in a pre-hospital setting.

It randomizes twenty participating agencies to switch from conventional weight based dosing to standardized age based dosing and that switch will occur at the same time for every agency and be done over a four year enrollment period, and the period of the study is for five years.

The goal of this study is to show that using weigh based age appropriate dosages for midazolam, it will be associated with a lower frequency of active seizures upon ... arrival.

That comes forward as a second in motion and Dr. ... if he's on and help answering the questions, if you may have questions. Hearing none, Dr. Doynow, would you like to --

THE CHAIR: Sure.

MR. MARSHALL: -- call for a vote. It's a motion number four, I believe, yeah.

THE CHAIR: Val, if we have ...

MR. DAILEY: Actually, my apologies. I was trying to get off mute, Don. I just wanted to comment briefly that this is an excellent opportunity for the folks in Buffalo to assist with the lexicon of pediatric research. I'm excited this is being done in New York and I'm glad we can be supportive of it. Thank you.

THE CHAIR: Thanks, Mike ...

MS. OZGA: Dr. Doynow, I couldn't hear you. Do you want me to do the roll call?

THE CHAIR: Yes, please.

MS. OZGA: Okay. Dr. Alexandrou?

MR. ALEXANDROU: Yes.

MS. OZGA: Dr. Bart?

MR. BART: Yes.

MS. OZGA: Dr. Berkowitz?

MR. BERKOWITZ: Yes.

MS. OZGA: Dr. Bombard?

MS. TIFFANY: Bombard, yes.

MS. OZGA: Dr. Cooper?

MR. COOPER: Cooper, yes.

MS. OZGA: Dr. Cushman?

MR. CUSHMAN: Cushman, yes.

MS. OZGA: Dr. Dailey?

MR. DAILEY: Yes.

MS. OZGA: Dr. Detraglia?

MR. DETRAGLIA: Detraglia, yes.

MS. OZGA: Dr. Doynow?

THE CHAIR: Yes.

MS. OZGA: Dr. David Kugler?

MR. KUGLER: Dr. Kugler, yes.

MS. OZGA: Dr. Lynch?

MR. LYNCH: Lynch, yes.

MS. OZGA: Dr. Markowitz?

MR. MARKOWITZ: Markowitz, yes.

MS. OZGA: Dr. Lewis Marshall?

MR. MARSHALL: Marshall, yes.

MS. OZGA: Dr. Murphy?

MS. MURPHY: Murphy, yes.

MS. OZGA: Dr. Olsson?

MR. OLSSON: Olsson, yes.

MS. OZGA: Dr. Talbott?

MR. TALBOTT: Talbott, yes.

MS. OZGA: Dr. Walters?

MR. WALTERS: Walters, yes.

MS. OZGA: Walters was yes. Dr. Wicelinski?

MR. WICELINSKI: Yes, Wicelinski.

MS. OZGA: Well, Dr. Wicelinski, that was yes?

MR. WICELINSKI: Yes.

MS. OZGA: Okay. Thank you so much. Motion passes.

MR. MARSHALL: Thank you. Can you bring up the next motion? The next motion is to improve E.M.S. treatment of acute opioid withdrawal. This was brought forward by the collaborative, I believe, and it allows for patients who are in acute withdrawal to receive the option of getting buprenorphine that would be prescribed by a physician who was specifically trained to and approve for this medication.

And also, there's called Matters M-A-T-T-E-R-S Medical Direction. And, Dr. -- the collaborative will write that out in the document and as well as defining what P.C.M.C. was, which is actually pointing to the motion being removed to medical control facility.

And then, I got to also add the cows ... criteria. Some people are using this protocol or have those criteria in front of them and --

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MR. DAILEY: Dr. Marshall, the changes have been made to that document, it's been uploaded to Boardable with -- with those, cows will be an appendix within the protocols as our other scores have been.

MR. MARSHALL: Okay.

MR. DAILEY: We'll also encourage the use of MDCalc through our educational interventions.

MR. MCEVOY: Could those -- that document be uploaded into the SEMAC Boardable? It's not visible to us.

MR. DAILEY: I can't upload it there, I'm like -- I unfortunately don't have access to the SEMAC Boardable only to this -- to the med standards one.

MS. EISENHAUER: What folder did you put it in, Dr. Dailey?

MR. DAILEY: It's in the med standards protocol -- med standards folder for today's meeting.

MS. EISENHAUER: Okay. I will go look. Dr Dailey, Dr. Dailey, I don't see it in the other documents. Can you email it to me and then I can share it?

MR. DAILEY: Certainly can.

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MS. EISENHAUER: Thanks.

MR. LANGSAM: Marshall, do you have any elevator music to put in the background?

MR. MARSHAL: Yeah, I know, right?

MR. DAILEY: Without due deference to Dr. Langsam and the way this needs to proceed, can we move onto the next item while we wait for Boardable and email to do their thing?

MR. LANGSAM: Certainly can. There's nothing wrong with doing that.

MR. MARSHALL: So while we're waiting for that, the next two items on the agenda were advisories from ... One has to do with E.M.S. Geriatric TeleConsult Algorithm and that would allow or -- sorry.

For teleconsult for geriatric patients and guidance by the physician, they have a specific facility algorithm for Geriatric TeleConsult.

Dr. Cushman, did you want to address anything? So this was -- this comes as a seconded motion. Both of these were reviewed and the motion was to move both of these to SEMAC.

And so, there was no --there's a very little discussion on protocol versus regional

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advisory. And the endpoint was that this was a regional advisory and it comes forward as a seconded motion as -- as a regional advisory for SEMAC discussion and vote.

MR. MCEVOY: McEvoy here. This is a similar issue. Again, we have no eyes on this.

MR. MARSHALL: Can you get into the med standards Boardable?

MR. MCEVOY: Negative.

MR. MARSHALL: All right.

MR. DAILEY: So if I can actually open some of the background on this. So the Geriatric TeleConsult Algorithm and advisory for alternative transportation.

Both of these were procedures that were originally developed to address local conditions. If I may, elegantly ... Monroe Livingston, regional E.M.S. on a council and I have absolutely no idea how these were not brought to the SEMAC and the SEMSCO as examples of best practices.

Rather, MILREMS ... was asked to remove these from operation pending this meeting. These are both exactly how regions should function, demonstrate excellence in E.M.S. And I would argue

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that both of these particularly in these trying times, difficult to access health care and crises and behavioral health are exquisite demonstrations of teamwork within healthcare and within behavioral health.

And we should immediately not only past these but encourage similar collaborations to occur in other regions and find out exactly why these were not allowed to move forward because there's nothing within Article 30 that should restrict such regional approach to appropriate care.

MR. KUGLER: Question for the Chair. This is Dr. Kugler.

THE CHAIR: Go ahead.

MR. KUGLER: So along the lines of Dr. Dailey's very eloquently stated discussion just now, I would ask that if we are to start passing a regional -- approving regional policies at the SEMAC and SEMSCO levels, where the Article 30 does allow for the regions to create policies and procedures that are specific to their region.

I think we're sort of trending on a very fine line, where now the state is overtaking the regional authority, which is allowed to that. I

think that we should acknowledge the great work that MILREMS is done and give Dr. Cushman and his team kudos and move on.

We do not need to approve this because this is a regionally approved policy that the state has no bearing on.

THE CHAIR: Thank you. Any other discussion?

MR. WALTERS: I have a question for Dr. Cushman.

MR. CUSHMAN: What?

MR. WALTERS: Dr. Cushman, I saw a -- I guess, as I'm looking at this, basically, this algorithm is just essentially inclusion and exclusion criteria to either transport via standard protocols or to engage a geriatrician or to do a teleconsult with a geriatrician to evaluate these patients, where they are during the height of a pandemic and the Department of Health told you, no?

MR. CUSHMAN: Cushman, sum and substances, that's -- that's accurate. So Advisory 2113 was developed in concert with geriatricians from both of our health systems. That was borne out initially because of very large numbers of

asymptomatic COVID positive patients that were being transported out of sniffs in-house, without actually getting their docs involved.

And so we started having conversations that ultimately led to Advisory 2113 supported by both Rochester Regional Health as well as UR Medicine, both of their geriatrics groups and so forth, to really provide Geriatric TeleConsult, does he notice within the algorithm in no way whatsoever does it say that we will refuse a patient's transport.

It was to engage someone that is much better qualified to determine the best disposition for the patient in the specific facilities. And you notice that it was very facility specific, because those are specifically facilities that are overseen by those two geriatric groups.

It is not inclusive of all sniffs in-house within the Rochester region because of that -- that simple fact. That advisory was issued on September 29th of 2021. That was issued based upon my understanding of Article 30.

And -- and really, kind of specifically, Section 3003-4, which allows the REMAC

to develop those policies, procedures and triage treatment transport protocols consistent with the SEMAC. I felt -- REMAC felt, we did a purpose at the time that that was consistent with existing policy and practice.

I received a call from -- from the director and deputy director on October 21st indicating that there were some complaints received regarding that, which I have not had any substantiation to rather, they were patient care concerns or what have you to run for a quality improvement process and was directed to rescind that policy immediately, it was done the following day.

Through that conversation, I was told that this is a protocol and had to be rescinded because it was not reviewed and approved by the SEMAC. Doesn't mean cluttering everyone's inboxes, as well as, using up your fine time today regarding these two regional advisories regarding both engagement of geriatric medical control, if you will, as well as transporting our patients to a behavioral health access and crisis center, which I won't get into that but if folks want background on that, as well, I'm happy to provide that.

So here -- here and we live and I appreciate the wisdom of the SEMAC in the end. Our goal was simply to provide the best possible care to our patients regardless of -- of where they are.

THE CHAIR: So yeah, Doctor, I agree with you when -- when you're reading this Section 3004 ... what the concern was, but now, it's in front of SEMAC, my suggestion is we bring it up to a vote and move it forward because it does appear to be appropriate ...

MR. CUSHMAN: Cushman to the chair. Again, my only concern with bringing it to a vote is does a vote confer that that is the expected practice for the advisory or not. Else, my great friends in New York City just -- just did something that I, absolutely, we should be doing.

But that would mean that every single thing has to come before this body and I think that's ultimately the question that the bureau in our regions all grapple with.

And so I just -- I just -- I appreciate the support but at the same time I'm concerned about the precedent that something like that sets.

MR. DAILEY: I would argue --

THE CHAIR: ...

MR. DAILEY: -- actually, we brought this here for discussion. But I think what we do is we endorse the efforts that you're making and that ultimately should be our mission here today and the motion that we bring forward should be to endorse regional efforts to expand teleconsult as appropriate and work towards alternative destinations when possible.

MR. LANGSAM: You can make that as a substitute motion get a second if you vote on that, it happens and that's the end of it.

THE CHAIR: Would you like to make that motion?

MR. DAILEY: Certainly. Certainly, Dr. Doynow. I vote -- we do not vote to approve these advisories but to endorse them and that we support regional teleconsult and alternative transportation initiatives to assist the E.M.S. system.

MR. PHILIPPY: Mark Philippy, I second.

MR. OLSSON: Olsson, third. Do we

need to be specific as opposed to we're going to endorse regional policies that come to this body without limiting ourselves to telemedicine and everything else? Just by -- I don't know.

MR. LYNCH: It's -- it's Lynch. Do we need to have any action on regional policies? I mean, I guess, I'm -- I'm not really sure if they're -- if there's something that we're -- that we have to do right now because of this or we say thank you and move on.

MR. PHILIPPY: Dr. Lynch, it's Mark Philippy --

MR. WALTERS: It's Walters.

MR. PHILIPPY: Walters, I'm sorry.

THE CHAIR: Dr. Mark, and then, Dr. Walters. Go ahead.

MR. PHILIPPY: Thanks, Dr. Doynow. I think the issue with it, Dr. Lynch, is is something we talked about briefly at med standards, is that there is some confusion at some level of state government has the understanding of what is the policy or procedure and what is a protocol.

And when we started throwing the word protocol then people start looking for a certain

format and -- and certain ways things are done. It was good at it that standards that the New York City procedure or policy and physician did not appear in a protocol or algorithm, boxes and arrows kind of format. Therefore, perhaps, that's how they get around it.

It's calling an apple an orange ... I don't particularly care. I think what we're looking to do here is at some point, maybe not today, but at some point, decide what the heck is a policy, with an X procedure and what's X protocol.

For the time being it lifted moment, we've got two things before the body and I suggest that supporting the concepts that are in this goes a long way toward at least alleviating the issue temporarily until we can get a chance to sit down and make those decisions in writing. That's my point.

MR. GREENBERG: Dr. Doynow, ... Bombard and Jeremy thanks for providing their background on where this all came from. Two, and when that did come up and the issue came up, it was, you know, brought forward to division of legal ... which is where they came back feeling this was a protocol, which by their ... approval by med

standard, SEMAC ...

I think, you know, I think what really helps in clarity and we had the conversation on the earlier meeting today is helping me, either having this group or med standards, whichever the Chair feels is appropriate to do it, further -- not even further, you know, to put ... on paper, what is a policy versus what is a protocol in order to allow the regions to have the regional policy.

And to know where that line crosses for when something falls into a medical treatment and protocol versus a regional policy. And then everybody I think is on the same page statewide opposed to, you know, because some doing this one way, some doing something else. And I believe that is what Chairman Philippy was talking -- had mentioned before.

So, you know, when you talk about whether it be this and how he choose to do that, but also the long term in getting to the point to where regions are doing what they need to with -- with the policies as they should, first when they need to know, okay, this passes that line, it needs to go up for the protocol.

But yes, when that -- when the incident did occur, it was brought up, you know, to the leadership and the division of legal affairs, which is where that conversation happens and where we are today.

THE CHAIR: Thank you, Ryan. Dr. Bart, do you have comments as well?

MR. BART: I did not, ... that's all I got.

MR. WALTERS: It was Walters. I think I did.

MR. BART: We always confusing me and Walters ... anymore.

MR. WALTERS: Western accent.

MR. BART: Because we were sound like we're from Canada?

THE CHAIR: Dr. Walter?

MR. WALTERS: My -- yes. So I guess, my comment is, I -- listen, I'm fine with endorsing this, you know, alleviates the issue in the short term, then fine, we can do that but I guess I'm just echoing some of the other sentiments here when I -- I look at this and I say every -- every region or most regions, I don't know if everyone does, but I'm going

to presume every region has some type of, you know, refusal of care type policy, which has similar type criteria, sometimes vital sign criteria or injury criteria similar to this.

So when you get transported or in this case, whether or not you get, you know, sign off, but you are eligible for a teleconsult, you know, evaluation. And so I just think this is, again, a slippery slope to endorse or to be approved "a regional policy", and again, I just want to come back to the fact I think it's shameful for the Department of Health in the middle of a pandemic to have chosen the highest risk people, the geriatric population to hospitals and more people and potentially COVID, as Dr. Cushman pointed out.

I think for a bunch of attorneys for the states to weigh in on this, who are not medical experts, who misinterpret this as a protocol. And for the bureau to be complicit in that, I think, is just -- I think we need to call a spade a spade and say that it's shameful and should never have happened and should not happen again.

I mean, if this is really what the Department of Health is spending their time on, we

can't even -- when they're too busy to have two days of SEMAC and SEMSCO meetings but yeah, we can prohibit a region from trying to provide high quality care to the highest risk population during a pandemic.

I just, am not even sure what we're doing, if that's our stand at the D.O.H. hearing.

THE CHAIR: Thank you.

MR. LANGSAM: Can I make a suggestion because we're going to be here all day long?

THE CHAIR: Yes, Dr. Langsam, please.

MR. LANGSAM: We possibly have a motion that says, I'm not going to make motions. Do we have a motion that saying, one, without establishing a precedent SEMAC has no objection to these two advisories ... and then just go on.

THE CHAIR: I one hundred percent agree with you. Would somebody like to make that motion?

MR. DAILEY: Also I'll make that.

THE CHAIR: Do we have a second?

MR. MARSHALL: Marshall, second.

THE CHAIR: Okay. Is there any discussion before we vote ...

MR. WALTERS: We are -- are we in agreement that if we -- if we -- if we approve this motion that was just made, we're basically saying we do not feel that this is a protocol but we are endorsing this as well. Is that correct?

MR. LANGSAM: We're just saying we have no problem with it, go ahead and do it. And we don't want to discuss it anymore. That's really what it's all about.

And at some later point, people get together and decide what's the protocol, what's an advisory. But I think you want to get this off the floor going and people don't want to commit themselves to any rules right now.

So let's just say without, it's very important, without establishing a precedent, the REMAC has no objection to these two advisories, just endorse, just says go out and do what you want.

MR. LYNCH: It's Lynch. I still don't understand why we have to do this.

THE CHAIR: I think if we don't do it, it's not going to move on because the D.O.H. has decided that ... I mean, we can only get this point out, but I don't know where we'll get other than

sending it back to D.O.H. ... be all the way.

MR. LYNCH: Has the D.O.H. made it clear what we -- what we -- what needs to come out of this group in order for it to be allowed to carry on? Does it -- is it endorsement enough? Does it need anything?

THE CHAIR: Ryan, do you want to explain that to us?

MR. GREENBERG: Yeah, the D.O.H. opinion on this one was that it was a protocol. I think maybe when we talked about that maybe the vote is, you know ... protocol. We'd move that forward.

MR. LYNCH: Well, the -- if the D.O.H. feels that it's a protocol and has officially weighed on it. If we endorse it as not a protocol, does that even make a difference in the -- in the Department's eyes?

MR. GREENBERG: I believe it would in regards to it being reviewed by this committee.

MR. RABRICH: Dr. Doynow, can I make a comment as well? It's Rabrich.

THE CHAIR: Go ahead.

MR. RABRICH: Yeah. So I mean, do we not have -- I mean, I can't make a motion either but

perhaps the motion is that the SEMAC affirms the authority of REMACS under Article 30 to make advisory statements and that the current ones being considered meet that criteria and are not considered a protocol.

MR. KROLL: Now, if you said that slower, maybe someone, you know, can type that too.

MR. RABRICH: Yeah, someone else would have done a non-voting member of this committee. So I think someone else would have to make that motion but --

THE CHAIR: Well, I think we already have --

MR. : Rabrich, speak for me, please.

MR. RABRICH: Okay. So the SEMAC affirms the authority --

THE CHAIR: Hold on.

MR. RABRICH: Sure.

THE CHAIR: Before we get there, Val, are you ready to -- to type that way, Jeff, you don't have to second ...

MS. OZGA: I will do my best but please talk slowly.

MR. RABRICH: Sure. That the SEMAC affirms the authority of REMAC to issue advisories --

MS. OZGA: Hold on. Okay.

MR. RABRICH: -- to issue advisories under Article 30 and that the above advisories, so you could just copy it. It's 21-13 and 21-14, meet the criteria of advisories and are not considered protocols.

MR. DAILEY: Jeff.

MR. RABRICH: Yes.

MR. DAILEY: If I can make a suggestion.

MR. RABRICH: Please.

MR. DAILEY: I think the language that we actually want to use is that Regional Emergency Medical Advisory Committees shall develop policies, procedures and triage treatment and transportation protocols, which are consistent with the standards of the State Emergency Medical Advisory Committee, which address specific local conditions.

Regional Emergency Medical Advisory Committees may also approve physicians to provide online medical control, coordinate the development of regional medical control systems and participate in quality improvement activities, addressing system wide concerns.

MR. RABRICH: I see Article 30.

MR. DAILEY: That's three thousand ... slow clap, slow clap.

THE CHAIR: Guys, if I could just take control here for a second. I appreciate what Jeff has. There is a motion that and second on the floor already prior to this that needs to be rescinded. I will however, Dr. Langsam thinks we need to remove it if we're going to move on to this one.

MR. KROLL: All right. This one, I would offer as a substitute motion but I don't know how we do that.

THE CHAIR: Dr. Langsam, can you assist us with this?

MR. LANGSAM: Okay. Substitute motion you just vote this as a substitute motion, if it's approved, it's done.

THE CHAIR: Do we have a second ...

MR. DAILEY: So I'm going to make the motion that, firstly, the motion on the floor I believe was mine. I'm going to remove it. The motion I'm going to make is that the SEMAC endorse three thousand and four A and that these advisories issued by the MILREMS qualify as such.

MR. BART: That's essentially what it says in Article 30.

MS. OZGA: So am I removing what Dr. Rabrich said and put them down with Dr. Dailey said?

THE CHAIR: Dr. Dailey, are you are changing that -- you're actually making a motion. So how do you ...

MR. DAILEY: I saw Dr. Langsam getting upset with me but I will leave the motion as the SEMAC endorses Article 30, 3004-A and says that the MILREMS advisories qualify as such.

MR. LANGSAM: And I'm not going to get upset with you because that's a perfectly good motion. And you just need a second that says the same thing, Dr. Rabrich says but that's fine.

MR. DAILEY: Yeah, you were more eloquent.

MR. LANGSAM: And that's fine.

MR. DAILEY: Like always.

MR. KUGLER: This is Dr. Kugler. I would like to second that motion.

THE CHAIR: Okay.

MS. OZGA: Can I have Dr. Dailey -- can I have Dr. Dailey repeat that one more time so I

can pin all the verbiage correct?

MR. DAILEY: SEMAC endorses Article 30, Section 3004-A and states that the MILREMS advisories qualify as such.

MS. OZGA: I get it.

MR. DAILEY: Yes, ma'am.

MR. LANGSAM: You need a second --

MS. OZGA: Okay.

MR. LANGSAM: -- you need a second and this has been offered as a sec -- as a substitute motion. So when this passes, which I hope it will, we're done.

MR. KUGLER: This is Dr. Kugler. I'd have to reaffirm my second ...

THE CHAIR: Excellent. Valerie, can we have a vote, please?

MS. OZGA: Yes, it will be my honor to do a roll call. Okay. Dr. Alexandrou?

MR. ALEXANDROU: Yes.

MR. COOPER: Wait, wait, are we allowing Ms. ...

UNIDENTIFIED SPEAKER: Once we start a roll call ...

MR. COOPER: I think we are beyond

that. Dr. Doynow, are we allowing ... of the motion?

THE CHAIR: Dr. Langsam, I think we started the roll call, again, we stop for discussion.

MR. LANGSAM: You actually should have asked for discussion before we started the vote. I was afraid I would be lynched if I interrupted you. So yeah, Dr. Cooper is correct, you can have a discussion and let's start the vote again.

THE CHAIR: All right. Dr. Cooper ...

MR. COOPER: With all due respect, I think it is presumptuous about the SEMAC to say that we endorse what the people of the State of New York have put in the law as our -- as our specific authority.

Dr. Dailey is on the right track in -- in suggesting that because we have the authority to develop policies and procedures consistent with those of the SEMAC and address specific local condition, you know, that that these policies that MILREMS would develop probably need that that test.

So I personally do not believe that these motion are statutory and, furthermore, I believe it's out of order. Thank you.

THE CHAIR: Any other discussion before

we vote? Okay. Well, then, I will call a roll call vote, please.

MS. OZGA: Okay. I will start over. Dr. Alexandrou?

MR. ALEXANDROU: Yes.

MS. OZGA: Dr. Bart?

MR. BART: Yes.

MS. OZGA: Dr. Berkowitz?

MR. BERKOWITZ: Yes.

MS. OZGA: Dr. Bombard?

MS. TIFFANY: Yes.

MS. OZGA: Dr. Cooper?

MR. COOPER: No, for the reasons I stated.

MS. OZGA: Dr. Cushman?

MR. CUSHMAN: Cushman, yes, and thank you.

MS. OZGA: Dr. Dailey?

MR. DAILEY: Yes.

MS. OZGA: Dr. Detraglia?

MR. DETRAGLIA: Detraglia, yes.

MS. OZGA: Dr. Doynow?

THE CHAIR: Yes.

MS. OZGA: Dr. Kugler?

MR. KUGLER: Dr. Kugler, yes.
MS. OZGA: Dr. Lynch?
MR. LYNCH: Lynch, yes.
MS. OZGA: Dr. Markowitz?
MR. MARKOWITZ: Markowitz, yes.
MS. OZGA: Dr. Marshall?
MR. MARSHALL: Marshall, yes.
MS. OZGA: Dr. Murphy?
MS. MURPHY: Murphy, yes.
MS. OZGA: Dr. Olsson?
MR. OLSSON: Olsson, yes.
MS. OZGA: Dr. Talbott?
MR. TALBOTT: Yes.
MS. OZGA: Dr. Walters?
MR. WALTERS: Walters, yes.
MS. OZGA: And Dr. Wicelinski?
MR. WICELINSKI: Wicelinski, yes.
MS. OZGA: Motion passes.
THE CHAIR: Thank you, Val. Dr. Marshall, what else do you have?
MR. MARSHALL: I got plenty more.
THE CHAIR: Okay.
MR. MARSHALL: Not to worry, I haven't run out of motions yet. But the next one is also

from MILREMS and this is care guidelines for a persistent ... and a hospital algorithm for ...

Evidence is showing that patients who are in persistent -- persistent ... may benefit from ECMO and by taking them to a facility that has that capability.

There has been some increased functional in tax survival, one reported up to forty-eight percent. The reason this is coming to SEMAC is because in the protocol that they develop two things have happened, one is, they stop epinephrine and after the third dose, then, the second is the limit amiodarone to three hundred milligrams.

Other than that, there was no change in the ... protocol. And this is being brought forward as a second motion.

THE CHAIR: Okay. Do we have any -- any discussion? Lewis, do you want to bring it up for a vote?

MR. MARSHALL: Yes, it was seconded, so we just need a roll call though.

THE CHAIR: Val, please.

MS. OZGA: All right. Dr. Alexandrou?

MR. ALEXANDROU: Yes.

MS. OZGA: Dr. Bart?
MR. BART: Yes.
MS. OZGA: Dr. Berkowitz?
MR. BERKOWITZ: Yes.
MS. OZGA: Dr. Bombard?
MS. TIFFANY: Yes.
MS. OZGA: Dr. Cooper?
MR. COOPER: Yes.
MS. OZGA: Dr. Cushman?
MR. CUSHMAN: Cushman, yes.
MS. OZGA: Dr. Dailey?
MR. DAILEY: Dailey, yes.
MS. OZGA: Dr. Detraglia?
MR. DETRAGLIA: Detraglia, yes.
MS. OZGA: Dr. Doynow?
THE CHAIR: Yes.
MS. OZGA: Dr. Kugler?
MR. KUGLER: Dr. Kugler, yes.
MS. OZGA: Dr. Lynch?
MR. LYNCH: Lynch, yes.
MS. OZGA: Dr. Markowitz?
MR. MARKOWITZ: Markowitz, yes.
MS. OZGA: Dr. Marshall?
MR. MARSHALL: Marshall, yes.

MS. OZGA: Dr. Murphy?
MS. MURPHY: Murphy, yes.
MS. OZGA: Dr. Olsson?
MR. OLSSON: Olsson, yes.
MS. OZGA: Dr. Talbott?
MR. TALBOTT: Talbott, yes.
MS. OZGA: Dr. Walters?
MR. WALTERS: Walters, yes.
MS. OZGA: Dr. Wicelinski?
MR. WICELINSKI: Wicelinski, yes.
MS. OZGA: Motion passes.
THE CHAIR: Thank you. Dr. Marshall.
MR. DAILEY: Can you bring it on -- I think it's actually important for us to follow-up on that one with -- with a reminder that if any other REMAC were to have resources similar to these and want to implement this policy, that is the same as the policy and MILREMS, that they'd be allowed to do so.
THE CHAIR: So Mike, I'm not sure are you -- are you trying to make a motion that we adopt that or do you --
MR. DAILEY: No, that's -- that's not a motion on -- that's just a reminder to the group.

THE CHAIR: Okay.

MR. DAILEY: We've passed that as policy, therefore, if this were to be adopted by policy in Erie County, for example, they would be able to implement the same thing.

THE CHAIR: It sounds quite reasonable. Dr. Marshall, back to you.

MR. MARSHALL: Yeah, can you bring up motion eight, which I hope is the last one. The next one has to do with the automated compression devices. So MILREMS is implementing protocol in their region which will allow for the use compressive devices in a pre-hospital setting for those patients who would benefit and this goes along with the previous one that we just approved for persistent ... protocol.

There are multiple devices that that exists in the marketplace. Their protocol specifically mentions LUCAS device and that's because all the agencies that are participating in this use the same device in the region. And we did have some discussion about endorsing specific products, but this motion comes forward as an approved secondary second -- secondary motion.

MR. CUSHMAN: Dr. Marshall, Dr.

Cushman, if I may.

MR. MARSHALL: Yes.

MR. CUSHMAN: Given the action of the SEMAC related to my -- my other advisories earlier, it would seem to me that approval of -- of this guidance is superfluous by the -- by the SEMAC, again, anything, -- anything we create is -- is more than welcome to be plagiarized excessively.

But it's really a training and use guidance, which would be reinforced by the earlier motion by the SEMAC, I welcome alternative interpretations of that but.

MR. MARSHALL: I don't think that's an unreasonable interpretation. But as a seconded motion, Dr. Langsam, would be our --

MR. LANGSAM: Once again -- once again, if someone wants to, they can make the identical motion you made before and vote on that one to substitute for this motion. No one wants to do that, then you're stuck with this, because this is a motion on the floor.

So if you want to do exactly the same thing you did before, that would be fine. I would certainly be in the spirit of what you approved a

moment ago. I would agree that that is probably the reasonable thing to do but someone has to do it. Otherwise, you're forced to vote on this.

MR. KUGLER: I would make that motion, Dr. Kugler.

THE CHAIR: All right. Dr. Kugler made a motion and Dr. Murphy seconded. Is that correct?

MR. KUGLER: Yes.

THE CHAIR: All right. So we'll need that motion typed up ... if we can and we'll --

MR. DAILEY: Pull up the other one.

THE CHAIR: Yeah, pulled the other one.

MS. OZGA: Okay. So is the -- the same verbiage as the last one, correct?

THE CHAIR: Correct.

MR. KUGLER: That's the advisory motion.

MS. OZGA: Okay. All right. Hold on one moment and I will get it up there.

THE CHAIR: Okay.

MR. KUGLER: It said the SEMAC endorses section Article 30, 3004-A, adopt the

MILREMS advisories qualify as such, as a substitute in motion.

MS. OZGA: Okay. Can everybody see that?

THE CHAIR: Yes, it looks fine.

MR. KUGLER: Yes.

THE CHAIR: Any discussion before we vote on this? Okay. Val, hopefully one last roll call vote here.

MS. OZGA: For this meeting anyway. We still have one more meeting to go. Okay. Dr. Alexandrou?

MR. ALEXANDROU: Yes.

MS. OZGA: Dr. Bart?

MR. BART: Yes.

MS. OZGA: Dr. Berkowitz?

MR. BERKOWITZ: Yes.

MS. OZGA: Dr. Bombard?

MS. TIFFANY: Bombard, yes.

MS. OZGA: Dr. Cooper?

MR. COOPER: No, for the reasons I stated previously, thank you.

MS. OZGA: Dr. Cushman?

MR. CUSHMAN: Cushman, yes.

MS. OZGA: Dr. Dailey?
MR. DAILEY: Dailey, yes.
MS. OZGA: Dr. Detraglia?
MR. DETRAGLIA: Detraglia, yes.
MS. OZGA: Dr. Doynow?
THE CHAIR: Yes.
MS. OZGA: Dr. Kugler?
MR. KUGLER: Dr. Kugler, yes.
MS. OZGA: Dr. Lynch?
MR. LYNCH: Lynch, yes.
MS. OZGA: Dr. Markowitz?
MR. MARKOWITZ: Markowitz, yes.
MS. OZGA: Dr. Marshall?
MR. MARSHALL: Marshall, yes.
MS. OZGA: Dr. Murphy?
MS. MURPHY: Murphy, yes.
MS. OZGA: Dr. Olsson?
MR. OLSSON: Olsson, yes.
MS. OZGA: Dr. Talbott?
MR. TALBOTT: Talbott, yes.
MS. OZGA: Yes.
MS. OZGA: Dr. Walters?
MR. WALTERS: Walters, yes.
MS. OZGA: And Dr. Wicelinski?

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

MR. MARSHALL: That's the updated one.
MS. EISENHAUER: Yes.
MS. OZGA: Shall we give the members a few minutes to look at that or bring it up on the screen?
MR. MARSHALL: If you can bring it up quick, that would be fine.
MS. OZGA: Okay.
MR. MARSHALL: And we could --
MS. OZGA: Give me one moment.
MR. MARSHALL: Since we already had some discussion on it, I think we can move pretty quickly to a vote.
MS. OZGA: Amy, did you say it was in SEMAC?
MS. EISENHAUER: It's at the bottom, it's E.M.S. treatment of acute opioid withdrawal amendment doc. It's the last one.
THE CHAIR: It is there.
MS. OZGA: Okay. I have to refresh my page. There we go, okay. Okay. Can everybody see that?
MR. MARSHALL: Yes. Can you enlarge a little bit, but yeah, we can see it. And then the

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

MR. ALEXANDROU: Yes.
MS. OZGA: Dr. Bart?
MR. BART: Yes.
MS. OZGA: Dr. Berkowitz?
MR. BERKOWITZ: Yes.
MS. OZGA: Dr. Bombard? Is Dr. Bombard still off?
MS. TIFFANY: Bombard, yes.
MS. OZGA: Dr. Cooper?
MR. COOPER: Cooper, yes.
MS. OZGA: Dr. Cushman?
MR. CUSHMAN: Cushman, yes.
MS. TIFFANY: Bombard, yes.
MS. OZGA: Dr. Dailey?
MR. DAILEY: Dailey, yes.
MS. OZGA: Yes, Dr. Bombard, I got your vote.
MS. TIFFANY: Thank you.
MS. OZGA: Dr. Detraglia?
MR. DETRAGLIA: Detraglia, yes.
MS. OZGA: Dr. Doynow?
THE CHAIR: Yes.
MS. OZGA: Dr. Kugler?
MR. KUGLER: Dr. Kugler, yes.

MS. OZGA: Dr. Lynch?
MR. LYNCH: Sorry, Lynch, yes, I was too excited emailing Dr. Wicelinski.
MS. OZGA: Dr. Markowitz?
MR. MARKOWITZ: Markowitz, yes.
MS. OZGA: Dr. Marshall?
MR. MARSHALL: Marshall, yes.
MS. OZGA: Dr. Murphy?
MS. MURPHY: Murphy, yes.
MS. OZGA: Dr. Olsson?
MR. OLSSON: Olsson, yes.
MS. OZGA: Dr. Talbott? Dr. Talbott? Dr. Walters?
MR. WALTERS: Walters, yes.
MS. OZGA: And Dr. Wicelinski?
MR. WICELINSKI: Wicelinski, yes.
MS. OZGA: All right. Going back. Dr. Talbott, are you still on? Okay. Motion still passes.
MR. MARSHALL: Thank you. And thank you for all your participation then. I need to inform you, but I have no further motions for this meeting. But I will bring some to the next one.
THE CHAIR: Thank you, Dr. Marshall,

we appreciate everything. We're running a little over here. Let's try and move it along quickly here if we can. E.M.S.C., Dr. Cooper, do you have anything to mention? I know you have your meeting coming up next week.

MR. COOPER: I'll comment briefly on two things, Dr. Doynow. And thank you for the opportunity to advise our SEMAC colleagues. First, as we continue to work on a pediatric agitation protocol update, I expect that we're going to have something that's close to final and our upcoming meeting.

We also continue to work on the issue of early identification of success in the field and, of course, so that ties in some level to our new assignment I got today to work on the pandemic triage protocol.

In the interest of time, I'll stop there. I think those are the major issues that are before, any ... she feel is important enough to comment on ... Thank you.

THE CHAIR: Thank you, Dr. Cooper. Amy, do you have any comments?

MS. EISENHAUER: Thank you, Dr.

Cooper. I do have a presentation but I can pretty much sum up everything. Like Ryan had said in the beginning, in the bureau report, every year there's an E.M.S. for children, E.M.S. agency survey and it starts tomorrow. I email every agency in the State.

And I believe all of you and the E.M.S. coordinators and the program agencies will also get an email just for situational awareness for agencies to complete the survey, last year, we had a twenty-five percent response rate, which was expected to some extent just due to the pandemic and everything that was going on.

And so this survey covers performance measure number two and performance measure number three. And so number two is the Pediatric Emergency Care Coordinator program. And then, number three is using skills scenarios during training for all agencies.

So that survey assesses those things, ask general questions and it helps me and also the federal E.M.S.C. program, kind of gauge what kind of tools and education E.M.S. providers need to best treat pediatric patients.

So if you have agencies, if you can

follow-up with them and let them know that the survey will be coming their way and if they don't get it, please email me and I'll be happy to resend it and that's everything.

THE CHAIR: Thank you, Amy, I appreciate that. All right. Moving onto some old business. Good news, just to mention to every members of the SEMAC to recall, we were tasked with sending a letter to the commissioner to meet with her and our Philippy and I will be meeting with her in January.

We're trying to set up a date. She was very receptive. I think that's great that we ended up, having such a quick response. If anyone has any specific issues they would like to bring up, please email me and I'll be more than happy to bring those to the meeting.

Moving to new business, there's a few issues here. I don't know if we have too many comments. First responder PCR/documentation is on the list.

MS. OZGA: We can do it, right?

THE CHAIR: Any comments on that?

MR. GREENBERG: Valerie, I don't think

you're on mute. I think that was ...

THE CHAIR: All right. If there's no comments on that, hospital overcrowding and the E.M.S. wait times. I know for my hospitals, it has been very difficult but we've been managing to work with E.M.S. to get them in as quickly as possible.

Does anybody have any comments or any suggestions as how it's working at their particular shops in -- in getting folks in? Okay. I can see everybody wants to get through this meeting.

Suffolk County, R.S.I. data, Dr. Winslow. Are you here to give us some information? I know it was sort of rushed through at the last meeting. Okay. Nothing heard there.

The only last thing I'd like to bring up is I really appreciate Dr. Langsam help on every one of our meetings and I know sec -- part eight hundred doesn't have a specific place for a parliamentarian.

However, as best as I read the regulations, I don't see anywhere where I can't share appointing a parliamentary advisor to the committee unless Dr. Langsam thinks I cannot do that, in which case I would like to officially do so, if you're

willing to accept that.

MR. LANGSAM: You -- you can do that, okay, because a parliamentarian simply provides advice to the Chair. And I appreciate the thanks, I really do.

But also when the bylaws eventually get done, remember this from the last meeting, it should go into the bylaws as well. But yes, you can do that.

THE CHAIR: Well, thank you for accepting that position. Thank you for all your help.

MR. LANGSAM: You're welcome.

MR. WINSLOW: Hey, Dr. Doynow, it's Dr. Winslow from Suffolk County.

THE CHAIR: Hello, Dr. Winslow, how are you?

MR. WINSLOW: I was in the ... so they moved me into the meeting. Hello.

THE CHAIR: Hello. Would you like to give your information to us?

MR. WINSLOW: I had sent my slide presentation to Val. I wasn't sure if I was able to share that.

MS. OZGA: Yes, it did go through the A.D.C.C. process so you -- you can share it. Do you want me to share it or, Jacob, if you could give Dr. Winslow ... with the patient?

MR. WINSLOW: I just shared my screen. Can people see that?

THE CHAIR: Yes, it's there.

MR. WINSLOW: Okay.

MS. OZGA: Yes.

MR. WINSLOW: Okay. I'll go very quickly. I did want to review our data, it was a ten year anniversary of us having a rapid sequence intubation in Suffolk County.

We represent a large system ... we have a hundred and eight different E.M.S. agencies and represent a population of over five thousand E.M.S. providers of which about a hundred and fifty ... are R.S.I. medics.

This is a copy of the protocol. It's slightly different from the collaborative but that will be my last slide. So instead of wasting everyone's time reading through the protocol, I'll just go with the data that I was asked to present.

This began as a ... in 2011 for three

agencies. It involved three agency medical directors and fire paramedics. We went through the initial credentialing ... as certain medications and equipment. We undergo further education and training on the procedure.

It began as a two A.L.S. provider skill with one hour psych medic ... and then one ... A.L.S. provider for assistance. Now, it is standing orders for a solitary R.S.I. paramedic as the sole provider.

What began as just ... and succinylcholine as the only medications, now we have added ketamine and ... as alternate medication choices and we've added fentanyl as pretreatment consideration in selected patients such as head injury and stroke.

We also added -- I'm sorry ... fifteen liter per minute ... We also have added over the years the use of an automated transport ventilator if the agency so chooses to purchase trained and equipped and authorized its use.

Currently, the number of providers and agencies participating in R.S.I. in Suffolk has grown. We have twenty-six E.M.S. agencies, one

hundred and fifty ... R.S.I. paramedics.

So the R.S.I. agencies are approved by the Suffolk County REMAC. The application is brought before the R.S.I. subcommittee which is made up of members of the REMAC and some are agency medical directors of R.S.I. agencies, some are R.S.I. credential paramedics with experience, some are R.S.I. educators.

E.M.S. agencies are required to have proper training education for its providers and to have the proper equipment, including video laryngoscope and Supraglottic airways. Over the years we found that adding video laryngoscope became -- increase in the success rate of endotracheal passage, and now, it is required by several agencies at the agency level as a first pass.

Many agencies also require the use of ... so the E.M.S. -- sorry, the E.M.T. paramedics can then apply after having a minimum of three years of quality field medical care in the 911 system as a medic and having ten successful documented field endotracheal tubes to become an R.S.I. trained paramedic.

R.S.I. paramedic credentialing

requires annual skills verification with a high fidelity management and successful performance of the R.S.I. procedure in person with standardized patient scenarios. Notes of a written exam that is periodically reviewed and updated, it does have an online version that was added during COVID.

What we like is it involves the agency medical director, the agency medical director can perform the skills pre-credentialing and -- and provide the skilled credentialing for their paramedics at the agency level.

Also as a secondary level of oversight and the regional E.M.S. system medical director in the Suffolk County chief of E.M.S. education and training, that's Mike Matheson and I serve as the medical director. We're also involved heavily in the training and credentialing, but then ... the process.

The R.S.I. subcommittee currently serves as an ad hoc committee of our REMAC and has both position in paramedic members. It involves also Stony Brook University Hospital E.M.S. Medical Director, Dr. Marshall, Trevor Marshall, and the paramedic supervisor, John Edward, for Stony Brook E.M.S.

We kind of think it's a best practice and then we've linked ground and aviation under the same umbrella, use the same protocol, have the same -- same credentialing, the same equipment. It also makes it great for a handoff in the field if a patient has to be transferred from a field agent -- a field provider to an aviation provider.

So we've done more than five hundred total performances of R.S.I. over the ten years, averaging eighty to ninety cases per year on average. This was actually written for the November meeting and so we had fifty-five already up until November of 2021.

And we closed out the year with a total of seventy-eight, even during COVID. In 2021, there were ninety cases, sixty-eight by ground and twenty-two by aviation. There are eighty-two successful endotracheal placements, seven supraglottic airway placements, and one patient was an unsuccessful procedure out of the total number.

This actually happened to be a patient that had a complete airway obstruction by impacted turkey over the Thanksgiving holiday. The patient wasn't able to be intubated in the E.R. by multiple

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physician attempts as well.

Overall success rate of the advanced care and placement in 2020 therefore is ninety-nine percent, eighty-nine out of ninety procedures with one failure. The overall success rate of endotracheal tube placement was ninety-one percent, that is eighty-two out of ninety total procedures.

For more data metrics, sixty percent of the time the sedation choice agent was accommodate to forty percent of the time it was ketamine. Ninety percent of the time the paralytic choice agent was succinylcholine and ten percent was ...

The quality improvement process is a five step process. It's evolved over many generations -- many different ... generations that we've had over the years. What we like is that it involves the agency level first.

The first is, of course ... notification in Suffolk County Medical controls so that the call can be flagged in the system. Step two, an audit form is signed by the physician at the receiving hospital to verify the only placement.

This R.S.I. audit form -- formally documents the advanced airway placement confirmation

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as well as offers the ability for the physician in the E.R. to do real in time any re-education, comments on the care of the patient and to be able to allow for that teachable moment at the bedside.

This a copy of the audit form documenting pre and post end-tidal CO2 and end-tidal CO2 documenting the indication for the procedure mounds and lemons ... the medications given and some patient characteristics, age, weight, etcetera.

Step three, the R.S.I. medic then calls our agency medical director within twenty-four to forty-eight hours, this is another key component to the success of the program.

If that case was a success, this is a great moment to not only applaud the medic for the good job well done, but it's also a great case to discuss what was the medication he chose, how did your patient fare, is there anything that I can do as the agency medical director to follow up on the patient care.

And if there was a problem, it's something that involves the agency medical director right off the bat so they can be involved in any kind of review of the case.

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Steps four and five are more formal peer review. Step four is done at the agency level and step five is done by the R.S.I. subcommittee where every single P.C.R. is reviewed.

We have noticed that ninety percent of the time there are three clinical scenarios for six -- for the use of R.S.I. One is for the head injury or multi system injury trauma patient with a decrease in mental status and clench job.

Two is the impending respiratory failure patient, many are elderly with either C.H.F. or C.O.P.D. and the third is the altered mental status with ... from either stroke, overdose or sepsis.

Pediatric R.S.I. is exceptionally rare. In our ten years, we've only had two incidents of use of pediatric R.S.I. We defined pediatrics in our county as less than fifteen years of age or thirty-six-kilogram weight of the patient.

Currently Suffolk County REMAC has approved pediatric R.S.I. only as a medical control option. The medics in the field feel that having online medical control physician presence to assist with medication choices, dosage and to be there

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online in case there was an issue is a bit of a safety net that the medics enjoy.

The agencies also, therefore, are not required to supply every agency ambulance with pediatric sized equipment must they wish to do so. R.S.I. paramedics are not obliged to try to perform a pediatric R.S.I. on a pediatric patient unless the R.S.I. medic feels comfortable with the situation.

As compared to the New York State Collaborative Protocol, this is kind of a slide that I think I will leave on the screen for a few moments because I think it's pertinent to the SEMAC.

We currently do not require a G.C.S. less than eight to perform the R.S.I. I did an audit of the last twenty-five successful R.S.I. performances in Suffolk County and noted that eleven out of twenty-five at a G.C.S. greater than eighty, which is forty-four percent.

Suffolk County allows for two attempts of endotracheal placement by the R.S.I. paramedic before clearly stating that the medic must place a supraglottic airway.

The collaborative language is a little different here. They allow for three attempts and

they say consider insertion of an alternate airway device. They are different, Suffolk County does not have a second rescue assist with laryngeal manipulation.

The R.S.I. medics in our area have ... not helpful, and many of our E.M.S. agencies use video laryngoscopy, practically eighty percent of the time and, therefore, it would not actually be helpful.

We also have the fourth differences, we supply fentanyl, two micrograms per kilogram as a priests -- as a pretreatment sedation dose, especially in cases of increased intracranial pressure or stroke, this was brought forth by a neurologist.

That's all I have. That is our experience in Suffolk County R.S.I. program. It's been in place for ten years. It represents the ability for ground and aviation E.M.S. units alike to work together and also represents a very robust quality of ... peer review process that I think represents the best practice in medicine. That's all I have, thank you.

THE CHAIR: Thank you, Dr. Winslow,

for the very nice presentation. Does anybody have any comments or questions for Dr. Winslow?

MR. WINSLOW: If any would like it emailed to them directly, please send me an email. I had sent it to the majority of the November SEMAC attendance, but if anyone is missing out, please send me an email, I'll put my email up in chat.

THE CHAIR: Thank you.

MR. MARSHALL: Thank you. It's great study.

MR. GREENBERG: And Dr. Winslow, it should be obviously on Boardable but ... be up on our website under the documents for this meeting as well.

THE CHAIR: Thank you.

MR. WINSLOW: I'm trying to un-share my screen, one moment.

MR. MCEVOY: Dr. Chairman, Mike McEvoy, I have one more item.

THE CHAIR: Go ahead, Dr. McEvoy.

MR. MCEVOY: I know that we killed a lot of met standards and wasted about an hour of time here as well with the viral pandemic protocol but we're now left with one that I think this body considers ineffective.

Is there any -- does anyone have any idea as to what we should do with the one that's left remaining, kill pad, leave it.

MR. BART: I was just going to thank you, Mike, for bringing that. I was going to bring up -- that last item was going to be that exact same thing. So thank you, Dr. McEvoy, for bringing that up.

I think we -- we voted down some changes there to improve on a document that is probably not functional right now. So to leave the old documents in place right now, to be the remaining protocol doesn't seem to make a lot of sense. I don't think that was the spirit of that discussion and it was not what I intended as well.

So as far as the intent of what the -- the old protocols at the range, I think a final remaining item there would be to create some, you know, language saying that we want to either permanently suspended or just get rid of it entirely, or leave it up to the regions.

And I'd like some -- maybe some comments or from my colleagues that -- they think there might be still value to it if they feel like

there still is, but it's current census that out there doesn't -- doesn't make sense to us. So we need to do something with it before we let this meeting go.

MR. MARSHALL: Hi, it's Dr. Marshall --

THE CHAIR: ... we have an interesting question. Sorry, go ahead.

MR. DAILEY: Dr. Marshall and then Dr. Dailey.

MR. MARSHALL: Yeah, so thank you for that. I think that with our plan to have a broader disaster protocol, I think leaving this there for regions to use would not be inappropriate, nor would deactivating it at a statewide level.

But -- and my preference would be to just leave it and go with the broader disaster response protocols that we plan on developing, thanks.

THE CHAIR: Dr. Dailey?

MR. DAILEY: I think we have an interesting question before us too. The City of New York as a region has issued their own directive regarding this same situation.

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So I think that leaves us in a position where it either -- well, first, we should probably deactivate this protocol. The second is whether or not that advisory the City issued is appropriate to stand, and if so, whether or not regions are free to issue their own in the model of New York City's.

MR. WASHKO: I'd like to throw out real quick and bring to the group's attention that this does have potentially financial ramifications from an E.M.S. sustainability standpoint, given C.M.S. waivers in which reimbursement is available for treating place or not transport for COVID patients as long as there's a regional protocol in place in -- in, you know, in effect.

So removing this option could have some potential financial implications to the region's just so everyone is aware of that.

THE CHAIR: Thank you. ... on the issue?

MR. MCEVOY: I do think that there -- there should be some, you know, as Dr. Dailey points out, there should be some ability for regions to make their own selection here.

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THE CHAIR: Mark Philippy, you also have a comment?

MR. PHILIPPY: Thank you. Mark Philippy. I -- I struggle with this because I understand where Dr. Bart is coming from but at the same time, we're -- we're at a point of crisis throughout our system and I -- and I keep using that term, but I don't think it's any more applicable ever before then the time right now.

We're -- we're looking at a ten, fifteen, twenty calls waiting for ambulances in a community the size of Rochester, Monroe County, where potentially a protocol like this, and I want to speak for Dr. Cushman, but I'm just using this as a -- as a -- for instance, potentially, some of those patients could be treated in place with a protocol like this.

So, you know, I was very hopeful coming to this meeting today and with met standards earlier this morning that we would come away with some ideas of how we can mitigate the current situation, and how we could deal with both -- with -- with all of the options that are available to us.

Telehealth, treating place, alternative destination and what I -- what I hear is

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that, well, we're going to -- we're going to work on that later, we're going to push that off to another meeting. We're going to work on that some other time.

I'm sorry, doctors, but -- but my people are struggling right now just getting ambulances out the door. We're waiting in hospitals for hours on end, and I -- I'm looking to this body into you folks, as our -- our subject matter experts to help us with solutions. And -- and I'm -- I'm very frustrated, I don't know what else to do right now.

So I'm sorry if there's a little bit of emotion in my voice, but -- but the fact that we keep pushing these -- kicking this can down the road, when -- when our system is -- is about ready to fall apart, and I don't think that's hyperbole, I -- I don't know what else to say.

So I -- I thank you for bringing this up. I -- I hope that we can come to some decision about something that will help keep our system functioning.

MR. BART: It just wasn't that protocol, Mark, and -- and I totally appreciate what

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you're saying there. I'm not saying it has no value. I'm saying that protocol has been changed a bunch of times to where the value of the protocol was.

If you didn't meet the inclusion criteria, E.M.S. didn't have to transport you, which involve our E.M.S. professionals doing an initiated code four refusal from their perspective, not the patient's perspective.

In which we asked for the teeth of that protocol and ultimately we're told no, it was -- it was changed to the bureau and actually the feeling of the states of the Department of Health that we couldn't issue such a protocol that allowed providers to initiate that refusal of care.

So the cross section here where we have something that we -- we can't actually fix is not necessarily medical direction. I think the medical directors all appreciate the idea that we want to empower the system to utilize its -- its own resources, how it ... sees fit, and maybe not the person on the other end that says, I just want an ambulance to be transported.

And these are the situations where we wanted to identify patients that were at lower risk

who were complaining of some viral illnesses that maybe wants to go to the hospital. But we're saying, listen, we're out of resources for you today so we can't do that.

But the protocol that exists right now, doesn't and never have the teeth to say that, or to have something that inclusion criteria, that ultimate, the end says, we'll contact online medical direction, I was at any different than what we do every day.

So if that's all it says right now that I don't think that protocol is useful. So to keep it alive or to make modifications to it is -- is just -- is just painting an old house, it might look fresh and might come with a new date on it but it still doesn't give you any more authority, or give any provider any more authority to do the job we wanted to do in the first place.

So I'm not against the idea, I don't think anybody is, I'm against what that protocol is actually doing. Because I think it's functionless, it's the lame duck protocol here. And if it comes out positive beyond ... like that's what we want to do, I don't think we've made any market improvements

today.

THE CHAIR: Thanks, Joe.

MR. ALEXANDROU: Don, if I -- if I may, it's Nick Alexandrou. I just want to talk along that lines for a second because I think the protocol with the modifications allowed a lot of outs. And it also empowered the -- the providers in a way as well, they were allowed to R.M.A. patients or leave them at home.

If the patient disagreed there was an ability to transport the patient, and calling telemetry did perhaps assist the -- the providers in making that -- making that decision when they're difficult patients or difficult decisions where it can become an argumentative kind of a situation.

So there was the possibility, I mean, there was the option there of empowering the -- the providers and allowing for flexibility or online medical control or a physician on the other line to back up the situation where it might have been a difficult situation where patients may not want to go to the hospital, because -- just because the E.M.T. or paramedic tells them that they can't.

And it also allows for those

ambulances to be freely available afterwards when the call volume is very high and those resources are very needed. So, you know, here in New York, especially, we have forty-six hundred calls a day.

So it really and we have a forty percent call out rate right now, a sick rate. So we're working our numbers with even with, you know, forty percent less of staff, where this protocol does assist us and allows us to make those decisions and doesn't overwhelm our telemetry either, because that's another issue.

With so many calls, you know, we do overwhelm telemetry, perhaps in other regions that's not the case but here in New York, that is a -- that is a major issue, so I wanted to bring those points out because I agree that we should have something out there that helps guide us and allows us to make these decisions. That's my point.

THE CHAIR: Thanks, Nick.

MR. MARSHALL: Dr. Marshall.

THE CHAIR: Dr. Marshall, you're next.

MR. MARSHALL: Yeah, thanks. Yeah, I want to just follow up with what Nick said, I think that the old protocol did have some teeth because at

the end, it says this patient meets criteria for non transport and or treatment in place and that gives you the authority on a reasonable basis to utilize that.

And certainly a region could, you know, require their -- their teams to call medical control for that, but this policy the way it was originally written in March of 2020 allowed units to leave cases at home without calling medical appropriate patients, of course.

They think that what the amendment or the adjustment was at medical standards and the discussion at least around this part was, you know, contact medical control or following regional policy and I think that that's where, you know, New York City comes in, because that's our regional policy in terms of -- of -- have been in place for non transport.

So I -- I think it does have some teeth and may not have as much teeth as we want, but the way it currently exists, it -- it does have some teeth, and it does need to be revised, I -- I agree with that. But I think in place it has some value. Thanks.

MR. GREENBERG: I guess the question would come from the difference of opinions in the region is, you know, if you're leaving the current one in place do you just add the line in at the discretion, you know, make a modification to the current one at the discretion of the region to have in place.

You don't make the other modifications and you only make the modification of whether or not the region chooses to have it on or off.

MR. ALEXANDROU: I'm going to say something here as well, I'm sorry, it's Alexandrou again. But the -- the present protocol and triage -- the present pandemic protocol has the error built into it and you're going to be transporting patients, perhaps with just a fever to the hospital and that's one of the things we try to avoid here.

And the purpose of this triage was to be able to minimize transports to the hospital and overwhelmed both the ambulance services and the hospitals. So if we leave this in place the way it is, it doesn't serve a purpose, we're going to be still transporting those patients to the hospital.

One of the issues, I think that, you

know, helped to vote this down was the change to the adult protocol where we didn't have something for pediatrics and there was a lot of discussion on this. Perhaps in that criteria where we also have an age criteria of greater than sixty-five, we could have put something in there that said, less than -- less than fifteen for pediatrics.

And then if you look at the hour to the right of that box, it does suggest call telemetry, or call medical control which the physician can assist in making that decision. And it would solve probably both of our problems, or address the issues at least to some degree until E.M.S.C. can get together and provide further assistance. That's all I have to say.

THE CHAIR: Well, I'm not sure where to go with this at the moment. We voted down the new protocol, we had that standards discussion on it for quite some time. And somebody wants to bring it up again with some modification, I have no problem doing that.

MR. ALEXANDROU: I think that we don't --

MR. MR. DOYNOW: I think that motion

to bring it back up, yes.

MR. RABRICH: Maybe we should have a motion to ... motion to reconsider. I think we're trying to let perfect be the enemy of good. I think we all acknowledge the problems, but we need something in the short term until we get to where we ultimately want to go.

THE CHAIR: I would agree. I think we can get rid of it. All right. So we have a motion to bring it back up, did we have anybody to second it, Jeff, you can vote but I don't think you can make a motion. Is that correct?

MS. BOMBARD: Bombard, I'll second.

THE CHAIR: Someone else would have to make the motion, which Nick did, I believe.

MR. ALEXANDROU: Yes.

THE CHAIR: I -- I would hate to ... I would hate to make another roll call because that takes forever. So let's try this, does anybody ... from the vote to bring this back up?

Okay. I hear nothing, so it's brought back up. Let's discuss it again. We only have twenty-six minutes to the next meeting.

MR. WALTERS: Dr. Doynow, it's

Walters.

THE CHAIR: Go ahead.

MR. WALTERS: So I -- I think one of the discussions -- we seem to get a little wrapped up around sending this to E.M.S.C. and -- and, I guess, when I look at -- at the, you know, the draft we're looking at or working off of really we weren't asking E.M.S.C. to come up with a -- many changes to the protocol and that really -- I think it was really centered around the -- the differences in pediatric vital signs, right.

I -- I don't think there's anything else in there that really would change, the symptoms of this are the same, essentially, and -- and probably the high risk ... I mean, pregnancy doesn't apply to most of your pediatric patients.

But -- but otherwise, your -- your other comorbidities and things that make them high risk are -- are probably in there. So if that's a sticking point, I guess, the question is, do we make this just adult or if we want to include pediatrics and -- and then have E.M.S.C. review and provide some input for consideration at the next meeting.

Do we just go to saying, here are the

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vital signs or abnormal pediatric vital signs appropriate, you know, based on their age or something, right, because even if E.M.S.C. comes back with vital sign abnormalities, they're going to have to be age specific, it's not going to be a one cut off of a certain number, right?

Your respiratory rate could be very different for, you know, a one-year-old versus an eight-year-old, for example. And with that, I guess, the only other consideration I would say regarding pediatrics is, do you put, you know, a lower age on there is it, you know, less than a year less than six months, whatever we feel is appropriate.

Maybe those things should be considered if the ticking point is adult versus pediatrics.

MR. ALEXANDROU: Well, I'm going to come back and make my suggestion about putting in something for pediatrics. In the meantime, perhaps, when that box where it says greater than sixty-five we could put something that mimics pediatrics age of less than fifteen where that covers it for now and if there's any discrepancy or concerns, the box to the right of that says to reach out to online medic

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control to make a decision.

And the physician can assist with the vital signs and the condition of the patient and make a decision with the -- with the provider. And then that -- that would solve some of the problem right now in the immediate time and -- and then we can let E.M.S.C. reevaluate that or come up with something perhaps different.

THE CHAIR: Val, can you put it back up so we can see those changes and then we can perhaps put that in there and vote?

MS. OZGA: Yes, this was the version --

THE CHAIR: The last version that we had of the pandemic protocol, it got voted down.

MS. OZGA: Okay. Just hold on.

THE CHAIR: Those modifications that Dr. Walters, Dr. Alexandrou suggested.

MR. OLSSON: This is Olsson. While she is doing that, two quick comments. First, right at the top E.M.S. adult viral pandemic triage. Number two, the inbox for refer to the B.L.S. protocols. It's already done, if you've got a kid you go to B.L.S. protocols or consult with medical

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advice. I -- I don't see it needs anymore. Thank you.

THE CHAIR: Thank you, Dr. Olsson.

MR. PHILIPPY: Dr. Doynow, could I ask -- or Dr. Bart to -- if he could, maybe or one of the other physicians who voted against this in the first go around.

What would you want to see added to this? What can we do to -- to make this more palatable for the -- or more effective, I -- guess that's where I'm also a little bit at a loss.

MR. CUSHMAN: Mark, I'll -- I'll -- I'll speak to my no vote. My -- my no vote is that this is just exemplary of a failed process, you know, we -- we -- we get these documents to review with very little time, there's no opportunity for really, I mean, you know, how long our region takes to that public comment, review, modify public comment again, and then, finally, approve a protocol.

And there's a reason for that, it's because there are many -- many unintended consequences of -- of making well intentioned, but reactionary decisions to -- to try to make everybody happy without truly thinking them all through, a

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pilot testing a protocol to make sure that how it is written is a -- is -- is interpreted by both B.L.S. and A.L.S. providers with the intent that it was created.

You know, that -- that to me is -- again, with -- without it saying that you can deny the patient being transported to a hospital, then it's no different than what our providers do every day is they use their clinical judgment based upon the presentation at the time to make a -- to make a clinical decision.

THE CHAIR: It is back up here. So can we have those changes that you folks want to make?

MR. ALEXANDROU: Well, I, you know, it all depends on every -- if everyone wants to add something for pediatrics and get this out sooner and probably, you know, fit a lot of our patients, we would have to take out adult on the top.

THE CHAIR: Right.

MR. ALEXANDROU: And then, down in the one, two, three, fourth box, where it says, age greater than sixty-five, I would just add age less than fifteen is another criteria for -- for

pediatrics, where now would be to the right -- it would go to the right in the -- in the box on the right where you would either follow your protocols or call online medical control and make that decision.

Leave it to the region and it leaves it to the physician in difficult circumstances.

THE CHAIR: Okay. That was --

MS. BOMBARD: Bombard here. I would like to make a motion.

THE CHAIR: Yes, who -- who is this? Tiff?

MS. BOMBARD: It's Tiff.

THE CHAIR: Okay.

MS. BOMBARD: All right. I'd like to propose a motion making three changes to this protocol. One, we get rid of adult at the top. So delete adults -- adult for the viral pandemic protocol.

Two, in box four the one that says patient assessment reveals any of the following after the asterisk, add for patients under fifteen years old.

And the third change would be get rid of the last box, the one in red that says contact

medical control. The whole intent of this protocol was that we were giving our E.M.S. providers an avenue to not contact medical control.

So when we're invoking this protocol that shouldn't be there, when we're not invoking this protocol that's implied. So let's get rid of that box. So that is my proposal.

MR. MARSHALL: Marshall. I -- I agree with everything you said, except removing the last box, because I think the wording there allows a region to do that but it also allows a region who prefers to have them contact medical control to do that as well.

THE CHAIR: I would -- I would agree with Dr. Marshall on that.

MR. MARSHALL: I know it says it on the right and the boxes on the right, but I think that you still need that final -- you need something there to end the flow.

MR. BART: Which is then be permitted to use language that says, if there's no indication to transport the above sections, the patient is not required medical condition and transport by ambulance because we tried to have that once before, and as a

statewide protocol that was vetoed, that to me has some teeth to it that a region can say out of that fits with by metric or not.

Would that be part of the region non transport because if that's the case then it's a yes from me.

MR. MARSHALL: That would be my interpretation and that wording that's there now, with following regional policy would give a region the capability of putting that in place, non transport or treat in place.

THE CHAIR: Yeah. Or how about contact --

MR. DAILEY: I think there's one more thing that we have not covered here, which is the fact that we asked for whether or not there was any data over this protocol that is currently been accessible to our E.M.S. providers for the last eighteen months.

We need to make sure that before we approve this that there is a pathway that Deputy Chief Brody can put in place in order to assure that every utilization of this protocol can be reviewed to make sure that there are no misinterpretations and to

see what the consequences ultimately are so we can follow and see whether or not any of these patients are being touched twice in twenty-four hours and if so, what's happening?

MR. ALEXANDROU: I'm going to suggest that that is a regional QA issue that needs to take -- take place and not at the state level, although that information can be shared but I think that's, you know, I don't want to prevent this protocol from going out because we can ensure that the data gets up to the state. It should at least be at the regional level.

MR. GREENBERG: And -- and I can go one step further there and just say to -- to both Dr. Dailey, to ... that we're happy to work with, you know, how that can happen, you know, within E.P.C.R. platforms or not to document when this protocol is being used, or things like that, to the best of our abilities.

So happy to -- I think it's a, you know, a good suggestion, it helps with, you know, and then the regions can do the -- the quality on it, but at least it would help to flag the charts for it.

MR. DAILEY: If I may? So we did, and

we -- we followed ours. But we would like to make sure that indeed if we're going to promulgate a statewide protocol that there'd be a statewide quality initiative to make sure that this drastic change and additional emphasis doesn't incur additional harm to our patients.

MR. WINSLOW: Dr. Doynow?

THE CHAIR: Yes?

MR. WINSLOW: Yeah, it's -- it's Winslow from Suffolk. One thing that we found in our region was that many a time they weren't filing a P.C.R. without disposition code of no transport by protocol. And they were just R.M.A.ing everybody and that required in our region, the R.M.A. to go through medical control.

So it kind of screwed up the whole process of allowing them to, you know, transport. We kind of like there being a medical control option for the provider to be able to then double check with the medical control, either consultant paramedic or physician, whether the protocol will be in use.

And also to assist with the fact that now the paramedic isn't start telling a patient who may be argumentative on the scene of why they're not

going to the -- to the hospital.

So -- so in our region, particularly, we found it to be a quality improvement issue that we feel in our region if we were going to bring this back our medical control would be a big piece of it.

MS. BOMBARD: I don't think we took medical control out of this though, that's the box to the right, right? Consult with medical control for any difficult or unclear situations.

MR. WINSLOW: That's true.

MS. BOMBARD: Again, if we're revoking this protocol, the whole idea is to empower people to leave patients in place. If we don't need to do that because our volumes are down or because we need to have better oversight of our providers or for whatever reason, then we don't need the protocol at all at that time, right?

You know, the whole reason for this protocol is to get rid of to -- to be able to take the medical control part away, if needed.

THE CHAIR: Well, it says you don't have to contact medial local control. It just says or follow regional policy. So it leaves it open. I mean I hate to stop the discussion but we're really

running out of time. So --

MR. WALLERS: I -- I think the issue, Dr. Doynow, though, is -- is that, you know, most regional policies for non transport are -- are some type of refusal of transport, they're not an E.M.S. driven.

No, this patient does not meet transport criteria because of the healthcare crisis that we're in. I -- I -- I honestly, I -- I agree with what Dr. Bart is saying and I think what -- what Dr. Bombard is saying also, this bottom box needs to be changed. It needs to say, you don't meet criteria, you don't go to the hospital.

And -- and -- and we can even put in language like New York City did in theirs, something that says that there's a discrepancy, you know, contact med control or something like that. I mean, we can put in some wording like that, but -- but essentially this -- I don't think our regional policies for non transport are the same as what we're trying to do here, I think they're different.

Dr. Bart, as you're shaking your head, are you agreeing?

MR. BART: Yeah, I do agree that

that's the reason why this got procedurally voted down, I think, in the first place. It wasn't about the edits of this document. It's about the action items that this document would say.

And this is not a refusal of medical assessments, this is not an R.M.A. typically, in which you involve medical direction to say, listen, this guy doesn't want to go to the hospital, you know, what -- what can we do about it?

Oh, yeah, that's A.M.A., or that seems appropriate. This is us saying, you can go to the hospital if you want to, we're just not taking you in an ambulance and that's going to be possibly against what the patient is already requesting us to do.

And as an exceptional protocol during a pandemic or something that needs an exceptional pathway. That's what this protocol needs to say, and if it doesn't say that, that's kind of why I said I didn't need it, or don't want it.

So if -- if it's going to remain same like this, it's still getting a no vote in my opinion.

MR. MARSHALL: One -- one more comment -- one more comment, please. So in the March 2020

version, that last box says this patient meets criteria for non transport and -- or treatment in place, and then it tells you to leave the patient there and provide them with information from follow up.

That's what we had originally, but people didn't like that, I guess, because they didn't want to leave people at home.

MR. BART: We -- we liked it, Mark asked me a few minutes ago, like what -- what would make you say that you like this protocol, and that for me moves the needle --

MR. MARSHALL: It was changed. So that's what we had originally, but it was changed.

MR. BART: Changed by us.

MR. MARSHALL: So we can put that back in the way it is and then move on from there.

MR. ALEXANDROU: New York City protocol actually has that last bullet and it also that says, in difficult situations, if the patient can't be persuaded, transport them anyway.

So you could put that in as some kind of another option if these things are very difficult, instead of wasting time on scene or arguing with the

patient or calling telemetry that may waste more time.

You could just have that as in there that it's an option to transport the patient if they can't be persuaded.

MR. BART: It seems like a reasonable compromise, Nick.

MS. BOMBARD: And God, I would hope that's what we're doing anyway, but if we need to write that down for people, I guess, we need to write that down for people.

THE CHAIR: So how do you guys want to put that --

MR. COOPER: Yeah, I think it's --

THE CHAIR: -- somebody would have make --

MR. COOPER: Dr. Doynow, may I?

THE CHAIR: Yeah, Dr. Cooper.

MR. COOPER: Thank you. You -- you know, we are -- it appears to me that we're doing exactly what Jeremy Cushman was warning us about a few minutes ago or trying to develop this protocol in the last ten, fifteen minutes of our meeting with multiple different points of view being expressed.

So C.M.S.C. is meeting next week. Is there any reason med standards itself could be next week, and then we held an emergency SEMAC meeting, say in two weeks to -- to look at it's final versions of an adult and P.D.F. version of the protocol.

That would be my suggestion. I'll leave it to you to decide if that's a good idea, Dr. Doynow. So that would be my suggestion, thank you.

THE CHAIR: The problem, Mark, is then we have to get an quorum together, which may not occur and now, we need to get a SEMSCO quorum together to approve what we have. So there's a -- there's a -- probably a problem and may not occur at all --

MR. COOPER: Then, that will appear to preclude doing anything on the pediatric side, which I don't think it's a good idea.

THE CHAIR: Well, again, unless we modify this, we -- we're stuck with the old protocol or we deactivate the old protocol. My suggestion is we modify this one to the point that it's reasonable, that includes the age that we talked about, and whatever statement everybody's comfortable with at the bottom.

If we can't do that and we can't make that, we have nine minutes until SEMSCO ... So if somebody wants to make a suggestion how to change that last box, I'm all for it.

MR. BART: Do we have anybody that can modify the screen in front of us? It's kind of a working screen or we're doing this blindly.

THE CHAIR: I believe that the health department has a open version of this and they can modify. Or Dr. Marshall, do you have an open version of it?

MR. MARSHALL: Yes, hold on.

MR. BART: No some ... looks like they can grab it.

MR. GREENBERG: Yeah, the -- version on the screen is a PDF, but Dr. Marshall, let me -- Peter, can I have -- hold on one sec. Dr. Marshall, I'm going to send this back to you.

MR. MARSHALL: Okay.

MR. PHILIPPY: Sorry to be the kid in the classroom raising his hands and everybody is trying to leave, just for what it's worth.

MR. BART: You're ... we needed to do this.

THE CHAIR: It's okay, Mark, you're -- you're the chair anyway. So the next meeting can't start without you.

MR. GREENBERG: Dr. Marshall, it should be in your email.

MS. BOMBARD: And besides this we've been working on this since what, eight o'clock this morning. I don't think we're actually doing this in ten minutes, we're doing it like ten hours.

MR. MARSHALL: Which email did you send it to ...

MR. GREENBERG: ...

MR. MARSHALL: Two seconds. So do you want the language from the previous version?

MR. GREENBERG: So I think what they were asking for is -- is that one in publisher to be put up so that you can make your -- so you can type as they're looking for it.

THE CHAIR: So the most recent version that we can modify, the one that just up on the screen.

MR. GREENBERG: So I just put the language we had come up with for the original draft that went to the Department before the temperatures

all changed into the chat. That was the language in the box at the bottom.

MR. MARSHALL: I'm sharing my screen, this is publisher.

THE CHAIR: We've got it.

MR. MARSHALL: You see it?

THE CHAIR: Yes, they're there.

MR. MARSHALL: Adult is not on this version.

THE CHAIR: Great. You need to put a team to that next -- second next step.

MR. MARSHALL: Yes.

THE CHAIR: Don't worry about that.

MR. MARSHALL: I'll fix that later, yeah.

MR. ALEXANDROU: The part about the -- the gown has to be changed to appropriate P.P.E.

MR. MARSHALL: So just change this whole thing to appropriate P.P.E.?

MR. ALEXANDROU: I think that's how we had a -- the new one, yeah.

MR. DAILEY: Yeah, it says don appropriate P.P.E.

THE CHAIR: Yeah.

MR. GREENBERG: I guess don should be all caps.

MR. MARSHALL: Okay.

MR. CUSHMAN: When -- when I made that amendment, it was intentional for the underline bold capitalized that it simply say don appropriate P.P.E. before initiating close contact with the patient, period, end of story.

MR. MARSHALL: Up here, you're talking about at the top?

MR. CUSHMAN: That's correct altitude on it.

THE CHAIR: All right. So just put it up at that upper one, don appropriate. Just put appropriate in there and get rid of the other one.

I may need to move down to box number four with age variant sixty-five or less than fifteen if I recall our conversation.

MR. ALEXANDROU: I suggest you make it a separate line so it stands out.

MR. MARSHALL: What about down here at the asterisk putting -- wait.

MR. ALEXANDROU: No, perhaps right under -- right -- yeah, right there.

MR. MARSHALL: Yeah?

MR. ALEXANDROU: Yeah.

MR. MARSHALL: Okay. And then, here, anything else up here?

MS. BOMBARD: Yes, after the asterisk -- after the asterisk in that same box, yeah. Before refer, we're going to say for patients under fifteen years old.

MR. MARSHALL: Can't spell.

MS. BOMBARD: And just lowercase R for refer and then you're good.

MR. MARSHALL: I going to have to move this --

MS. BOMBARD: You may have to make that a less than sign instead of under to make it all fit.

MR. MARSHALL: Yeah.

MS. BOMBARD: You can probably get rid of for patients actually, if you just say less than sign at fifteen years old, you're good to go and you don't have to make it smaller so that old people can't read it like me.

MR. MARSHALL: How's that?

MR. OLSSON: You could -- you could

also eliminate for pediatric vital signs to refer to pediatric protocol, something like that.

MS. BOMBARD: Well, I think the only thing we're referring to is vital signs. That's the only difference.

THE CHAIR: Yeah.

MS. BOMBARD: We don't need to make this too crazy.

MR. ALEXANDROU: Last box.

MR. MARSHALL: The last box would be the language from the other one in criteria failure.

MR. WALTERS: I have a question about this age less than fifteen, right? Because everything if the age is less than fifteen you follow the arrow to the right, yes. And -- and this protocol doesn't apply, or are we just saying if the age is less than fifteen refer to B.L.S. protocol for pediatric vital signs?

Because if -- if the intent is to apply it to pediatrics by using the pediatric vital signs of the B.L.S. protocol, then I -- I don't think we want that age less than fifteen bolded up above. I think we just make a -- I think we're saying something separate.

MR. BART: I think it's -- it was insinuating as Jeremy has said earlier that respirations, heart rate, blood pressure, these are the adult values. So refer to your -- your protocol for your pediatric values for the age.

MR. RABRICH: Right, but Brian's point is in age greater than fifteen above should come out otherwise it will send you to the right.

MR. ALEXANDROU: Or if you put an asterisk after the less than fifteen in the first column.

MR. BART: You -- you need something indicates --

MS. BOMBARD: Can we just give an event age less than fifteen entirely and then I think we're good?

MR. BART: Yeah.

MR. ALEXANDROU: Yeah.

MS. BOMBARD: Take that back out --

MR. MARSHALL: That one? This one in the box or the one down here?

MR. RABRICH: The box, that one.

MS. BOMBARD: The one in the box, just get rid of that and then I think we're back to --.

MR. RABRICH: Now, we're good.

MS. BOMBARD: Sorry about that.

MR. MARSHALL: Okay. And so the language for the last box is patient meets criteria for non transport and/or treatment in place provide the patient with, but in the old one it says New York State COVID-19 hotline number and patient information handout.

MR. BART: That sounds reasonable to me, and if you want to add that comment from New York City, if everybody likes it or doesn't like it, I'm just suggesting it. You could put, you know, if the patient can't be convinced to transport the patient.

MR. MARSHALL: Or contact --

MR. BART: I think we say if they can't be -- exactly. I think we say if they can't be convinced contact like med control for guidance.

MR. MARSHALL: That's in the old one I'll put it in.

THE CHAIR: That's it, that looks good. You just eventually have to take the PA and put it attached to the tent or down there.

MR. MARSHALL: The what?

THE CHAIR: The -- the patient got

sort of separated into two -- two words there.

MR. MARSHALL: Okay.

THE CHAIR: Not a big deal.

MR. MARSHALL: No, we can just -- all right.

THE CHAIR: Does everybody happy with this and willing to vote on it since we now have a motion on the floor?

MR. ALEXANDROU: Just one last comment. Yeah, on that last statement that we put down there, are we still just saying, you know, instead of just transporting the patient, just call medical control?

I mean, you know, if the patient wants to go, why don't we just take him, the majority will be triaged out here and you don't have to, you know, in a busy telemetry unit you won't have to go down that route and call telemetry overwhelming.

MR. RABRICH: Nick, what if we play it and initiate transport or call medical control for guidance?

MR. ALEXANDROU: That depends on all the other regions and how they feel with those telemetry areas, you know, --

MR. RABRICH: Yeah.

MR. ALEXANDROU: -- during New York we're comfortable with that. We just say, you know, at this point we wasted enough time let's just go instead of spending perhaps in a busy telemetry unit, fifteen minutes on the phone trying to get the doctor discuss the case and then, you know, make a decision.

MR. BART: Add the per regional guidance.

MR. RABRICH: Yeah, let the regions decide.

MR. BART: ... control per regional guidance.

MR. ALEXANDROU: Well, how about per your regional guidance and local agency, because in some places you don't have that guidance in other places the agency making that decision.

MR. BART: You're -- you're --

MR. MARSHALL: Come on stop already -- ... stop already.

MR. BART: Comes up with their own, everybody else uses a region.

MR. ALEXANDROU: It should be a region, whatever.

MR. MARSHALL: Our regional guidance?

THE CHAIR: Yeah, for regional guidance and let's be done already.

MR. MARSHALL: That's it. My fingers are broken ... anymore.

MS. BOMBARD: Can you ... place?

MR. MARSHALL: No -- yes.

MS. BOMBARD: I was an English major, it's my only --

MR. MARSHALL: Okay. Okay.

MS. BOMBARD: Like, okay.

MR. DAILEY: That's all right, and I do formatting, it was soft return after the -- before the F.

MR. MARSHALL: What?

MR. BART: I agree.

MR. ALEXANDROU: Put your -- put your cursor in front of the F and hit a soft return.

MR. DAILEY: After packet in front of F, do a soft returns --

MR. GREENBERG: Right there.

MR. DAILEY: The next line.

MS. BOMBARD: That is nicer.

MR. DAILEY: I got it, I've -- I've been reformatting --

MR. GREENBERG: There you go.

MS. BOMBARD: Awesome.

MR. GREENBERG: Thank you.

MS. BOMBARD: All right. I revised my motion that we accept the changes as we have just outlined.

THE CHAIR: And I have a second on that revised motion, anybody?

MR. ALEXANDROU: I am, I do.

THE CHAIR: Who is that?

MR. ALEXANDROU: Alexandrou.

THE CHAIR: Okay. Well, we need one last roll call vote and then we can move on and end the meeting.

MR. GREENBERG: Dr. Doynow, just -- I just want to confirm. So your -- this -- this would replace the current one that's in place, correct?

THE CHAIR: That is correct.

MR. GREENBERG: Thank you very much.

THE CHAIR: Valerie, can we have roll call vote and then we can hopefully --

MS. OZGA: Do you promise this is the last one?

THE CHAIR: Yeah, I promise.

MS. OZGA: Okay. I'm running out of -- running out of paper here. All right. Let's -- let's get to this here. Dr. Alexandrou?

MR. ALEXANDROU: Absolutely, yes.

MS. OZGA: Dr. Bart?

MR. BART: Yes.

MS. OZGA: Dr. BERKOWITZ? Is Dr. Berkowitz still on? Dr. Bombard?

MS. BOMBARD: Bombard, yes.

MS. OZGA: Dr. Cooper?

MR. COOPER: Abstain ... E.M.S.C. review. I think it'd be either yes or no or an abstention, unfortunately.

MS. OZGA: Dr. Cushman?

MR. CUSHMAN: I didn't say abstain.

MR. COOPER: Okay. Sorry.

MS. OZGA: Dr. Cushman?

MR. CUSHMAN: Cushman will say yes, against my better judgment.

MS. OZGA: Dr. Dailey?

MR. DAILEY: Agree with Cushman, yes-ish.

MS. OZGA: Yes or no. Dr. Detraglia?

MR. DETRAGLIA: Detraglia, yes.
MS. OZGA: Dr. Doynow?
THE CHAIR: Yes.
MS. OZGA: Dr. Kugler?
MR. KUGLER: Dr. Kugler said ... yes.
MS. OZGA: Dr. Lynch? Dr. Lynch? Let's hope we still have quorum, guys. Dr. Markovitz?
MR. MARKOVITZ: Markovitz, yes.
MS. OZGA: Dr. Murphy -- I'm sorry. Dr. Marshall, first.
MR. MARSHALL: Dr. Marshall, yes.
MS. OZGA: Dr. Murphy? Is Dr. Murphy on?
MR. MARSHALL: No, she put into the chat a little while ago that she had to step out.
MS. OZGA: Okay. Dr. Olsson?
MR. OLSSON: Olsson, yes.
MS. OZGA: Dr. Talbott?
MR. TALBOTT: Yes.
MS. OZGA: Dr. Walters?
MR. WALTERS: Walters, yes.
MS. OZGA: Dr. Wicelinski -- Dr. Wicelinski? Okay. Let's see, one, two --

THE CHAIR: Hopefully we still have a ...
MR. LANGSAM: Don't ask about a quorum because that requires a quorum call and I was -- ... you have a quorum unless someone challenge.
THE CHAIR: That -- that sounds good to me.
MS. OZGA: I have a quorum, and we have thirteen in the affirmative and one abstain.
THE CHAIR: Okay.
MS. OZGA: So those two passes.
THE CHAIR: Excellent. Thank you, guys. What time is the pizza arriving ... All right. Let's close the meeting and move on to SEMSCO. Thank you, guys.
MR. MARSHALL: Make a motion to adjourn.
THE CHAIR: Yeah.
Mr. : Move to adjourn.
MR. : Second the motion. ...
(Off the record, 3:08 p.m.)
(The meeting concluded.)

STATE OF NEW YORK

I, ANNETTE LAINSON, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 158, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 19th day of January, 2022.

ANNETTE LAINSON

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