2/8/2023 - SEMAC - Troy, New York
NEW YORK STATE
DEPARTMENT OF HEALTH

STATE EMERGENCY MEDICAL ADVISORY COMMITTEE

DATE: February 8, 2023

TIME: 11:32 a.m. to 12:49 p.m.

CHAIR: DR. DONALD DOYNOW

LOCATION: Hilton Garden Inn
235 Hoosick Street
Ferris Ballroom
Troy, New York 12180

Reported by Danielle Christian

1 2/8/2023 - SEMAC - Troy, New York
2 **APPEARANCES:**
3 RYAN GREENBERG
DR. MIKE MCEVOY
4 DR. LEWIS MARSHALL
DR. JONATHAN BERKOWITZ
5 VALARIE OZGA
THERESA ALLEN
6 DR. DANIEL OLSSON
DR. JEFFREY RABRICH
7 DR. MATTHEW TALBOT
DR. JEREMY CUSHMAN
8
DR. BRIAN WALTERS
DR. JOSHUA LYNCH
9
DR. TIFFANY BOMBARD
10 CARL GANDOLFO
DR. DOUGLAS ISAACS
11 DR. JASON WINSLOW
DR. MICHAEL DAILEY
12 DR. ARTHUR COOPER
JON WASHKO
13 DR. MICHAEL REDLENER
DR. DAVID MARKOWITZ
14 DR. YEDIDYAH LANGSAM
AIDEN O'CONNOR
15
STEVEN KROLL
DR. PHILLIPY
16
DAVID VIOLANTE
AMY EISENHAUER
17
DR. PETER BRODIE
18
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1 2/8/2023 - SEMAC - Troy, New York
2 (The meeting commenced at 11:32 a.m.)
3 **CHAIR DOYNOW:** All right, everyone.
4 Why don't we -- why don't we start the meeting? If I
5 could have everyone stand for the Pledge of
6 Allegiance.
7 I pledge allegiance to the flag of the
8 United States of America, and to the republic for
9 which it stands, one nation under God, indivisible,
10 with liberty and justice for all.
11 If I could ask all of you to just
12 remain standing for a minute. We did lose Dr.
13 DeTraglia, who is a longstanding member of SEMAC and
14 medical director. If we could have a moment of
15 silence for him. Okay. Thank you all.
16 We'll ask, if you do speak, if you
17 could please mention your name as you start speaking
18 for the transcriber, so we can have the meeting
19 transcribed appropriately. Valarie, if we can have
20 the roll call.
21 **MS. OZGA:** Dr. Berk? Dr. Berkowitz.
22 **DR. BERKOWITZ:** Yes.
23 **MS. OZGA:** Dr. Berry? Dr. Bombard?
24 **DR. BOMBARD:** Dr. Bombard here.
25 **MS. OZGA:** Dr. Cooper?

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2 **DR. COOPER:** Here.
3 **MS. OZGA:** Dr. Cushman.
4 **DR. CUSHMAN:** Cushman here.
5 **MS. OZGA:** Dr. Dailey?
6 **DR. DAILEY:** Dailey here.
7 **MS. OZGA:** Dr. Doynow?
8 **MR. DOYNOW:** Here.
9 **MS. OZGA:** Dr. Gomez? Dr. Isaacs?
10 **DR. ISAACS:** Here.
11 **MS. OZGA:** Dr. Kugler? Dr. Lynch?
12 **DR. LYNCH:** Here.
13 **MS. OZGA:** Dr. Markowitz?
14 **DR. MARKOWITZ:** Here.
15 **MS. OZGA:** Dr. Maynard? Dr. Marshall?
16 **DR. MARSHALL:** Present.
17 **MS. OZGA:** Dr. Murphy? Dr. Olsson?
18 **DR. OLSSON:** Olsson here.
19 **MS. OZGA:** Dr. Talbot?
20 **DR. TALBOT:** Here.
21 **MS. OZGA:** Dr. Walters?
22 **DR. WALTERS:** Walters here.
23 **MS. OZGA:** Dr. Wislinski (phonetic
24 spelling)? Dr. Winslow?
25 **DR. WINSLOW:** Present.

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1 2/8/2023 - SEMAC - Troy, New York
2 **MS. OZGA:** And the non-voting members,
3 Oren Barzilay? Aidan O'Connor?
4 **MR. O'CONNOR:** Good morning.
5 **MS. OZGA:** Mark Phillipy?
6 **DR. PHILLIPY:** Phillipy present.
7 **MS. OZGA:** Mary Ann Portoro? Dr.
8 Rabrich?
9 **DR. RABRICH:** Here. Here.
10 **MS. OZGA:** Mike McEvoy?
11 **MR. MCEVORY:** Here.
12 **MS. OZGA:** Steve Kroll?
13 **MR. KROLL:** Present.
14 **MS. OZGA:** And Jon Washko?
15 **MR. WASHKO:** Present.
16 **CHAIR DOYNOW:** Do we have a quorum,
17 Val?
18 **MS. OZGA:** We're making sure. Yes, we
19 have a quorum.
20 **CHAIR DOYNOW:** Excellent. Thank you.
21 Can we have approval of the previous meetings
22 minutes? Would anybody like to make that motion?
23 **DR. MARSHALL:** So -- so second.
24 **CHAIR DOYNOW:** Okay. Dr. Cooper --
25 Dr. Marshall. All in favor? Anybody -- anybody

1 2/8/2023 - SEMAC - Troy, New York
2 against? Okay. So passed. Okay, Ryan, Bureau staff
3 report?
4 **MR. GREENBERG:** Good morning,
5 everyone. Try and be brief and it's going to focus
6 on two primary things and go from there. In
7 operations, we continue on with operations. Just a
8 reminder to everybody, make sure to have your
9 inspections in.
10 One of the biggest things with both
11 the operations and education is the new E.M.S. forms
12 page is it live. So if you go to the bureau website,
13 you go to E.M.S. forms, there's a drop down. It's
14 separated by operations, education Part Eighteens.
15 It is all centralized there. So I encourage
16 everybody to use that if you need to submit any
17 forms.
18 We are very excited to go from
19 literally getting buckets of mail every day to, you
20 know, enough that you can walk with it under your
21 arm. So thank you also to everybody here who has
22 helped with that part.
23 It is a new system. So please, if
24 there, you know, if you see anything that doesn't
25 look right, or something that needs to be fixed, by

1 2/8/2023 - SEMAC - Troy, New York
2 all means, feel free to provide that feedback to us.
3 We continue to execute our contracts on the P.A. side
4 and on the REMSCO side. Thank you for everyone who's
5 doing that.
6 If anybody's having any issues with
7 that, again, please make sure to come forward. This
8 is also, you know, really important too to make sure
9 that there's timely submissions of invoices, both for
10 program agencies, for REMSCOs, for core sponsors, so
11 that we can appropriately make sure that funding
12 that's allocated for the year is spent in that year.
13 So if anybody is holding on any
14 funding with their core sponsors, the program
15 agencies or their REMSCOs, that can be submitted.
16 Please make sure to submit that, honestly, within the
17 next like two weeks, so that it -- it falls into this
18 fiscal year.
19 Education wise, we're moving into some
20 new applications. We have renewal paperwork that
21 will be going out. There is a P.S.C. that will be
22 discussed, I think, leader, the beta test on the
23 P.S.C. We're excited about that one and some updates
24 on the regional faculty process as well as some
25 online training now for regional faculty members.

1 2/8/2023 - SEMAC - Troy, New York
2 Data and informatics, doing lots of
3 good things, moving things forward. There's also
4 been some feedback from multiple committees over the
5 past two days to talk about how often updates happen
6 with data and informatics and seeing what we can do
7 to reduce the number of updates that happen. While
8 still meeting the needs and meeting NEMS -- NEMSIS
9 standards. So we'll be working with that side to do
10 that one.
11 We'll be in Syracuse for vital signs,
12 October 17th to the 22nd. And there is currently a
13 call for presenters. So particularly to all our
14 physicians and our local ones to Syracuse, please go
15 ahead online to the bioscience conference website and
16 submit to be part of this year's conference.
17 The memorial, we have -- an -- Val,
18 please confirm. Is it seven or eight? Seven names?
19 **MS. OZGA:** We have eight names.
20 **CHAIR DOYNOW:** Eight names that will
21 be going up on the memorial this year. It will be
22 the same memorial as you've seen in the past. We are
23 working on the new one. And that is just showing to
24 be -- it's going to take longer than expected to get
25 there, but it will be done right. So we're patient

1 2/8/2023 - SEMAC - Troy, New York
2 with that one.
3 That will be in May. So please join
4 us in May for the E.M.S. Memorial. The OASIS grant
5 continues on, doing lots of good things around the
6 state with Jenny and her team and as well as the
7 regulations. So regulations have cleared some of the
8 initial processes. And this is important.
9 We hope that between this meeting and
10 the May meeting, the regulations for both education
11 and operations will go up for out for public comment.
12 So education and operations will go out for public
13 comment. That's work that has come from this
14 committee, or from the governing bodies here, the
15 state councils, and it will go out for public
16 comment.
17 Once it goes out for public comment,
18 if there's no public comment or no opposition, it
19 will come back to the -- the SEMSCO for final
20 approval and then turned into reg. But during public
21 comment is also the opportunity for everybody here to
22 comment, and also to comment for the positive as
23 well. So to go on and be able to see it.
24 We will make sure to share it widely.
25 We encourage you to share it also, you know, with

1 2/8/2023 - SEMAC - Troy, New York
2 others. And to please make sure to comment even if
3 that comment is we support. They do look at that as
4 well. So it's not just, you know, things in that
5 nature in the negative.
6 So again, between now and May,
7 hopefully that will be out. If, by chance, it gets
8 out for a sixty-day period and there are no comments
9 of opposition or no changes that need to be made, it
10 could be something that we'll be voting on as early
11 as the May meeting, but we won't be able to tell
12 until it actually goes up for public comment.
13 Most realistically, my guess is, it
14 will probably be open during the May meeting. It
15 will then close. We'll do any edits that need to
16 happen. It might have to go back out for public
17 comment again and then it would be voted on at the
18 September meeting.
19 Anything that has a timeline to it in
20 there is based on the date that the regs are
21 published. So there's not a date in there that will
22 say, these will go live on December 31st. It is
23 based on six months from the date of publish or so on
24 so forth. So just understanding on that side as
25 well.

1 2/8/2023 - SEMAC - Troy, New York
2 Last two things. I know it's going to
3 be spoken about, I think at this committee as well,
4 correct me if I'm wrong, but the E.M.S.
5 sustainability study. You all as members have
6 received the E.M.S. sustainability study in your
7 packet of information. It is also up on our website
8 under the meeting documents. We are really excited
9 about this document.
10 I want to applaud all the members both
11 from this council and the State Council and from
12 around the state who were part of that as well as
13 chief Benenati for starting all in a parking lot and
14 a conversation of some thoughts and spending the past
15 year putting together this seventy-page white paper
16 with twenty-five significant recommendations at the
17 start of it.
18 And so the work that has been done to
19 put this together and to make advisement and to
20 improve the E.M.S. system and to put it on paper, and
21 to put it on paper for both E.M.S. providers, but
22 also for people who are not a part of the E.M.S.
23 community to understand what those problems are
24 absolutely incredible.
25 So thank you to everybody who were a

1 2/8/2023 - SEMAC - Troy, New York
2 part of that committee. I encourage everybody here
3 to please not only read it, but to comment about it,
4 discuss it, bring it forward, bring it to your
5 REMSCOs. There's, you know, very, very excited about
6 it.
7 The second part on that is actually
8 the timing is very interesting. Yesterday, we had
9 our first rural health -- rural health E.M.S. task
10 force meeting. This is an action from a legislative
11 action, or a task force that was set up from a
12 legislative action. There was a copy, I believe, of
13 all the membership of the -- of the committee members
14 for the overall health E.M.S. task force in your
15 packet of materials.
16 And they had their first meeting
17 yesterday to discuss the issues of E.M.S. in rural
18 settings. They will be meeting now for next year,
19 and hopefully really taking the E.M.S. sustainability
20 study and taking it to next level as it relates to
21 the E.M.S. community and then making recommendations
22 to the elected bodies on how to improve E.M.S. in the
23 rural settings.
24 Last but far from least, I want to
25 talk about just for a minute, and I think we're going

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1 2/8/2023 - SEMAC - Troy, New York
2 to talk later in this meeting about it is the budget.
3 And the amount E.M.S. has mentioned in the budget and
4 supported in the budget, and new initiatives and
5 changes to improve.
6 I think when I was looking over the
7 E.M.S. sustainability study, there were about fifteen
8 of the twenty-five recommendations that would be
9 affected, whether it be in full or in part with the
10 changes that would come from the budget from this
11 year.
12 So again, exciting to see things line
13 up, exciting to see feedback from this council and
14 the SEMSCO from last year, Part F and seeing it in
15 Part S this year. So again, really excited to see
16 those things. I welcome all feedback, thoughts,
17 comments, likes, dislikes, recommendations.
18 I can't change anything in the budget,
19 but I'm happy to share information, share where the
20 positive is, share where the challenges are, and so
21 that we can, you know, move forward. There's a lot,
22 a tremendous amount of really great things in that
23 budget this year, and in the legislation that along -
24 - along with it. And we really excited to see that
25 hopefully move forward.

1 2/8/2023 - SEMAC - Troy, New York
2 With that, that's the end of my
3 report.
4 **CHAIR DOYNOW:** Thank you, Ryan.
5 Moving on to subcommittee's med standards, Dr.
6 Marshall.
7 **DR. MARSHALL:** Thank you and good
8 after -- good morning. Still morning. We have time.
9 So med standard is met earlier today. And while we
10 started off with zero -- zero motions, we wound up
11 with four. I don't know how that happened.
12 So we have four motions that come
13 forward to this body for a decision. And I'll just,
14 the first one is with some -- some -- for the past
15 couple of meetings, we've been discussing the
16 protocol change policy. And then some revisions were
17 made recently. And there was no further discussion
18 on it.
19 So the motion comes forward to approve
20 the protocol change policy. Now as unanimous
21 decision. When it comes to this body, it's -- it's
22 not a protocol change. So I don't think you need to
23 do a roll call.
24 **CHAIR DOYNOW:** I don't think we need a
25 roll call. We -- probably just, every -- let's put

1 2/8/2023 - SEMAC - Troy, New York
2 this way. Anybody against this policy? Any
3 abstentions? I'll assume everybody's in favor, so
4 that passes.
5 **DR. MARSHALL:** Okay.
6 **CHAIR DOYNOW:** Or we can everybody
7 raise their hands. Everybody in favor?
8 **MR. LINSTROM :** No, it was better the
9 first way. Now you can say it's unanimous.
10 **CHAIR DOYNOW:** Okay. Thank you, Dr.
11 Linstrom (phonetic spelling). We'll do it the first
12 way. All right. So it's unanimous. It's passed.
13 Let's move on.
14 **DR. MARSHALL:** Okay. So the next
15 motion is to accept the collaborative protocols as a
16 state B.L.S. protocols, excluding cities of one
17 million or more.
18 **CHAIR DOYNOW:** Any discussion on this?
19 Okay. Anybody against? Anybody abstaining? We'll
20 assume it's unanimous. It's passed.
21 **DR. MARSHALL:** Okay. The third motion
22 that comes forward is to approve the medical device
23 advisory that was sent out recently. I think that
24 the reason for this medical device advisory was to
25 make sure that an agency medical director knows what

1 2/8/2023 - SEMAC - Troy, New York
2 medical devices are being used and -- and actually
3 approves them for the agency.
4 **CHAIR DOYNOW:** Any discussion?
5 Anybody against? Anybody abstaining? Again,
6 unanimous. Guys are -- really have it together
7 today.
8 **DR. MARSHALL:** Yeah, we're working as
9 a team. Okay. And the fourth motion is actually a
10 protocol change that was brought forward. We have
11 some discussion on Super S.G.A. for A.M.T. And on
12 page -- what? Yeah. If you look at -- if you have
13 the collaborative protocols, I think on page -- Dr.
14 Dailey, please jump in on page one eighty-two, top of
15 one eighty-two, where it says alternative airway
16 device and unresponsive adults, changing that to
17 patients. The word adult to patient.
18 And then at the bottom of the page, it
19 also says if equipped and trained. And that would
20 permit A.M.T.s to use S.G.A. in unresponsive
21 patients.
22 **MR.:** Yeah, the -- the exact change is
23 removal of the word, adults, replacement with the
24 word patients with an asterisk next to it for
25 coordinating with the if equipped and trained at the

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1 2/8/2023 - SEMAC - Troy, New York
2 bottom.
3 **DR. MARSHALL:** Uh-huh. Thank you for
4 the clarification.
5 **CHAIR DOYNOW:** That I assume will
6 require a roll call vote as it's a protocol change.
7 **MS. OZGA:** Dr. Berkowitz?
8 **MS. BERKOWITZ:** Yes.
9 **MS. OZGA:** Okay. Dr. Bombard?
10 **DR. BOMBARD:** Yes.
11 **MS. OZGA:** Dr. Cooper?
12 **DR. COOPER:** Yes.
13 **MS. OZGA:** Dr. Cushman?
14 **DR. CUSHMAN:** Cushman, yes.
15 **MS. OZGA:** Dr. Dailey?
16 **DR. DAILEY:** Yes.
17 **MS. OZGA:** Dr. Doynow?
18 **MR. DOYNOW:** Yes.
19 **MS. OZGA:** Dr. Isaacs?
20 **DR. ISAACS:** Yes.
21 **MS. OZGA:** Dr. Lynch?
22 **DR. LYNCH:** Yes.
23 **MS. OZGA:** Dr. Markowitz?
24 **MS. OZGA:** Markowitz, yes.
25 **MS. OZGA:** Dr. Marshall?

1 2/8/2023 - SEMAC - Troy, New York
2 **DR. MARSHALL:** Yes.
3 **MS. OZGA:** Dr. Olsson?
4 **DR. OLSSON:** Olsson, yes.
5 **MS. OZGA:** Dr. Talbot?
6 **DR. TALBOT:** Yes.
7 **MS. OZGA:** Dr. Walters?
8 **DR. WALTERS:** Walters, yes.
9 **MS. OZGA:** And Dr. Winslow?
10 **DR. WINSLOW:** Yes.
11 **MS. OZGA:** Motion passes.
12 **CHAIR DOYNOW:** Thank you. There were
13 some other -- other items that were discussed and we
14 talked about last time, transport of the newborn and
15 neonate. And we actually had a demonstration of some
16 devices that can be used to transport newborns and
17 neonates with the mother in a safe -- in a safe
18 manner, which is, as was pointed out this morning, we
19 are probably not transporting neonates and newborns
20 as safely as we could.
21 So those -- the description of those
22 items are available on the E.M.S.C. website, maybe.
23 I forget.
24 **UNIDENTIFIED FEMALE SPEAKER:** ...
25 **DR. MARSHALL:** Thank you.

1 2/8/2023 - SEMAC - Troy, New York
2 **MS. EISENHAUER:** Information on safe
3 transport of pediatric patients can be found on the
4 New York State E.M.S.C. resources page. Alternately,
5 you can look on the NASEMSO Pediatric Emergency
6 Council page, and there's a special section on the
7 NASEMSO website for safe transport of pediatric
8 patients.
9 Also, if you want more information or
10 more specific details, you can email me, Amy
11 Eisenhauer. So amy.eisenhauer@health.ny.gov and I'll
12 be happy to help.
13 **DR. MARSHALL:** Thank you, Amy. We
14 also had an update. At the last meeting, we had
15 asked for some data on pediatric patients under the
16 age of three. And so we do have some data from 2021
17 and 2022 that I think is worth sharing.
18 In 2021, there were eighteen thousand
19 two hundred and fifty-nine pediatric patients that
20 were transported and E.M.S. providers documented the
21 weight in ninety-two percent of those, which is
22 really phenomenal.
23 Twelve percent of the eighteen
24 thousand received at least one medication and the top
25 five medications are oxygen, albuterol, Ativan,

1 2/8/2023 - SEMAC - Troy, New York
2 Midazolam and Decadron. And in 2022, there was
3 actually a thirty-eight percent increase in the
4 number of pediatric transports to twenty-five
5 thousand one hundred and fifty-four. That's a
6 significant increase.
7 And weight documented in ninety-eight
8 percent of those patients. So our -- our providers
9 are doing a phenomenal job of documenting weight in
10 pediatric patients. Again, fourteen percent received
11 at least one medication and that was oxygen,
12 albuterol, Atrovent, Midazolam and albuterol
13 ipratropium combination.
14 So as we are able to get more data, if
15 there are requests for additional data, please let us
16 know, so we can bring it back and share it with
17 everybody.
18 **MS. EISENHAUER:** Dr. Marshall?
19 **DR. MARSHALL:** Yes.
20 **MS. EISENHAUER:** Can I just make a
21 clarification on that?
22 **DR. MARSHALL:** Uh-huh.
23 **MS. EISENHAUER:** So that data that you
24 just read off was for newborn to three-year-olds?
25 **DR. MARSHALL:** Yeah.

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1 2/8/2023 - SEMAC - Troy, New York
2 **MS. EISENHAUER:** Not for all pediatric
3 patients?
4 **DR. MARSHALL:** Correct, yeah, yeah.
5 **MS. EISENHAUER:** Just for those out
6 there watching.
7 **DR. MARSHALL:** Okay. Thank you.
8 **MS. EISENHAUER:** Thanks.
9 **DR. MARSHALL:** All right. The other
10 thing we had a discussion on is the medication assist
11 protocol. We have a SEMAC policy. It's zero four
12 zero seven, but there are some changes in the -- in
13 the collaborative protocol. So the department and --
14 and I will look at that and bring it back to the next
15 meeting in May for discussion.
16 We also talked about participation in
17 the CARES program, which is the cardiac arrest
18 registry to enhance survival. And Director Greenberg
19 had mentioned revising a letter that went out a while
20 back, also encouraging E.M.S. providers in hospitals
21 and others to participate in registries.
22 And so for those who may not know.
23 This one is to help save more lives from out of
24 hospital cardiac arrests, strengthen collaboration
25 between 9-1-1, first responders, E.M.S. agencies and

1 2/8/2023 - SEMAC - Troy, New York
2 hospitals. And allow us to generate reports for
3 benchmarking within our regions and our state, which
4 we think will be very helpful moving forward.
5 So the department will be looking at
6 the previous letter and revising it and reissuing it,
7 so that should help support our participation in that
8 program. The other thing I'd like to just quickly
9 mention -- well, two things. We had a very long and
10 really great discussion on credentialing of A.L.S.
11 providers by regions.
12 What that means, what it doesn't mean,
13 what are the benefits of doing it at the local level.
14 And also talked about the process of taking away
15 credentialing and where that authority lies with --
16 with the department.
17 And so it was a very good discussion.
18 We didn't resolve anything, but I think that the --
19 the -- the -- the sense that I get from the group is
20 that all regions need to have some authority over
21 their A.L.S. providers. And I'm not -- we're not
22 talking about the -- the bad actors, the bad actors
23 that need to be reported to the department should be
24 reported to the department.
25 We talked a lot about quality issues

1 2/8/2023 - SEMAC - Troy, New York
2 and quality of care and, you know, what do you do
3 with, you know, in the -- in the region for the
4 individual who, you know, misses every intubation. I
5 mean, you know, how do you deal with that. So we had
6 that discussion as well. And I think that discussion
7 will continue going forward.
8 And the last thing I'd like to -- and
9 any -- if anybody wants to comment on that as well.
10 I see Dr. Dailey's light is on. The -- the last
11 thing I'd like to mention and then Dr. Dailey can
12 take over is, Dr. Cooper had mentioned -- utilizing
13 Just Culture and -- and E.M.S. And I know that most
14 hospitals are using Just Culture now in their -- when
15 we look at -- at what we do.
16 And so I think that that was a very
17 good idea and I would encourage all agencies to learn
18 about just culture and incorporate that in your
19 processes and Dr. Dailey?
20 **DR. DAILEY:** Actually, I was going to
21 comment on something you mentioned before, which is
22 the prescribed medication assistance. You know, just
23 -- for -- for this body to -- to remember. This was
24 a protocol that was developed specifically to assist
25 patients across New York State with rare diseases.

1 2/8/2023 - SEMAC - Troy, New York
2 One of the things that came out at the
3 National Association of E.M.S. Physicians, as I
4 interacted with some folks there, that were lobbying
5 specifically to states to make sure that this was an
6 option available to their E.M.S. providers was that
7 while New York had not done a particularly good job
8 of educating all of our providers to this protocol,
9 we stand not quite alone, but with very few other
10 states as to give this option to patients with rare
11 disease and to our E.M.S. providers to assist them.
12 So this body and, obviously the State
13 Council, but state E.M.S. as a whole is to be
14 complimented for being on the cutting edge of taking
15 care of patients with rare diseases, and making sure
16 that we have these kinds of options out there. So
17 thank you all.
18 **DR. MARSHALL:** Thank you. I would
19 just refer people to the medical standards minutes
20 when they come out for further review of the
21 credentialing discussion. I think is really good.
22 And that's my report. Thank you.
23 **CHAIR DOYNOW:** Thank you, Dr.
24 Marshall. Thank you, Dr. Dailey. Education.
25 **DR. MCEVOY:** Mike McEvoy, I'm the

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1 2/8/2023 - SEMAC - Troy, New York
2 chair currently of education and training. Don
3 Hudson is going to take that committee over for me
4 after this meeting, I think, he's ... ready -- ready
5 to go. Staff report gave some statistics for last
6 year.
7 In New York State, we had ten thousand
8 seven hundred and fifty-six students come through,
9 courses eight hundred and ninety-two of those were
10 C.F.R.s. Eight thousand nine hundred and seventy-two
11 were E.M.T.s, two hundred and three A.E.M.T.s and six
12 hundred and eighty-nine medics.
13 The reciprocity folks did twelve
14 hundred reciprocity applications and issued seven
15 hundred and fifty reciprocity certificates, primarily
16 E.M.T. ones. They denied a hundred and forty. Most
17 of those denials had to do with imbalance in class
18 hours versus virtual time.
19 And then they did some analysis of
20 using a program called Tableau, which looks at trends
21 over a ten-year time period of E.M.T. courses that
22 are run and sponsors. And basically, one of the
23 things that they saw is over the last ten years,
24 there's been very little change in the numbers of
25 providers that we've graduated from our courses.

1 2/8/2023 - SEMAC - Troy, New York
2 Despite the fact that that number
3 seems to have dipped in other places around the
4 country, there's been a little spike in the last two
5 years in paramedics who are graduating from courses.
6 And core sponsors overlooked for the last few years
7 have also not changed significantly. The same
8 numbers of core sponsors exist across the state.
9 There are two new P.S.I. electronic
10 testing sites that have opened, one in Burlington, I
11 think, Vermont. And the other in Erie, Pennsylvania.
12 And while that may seem odd to give New York state
13 exams out of state, those serve some rural areas of
14 the state that have difficulty accessing testing
15 centers.
16 One of the things we reported on at
17 the last meeting was the revisions to the B.L.S.
18 practical skills exam. And we did a little bit of
19 trial with that. We have another one coming up
20 shortly at one of the core sponsors downstate.
21 And the general finding from that is
22 that while the exam is significantly different,
23 testing people's critical thinking ability, more so
24 than just their ability to do skills, it's going to
25 create a comprehensive need to update instructors,

1 2/8/2023 - SEMAC - Troy, New York
2 update students, update examiners.
3 And so that process, rather than
4 happening instantaneously this year as we planned, is
5 probably going to occur over the course of the next
6 two years. One of the things that we're collecting
7 data on currently with the experimental application
8 of that is, revisions to the manual which are being
9 done through Boardable by the Bureau and the training
10 and Ed staff, as well as the cost, the financial
11 aspects of administering that exam.
12 And that will get incorporated in with
13 some new budget planning. We did speak with the
14 finance committee, and we're going to have a joint
15 workgroup of people from training and Ed and finance
16 to actually take a look at the core sponsor surveys
17 and come up with some suggestions for adjustments in
18 the rates that are reimbursed by the Bureau and
19 perhaps some of the policies as to who can be
20 reimbursed for versus not and other things that have
21 to do with the finances, pertaining to courses run
22 for E.M.S. providers.
23 There was also two workgroups that we
24 established in addition to that finance group. One
25 is going to take a look specifically at instructor

1 2/8/2023 - SEMAC - Troy, New York
2 recertification. And it's -- discussion came up at
3 the last SEMSCO meeting. And that was to talk a
4 little bit more about whether our requirements for
5 instructor certification and recertification are
6 actually contemporary or not, whether those could use
7 some revision.
8 They'll probably also take a look at
9 some of the issues that have to do with reciprocity
10 for out-of-state instructors who are coming into New
11 York. So that was one group that was put together.
12 And the other -- actually the other one was the
13 finance workgroup.
14 We also asked the Bureau last meeting
15 if they could give us some information about a
16 process they use called Zendesk, which are help
17 tickets that are submitted for the electronic exams.
18 And it depends on who you talk to. People have
19 varying stories about how well the testing vendor is
20 interacting with the Bureau and how efficient it is.
21 It turns out that roughly two percent
22 of the exams that are administered result in a
23 problem. And so we're going to get some regular
24 reporting from the Bureau of what those issues are.
25 They seem to be primarily related to interface

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1 2/8/2023 - SEMAC - Troy, New York
2 between the testing vendor and the Bureau's computer
3 system where scores don't transfer over as readily as
4 they need to be.
5 The other thing that happens is
6 scheduling assistance problems and those are
7 comprised most of the two percent of problems that
8 occur. So two things we got out of that. One is, we
9 could do a little bit better with the scheduling
10 processes and the Bureau is about to open up a method
11 where core sponsors can actually pre-register their
12 students at the end of a course.
13 And that will help to get people to
14 take the exam rather than -- then getting an email a
15 week later saying, take this test sometime in the
16 next year. So I think that will help a little bit.
17 There are some sponsors who are actually currently
18 pre-registering their students and paying for them to
19 take the test, which also seems to encourage them to
20 take it a little bit more promptly.
21 The other thing that we got from that
22 is that, of all of these problems that are occurring,
23 it would seem as though they're small. It's not a big
24 huge issue with the vendor. And they're things that
25 one by one the Bureau has been able to fix.

1 2/8/2023 - SEMAC - Troy, New York
2 They did post a new page on the
3 education website which talks about what a student
4 needs to do to take the exam and email that a student
5 can reach out to if they have a problem with the
6 exam. And most of us who have looked at that page
7 have found that the six most stupid questions that
8 anyone ever asks us are all answered on that page.
9 And so somebody who goes there could
10 quickly find out what -- what they need to know about
11 a problem that they're having with the exam. So
12 that's a very helpful resource that was put in place.
13 And I think the other thing that we had some
14 discussion about just to mention it here is, funding
15 for courses and the ability of paramedic courses to
16 have Excelsior funding when that program is actually
17 labeled as a certificate program rather than just a
18 program.
19 And if it's an official SUNY approved
20 program, and it's a certificate or an associate
21 degree, it's fairly simple for a student who's
22 eligible financially to get full funding for that
23 training. There also is money available through the
24 New York State Jobs funding administered by each
25 county that could pay for both paramedic training,

1 2/8/2023 - SEMAC - Troy, New York
2 advanced E.M.T. training and E.M.T. training.
3 So we're going to do some more
4 exploration of those things and see if we can
5 aggregate some of that data and perhaps put that
6 together in a format that we could distribute to core
7 sponsors, so that they're a little bit more aware of
8 it.
9 And Howard Hughes is going to work
10 with some of his colleagues to -- to put that
11 together. So unless there are any questions, that's
12 the training and Ed report.
13 **CHAIR DOYNOW:** Any questions? Thank
14 you, Dr. McEvoy. Sure, go ahead, Mike.
15 **MR. GREENBERG:** So separate from
16 training and Ed, but I think important for this group
17 as well. We had a meeting with the paramedic
18 directors last night, myself and the education team.
19 A lot of great discussions on paramedic education and
20 -- and number of different items.
21 One of the big ones was the field
22 training, and having a standardized field training
23 officer program, both the training program and the
24 curriculum as well as a program guide. And so that's
25 an initiative that the program -- the paramedic

1 2/8/2023 - SEMAC - Troy, New York
2 program directors said that they'd be very open to
3 helping us with.
4 It's part of their accreditation is to
5 have, you know, a field training program, you know,
6 and to have their students mentored. And I know many
7 of you are paramedic program directors or medical
8 directors. So just want to bring that one up, and I
9 think training and Ed will see that coming forward at
10 the next meeting as well, but an exciting, you know,
11 opportunity for many.
12 **CHAIR DOYNOW:** Thank you, Ryan. Dr.
13 Cooper, E.M.S.C.
14 **DR. COOPER:** Thank you, Dr. Doynow.
15 E.M.S.C. met recently and rather full agenda. First
16 want to report that the Pediatric Emergency Care
17 Coordinators survey is out for all E.M.S. agencies to
18 complete. And the Pediatric Emergency Care
19 Coordinator survey for emergency departments has
20 closed there.
21 The response rate given COVID was
22 probably not as robust as had been hoped for, but
23 there is information about that on the E.M.S.C.
24 E.I.I.C. website, the Texas group that just asked the
25 Innovation and Improvement Center for E.M.S.C.

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1 2/8/2023 - SEMAC - Troy, New York
2 In between our last meeting and this,
3 the pediatric agitation group met. And it was
4 largely determined that pretty robust education was
5 going to be required in order to implement a, you
6 know, a -- a system whereby psychological de-
7 escalation was the mainstay of care, at least for the
8 younger children.
9 Efforts are being made to actually
10 introduce that or develop and introduce that
11 education. There's already excellent -- there are
12 already excellent materials on the E.I.I.C. website
13 again. The -- the -- this information was actually
14 shared with the emergency medicine community through
15 the ASAP news -- newsletter late last year, a big
16 spread on that in that particular publication.
17 So I'm -- I'm presuming most of you as
18 emergency medicine physicians received that
19 publication and either had or will have the
20 opportunity to review that information for
21 yourselves. It is our hope that there will be
22 something about pediatric agitation and de-escalation
23 techniques on the vital signs program in the fall and
24 probably something as well on the -- on the learning
25 management system, the E.M.S. Academy sponsored by

1 2/8/2023 - SEMAC - Troy, New York
2 the Bureau.
3 The trauma triage group also met and
4 focused on again, the thought that what was needed
5 rather than protocol change was -- was education
6 about the various additional changes that were --
7 that were made in the -- in this edition of the -- of
8 the national trauma triage guidelines.
9 Probably, the key issues in the -- in
10 that document and aside from the formatting of it are
11 the inclusion of several criteria that suggest
12 examples of additional concerns that might cause a
13 provider to want to transfer a patient who does not
14 otherwise -- otherwise meet physiologic, anatomic or
15 mechanistic criteria to a trauma center.
16 In addition, as many of you are aware,
17 sort of a -- a strip down version of the shock index
18 has been added to the physiologic criteria. And all
19 of this probably requires some degree of education
20 for our pre-hospital providers and so will E.M.S.C.
21 in co -- in collaboration with a -- with the STAC
22 will be working on that project.
23 Those of you that had the opportunity
24 to attend medical standards earlier today had the
25 opportunity to view Amy Eisenhauer, Ryan Greenberg

1 2/8/2023 - SEMAC - Troy, New York
2 and Mike Dailey demonstrating some of the new
3 pediatric and neonatal transport devices that -- that
4 are -- are available.
5 There will be a -- a subgroup of
6 E.M.S.C. that will be reviewing the available
7 information on these devices. Of course, Amy's
8 predecessor in the role of E.M.S.C. program manager
9 for the Bureau, Martha Gohlke, had spent quite a bit
10 of her time focusing on the -- the child passenger
11 safety technician issues.
12 And all things transport, Amy has
13 considered that in -- in high style and is -- is a
14 very active member of the National Association of
15 E.M.S. Official's subgroup, which is focusing on
16 pediatric transport. Amy's major contribution to
17 that has been making sure that neonates are
18 appropriately addressed in that process.
19 Last but not least, an issue arose at
20 the last SEMAC meeting about the possibility of
21 incorporating high flow nasal cannula into pediatric
22 transport. The -- the group that discussed this
23 pretty universally felt that there was a, quite a
24 limited role, if any role, for high flow nasal
25 cannula in pediatric patients, particularly in short-

1 2/8/2023 - SEMAC - Troy, New York
2 term urban environments.
3 You know, and as most of you know, it
4 -- it's -- it -- the use of high flow nasal cannula
5 really really, you know, uses up your oxygen
6 resources in -- in rather a quick order. But it was
7 noted during that series of conversations that high
8 flow nasal cannula may have a role, and in fact, is
9 being used with some frequency during inter facility
10 transport mostly by critical -- critical care
11 transport teams from receiving hospitals, pediatric
12 receiving hospitals.
13 You know, teams that are staffed by --
14 largely by physicians and nurses. But then the
15 question arose. Well, what if we're talking about a
16 circumstance where, you know, there are paramedics
17 involved in that critical care transport on an inter
18 facility basis? What's the role there?
19 And you know, all present recognize
20 that we had not really taken a deep dive into the
21 inter facility issue with respect to, you know, our
22 advanced life support providers in some years. Many
23 of you remember that Dr. Deborah Funk emergency
24 medicine physician from the Albany area, led a task
25 force for the state council, you know, which focused

1 2/8/2023 - SEMAC - Troy, New York
2 in large measure on area ambulance issues.
3 But there are significant ground
4 transport issues as well. And so the thought came
5 from the group that discussed these issues that
6 perhaps it was high time that we get together a group
7 involving experts from both SEMAC and E.M.S.C. to
8 look at the more -- the broader issue inter facility
9 transport overall, and the potential role of -- of
10 certified E.M.S. professionals in that -- in that
11 realm.
12 So I spoke with Dr. Doynow about this.
13 Dr. Doynow is in agreement that this is perhaps
14 something we should consider. And he asked me to
15 bring it up here to get some feedback from the group.
16 I -- I, speaking for E.M.S.C., I think we would be
17 very, very interested in revisiting this issue.
18 We're particularly concerned about the
19 role of, you know, of advanced life support providers
20 assisting with pediatric transports between
21 facilities. Complicated issue, as you know, because
22 we're talking about, in many ways, Article 28 care on
23 an Article 30 platform. With Article 30 providers,
24 how do we -- how do we sort of, you know, crack that
25 tough nut.

1 2/8/2023 - SEMAC - Troy, New York
2 And so I, on behalf of E.M.S.C., we
3 think it's high time to revisit and I -- that
4 concludes my report. I'll turn the -- turn the
5 program back over to Dr. Doynow for a brief
6 discussion on this issue. Thank you.
7 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
8 **DR. COOPER:** Of course I'll entertain
9 any questions that anyone else may have?
10 **CHAIR DOYNOW:** Anybody have any
11 questions? A discussion on what Dr. Cooper
12 mentioned, do we have anybody who would be interested
13 in forming a taskforce with Dr. Cooper to look at the
14 issues? Okay. Dr. Winslow? Okay. So we have one,
15 two, three.
16 Okay. So what I would suggest is
17 after this meeting, why don't the four of you get
18 together and then decide on how you're going to look
19 at it and can bring it back to the next SEMAC meeting
20 as to where we want to go with this? Okay.
21 Excellent. All right. Quality Metrics would be our
22 next.
23 **MR. VIOLANTE:** Great, thank you so
24 much, Dr. Doynow. David Violante, chair of Quality
25 Metrics, and we put a brief presentation together.

1 2/8/2023 - SEMAC - Troy, New York
2 As you know, our -- our group had worked on a quality
3 improvement manual that's been updated and out. It's
4 on Boardable. And we put a QuickStart guide together
5 with that as well.
6 And so we're very happy with where
7 that's gone. We presented that to this group and to
8 the SEMSCO for feedback. Most of the feedback we've
9 received so far has been very positive. We're
10 encouraged by that. And we'll be looking to move
11 that forward at the SEMSCO meeting following this.
12 As we're waiting for this to come up
13 here, that was one of the first things that we had
14 discussed. The second thing that we had talked about
15 and provided some input on was a run chart. And the
16 ability to look at data, and the data that we had
17 looked at was, the use of blood glucometry and
18 stroke, potential stroke patients pre-hospitally, and
19 how every level of provider had done that over some
20 time as a means to looking at ways to improve the
21 quality of providing that measure.
22 And so that was ... then. And we had
23 asked everybody to be able to look at that measure at
24 their own agencies, and to work with the D.I. team to
25 be able to see what their agency had done and whether

1 2/8/2023 - SEMAC - Troy, New York
2 they could follow the QuickStart Guide and Manual and
3 what that looked like.
4 And some of the -- the feedback from
5 that has been very positive as well. For anybody
6 that's interested, they can go out into the hallway
7 here and check out what their own agencies look like
8 in, not only the image trend space, which is sort of
9 the back of house piece of this, nuts and bolts side,
10 but also the bio spatial side of it too, which is
11 what is going to look a little bit fancier, make it a
12 lot easier, have all these measures up.
13 And providers, agencies, program
14 agencies and med -- medical control physicians won't
15 have to do all the background work that's necessary
16 and image trend, it'll auto populate into bio
17 spatial. To that end, things that we're looking at
18 in terms of measures are what's next.
19 And so we're going to hopefully have
20 those up here fairly soon. If not, we'll just
21 provide a brief discussion about what those measures
22 might look like. Things that we want to do are
23 provide a core group of measures available to
24 everybody around the state that we would like
25 everybody to -- to do. Not as a requirement, but as

1 2/8/2023 - SEMAC - Troy, New York
2 something that they measure at the agency level to
3 demonstrate quality that the state has approved,
4 SEMAC and SEMSCO has approved as well.
5 From there, going out to larger
6 bundles, that would be a second level idea of
7 measures that folks can do that are inclusive of
8 those from E.M.S.C., cardiac measures, stroke
9 measures, STAC, et cetera. And then on from that,
10 much larger group of measures that any agency can do
11 on their own, should they want to.
12 Since the data is out there, it's
13 available. And it's something that we should all be
14 able to use, especially since there are variances
15 from agency-to-agency, region-to-region. And so
16 that's where we stand with those.
17 And so I'm going to turn this over to
18 Dr. Redlener to talk about the measures that -- that
19 we're looking for at the state level. Dr. Redlener.
20 **DR. REDLENER:** Thanks very much.
21 Michael Redlener. I sit on SEMSCO and reporting also
22 out with the -- the quality metrics committee. So to
23 what David has stated, we can move forward in the
24 slides, if you don't mind.
25 I think that the idea about creating a

1 2/8/2023 - SEMAC - Troy, New York
2 set of measures that are, kind of, viewed from the
3 state lens and offered to agencies across the --
4 across the state as measures that are kind of
5 verified as ones that are; one, evidence based, two,
6 clinically useful and three, give another barometer
7 of how we measure quality in E.M.S.
8 The idea is to, you know, that there
9 are existing measures out there that we would adopt
10 as part of this -- as part of this effort. So that -
11 - so that agencies and program agencies could know
12 where -- where they might focus their energies in a
13 productive -- in a productive way.
14 So there -- there's a range of
15 measures from the National E.M.S. quality alliance to
16 the -- there's a Florida project that looked to build
17 measures within NEMSIS. They're all available and
18 accessible through bio spatial.
19 And that's the group of pre-defined
20 measures that we would like to -- to look at as, you
21 know, po -- possibilities as opportunities for the
22 state to -- to look -- look to these already existing
23 measures that we can apply very easily and use it
24 with the quality improvement framework, right.
25 Again, there may be priorities of the

1 2/8/2023 - SEMAC - Troy, New York
2 state, as David mentioned, that are -- that are
3 several measures that the state would like to look at
4 at a -- at a specific time. And then there are, you
5 know, about twenty measures that all exist within
6 NEMSIS that we could use -- agencies could use as a
7 resource to help guide their -- their quality
8 programs.
9 And again, and then in conversation
10 with other organizations making sure that the -- the
11 whole system of care is focused around things that
12 are important to patients. And so that's the idea.
13 You -- you can go to the next slide.
14 And again, these are -- these are
15 familiar to a lot of people through different
16 channels that you've worked with in many different
17 areas related to stroke and STEMI, related to trauma,
18 respiratory pediatrics, et cetera.
19 So there would be a menu of these
20 measures that are op -- options for any given agency.
21 And again, like David said, I would refer you to the
22 bio spatial, right outside the -- the doors, there's
23 an opportunity to see what that would look like.
24 So yeah, I think that there's -- it's
25 a great opportunity. And again, we would roll that

1 2/8/2023 - SEMAC - Troy, New York
2 into the work we've -- we've done around the quality
3 improvement manual, and then, you know, kind of
4 create a quality improvement framework for folks to
5 look at these data and improve.
6 **MR. VIOLANTE:** Next slide?
7 **DR. REDLENER:** Next slide, please?
8 Here's a second set of measures that correspond to
9 the first slide there, things that we're looking at
10 as some of the core measures. Next slide. And so,
11 we'd like to turn it over here next to Peter Brodie,
12 who's going to talk a little bit about bio spatial,
13 just to give you an idea of what it looks like, what
14 to expect, how easy it is to use.
15 I again want to thank the quality
16 metrics team. They've done just a phenomenal job
17 with all of this, and the data informatics team as
18 well for being able to get the data out there,
19 crunching numbers and make it available in both image
20 trend and moving to bio spatial.
21 Our end game with all of this is
22 really for everybody to be able to log in and be able
23 to see their agency's data, do run charts and do
24 quality improvement from this. So Peter, thank you.
25 **DR. BRODIE:** Thank you, David. Peter

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1 2/8/2023 - SEMAC - Troy, New York
2 Brodie, Branch Chief, Data and Informatics Bureau of
3 E.M.S. and Trauma Systems. Bio spatial just, for
4 some of you, may be repetition, but just to clear --
5 to qualify. As soon as data from every software
6 vendor except for G.M.R. is received at this New York
7 State ... it is shipped off to bio spatial usually
8 within two to three minutes. And its analytics are
9 available three to five minutes after that.
10 G.M.R. has a separate contract with
11 bio spatial where they send all of their data
12 together. So that is why they're excluded from the
13 transmissions to bio spatial. Bio spatial provides a
14 variety of analytics. We opted for this display, and
15 to -- to make this brief yet informative.
16 To focus on the quality measure we
17 discussed at the last meeting of this body in
18 December of 2022. This refers to the testing of
19 blood glucose on a statewide basis over a twelve-
20 month rolling period for patients who are considering
21 -- who are being evaluated for potentiality for
22 stroke or a T.I.A.
23 So in this particular graph, it is a
24 twelve-month period and it is showing that eighty-
25 five percent of the time, the providers are looking

1 2/8/2023 - SEMAC - Troy, New York
2 at -- are evaluating the blood glucose on those
3 patients. What this does not take into account is
4 data that is not included on the chart is that, if
5 there was an -- an agency that does not have a ...
6 license and would therefore not be able to complete
7 that.
8 However, we -- the program agencies
9 and the E.M.S. agencies will have a better
10 understanding of that for each individual agency when
11 they're able to look. The data that you're looking
12 at here is statewide. Scroll down, please.
13 This shows that same information over
14 a twelve-month -- over that same twelve-month rolling
15 period in where it stays at approximately the eighty-
16 five to ninety percent. Throughout the course of
17 that, this is a week-by-week representation. There
18 are fifteen data points on there.
19 You can make it so you have just the
20 graphic line where you can make it, so it also has
21 the numbers that are identified as the data values on
22 each of the weeks as Alex turns them on and off. And
23 then scrolling down from the last one.
24 This shows the -- a different graphic
25 representation. The top line is those that included

1 2/8/2023 - SEMAC - Troy, New York
2 the blood glucose testing on the stroke or a T.I.A.
3 potential patient and the bottom red line is showing
4 the numbers who did not receive that.
5 This is all based on statewide data.
6 So there is no exclusions in them except they are 9-
7 1-1 intercept and mutual aid responses only. This
8 does not include inter facility moves for a patient
9 who may have gone to a local critical access hospital
10 and then been transported to a -- to a Stroke Center
11 Primary or Comprehensive Stroke Center.
12 But it does include patients who are
13 dispatched from an urgent care center as most of
14 those dispatches are handled through 9-1-1. So just
15 to further qualify that. Are there any questions on
16 this? And we'll be developing these and working with
17 the Quality Measures Committee to make sure that
18 these are all available.
19 The program agencies were going
20 through some internal review process and making sure
21 that we prepared information for the program
22 agencies. And we hope to have that information
23 completed and the process completed by the end of
24 March, so that in May, we're able to take some next
25 steps.

1 2/8/2023 - SEMAC - Troy, New York
2 Are there any questions on what you
3 have all seen?
4 **DR. BRODIE:** I'd just like to conclude
5 with that. It's been a pleasure working with David
6 and Dr. Redlener and -- and the remainder of the
7 quality metrics team. There's a lot of passion and
8 interest in not only data, which excites me, but also
9 combining the two together and using that data to
10 make it actionable. So -- so it's very exciting.
11 There is a bit -- yeah, there is if
12 any of you had attended vital signs, Dr. Alex Mold
13 (phonetic spelling) sitting next to me, Alex Blue
14 (phonetic spelling) who's over the ... meeting, were
15 presenting that and showing the two different sets of
16 analytics that are available with both tableau and
17 bio special and Alex Mold will be here for the rest
18 of the day to do that. Thank you, Mr. Chairman.
19 **CHAIR DOYNOW:** Okay, thank you, Dr.
20 Redlener and Dr. Brodie and Peter. Any comment from
21 E.M.S. Sustainability Committee? Okay, all right.
22 Moving on then. So old business, Ryan, if you want
23 to discuss the State E.M.S. Medical Director?
24 **MR. GREENBERG:** Sure, so that is
25 progressing along. It's going through some processes

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1 2/8/2023 - SEMAC - Troy, New York
2 on how it's going to do some back and forth going
3 through the department on how it's exactly going to
4 get put out there in position-wise and categories.
5 So hopefully by the main meeting that will have some
6 progress to it.
7 **CHAIR DOYNOW:** Excellent. Any
8 discussion on matters? The presentation?
9 **DR. LYNCH:** Yup.
10 **CHAIR DOYNOW:** Okay.
11 **DR. LYNCH:** Peter, can someone pull
12 that up? The matters presentation.
13 **DR. BRODIE:** ...
14 **DR. LYNCH:** The matters presentation.
15 It's a couple hundred slides so it might take a
16 little while to load. Mr. Chair, would you like to
17 move to another item while they're working?
18 **CHAIR DOYNOW:** It's up. Okay, we'll
19 wait.
20 **DR. LYNCH:** Okay. I'll also thank Dr.
21 Dailey for adding -- adding some shadowing to the
22 graphics on this presentation. Is that as good as
23 we're going to get? All right, we'll -- we'll roll
24 with this, for the sake of time. Thanks. So I'm
25 Josh Lynch from Buffalo, New York. And we -- we -- I

1 2/8/2023 - SEMAC - Troy, New York
2 brought this up in about two minutes last -- last
3 meeting and appreciate the opportunity to walk
4 through, I believe, six slides today.
5 So the -- the Matters program is -- is
6 a resource that is available to any first responder
7 agency in the state and has been for the last roughly
8 month. You can go to -- go scroll down. Yes. So we
9 -- we -- we built this program as kind of a
10 collection of resources That all aim to help reduce
11 the obstacles that patients need to get over to get
12 to treatment.
13 There -- there are a few things here
14 and I'll direct you to the website and I'll also
15 throw some one pagers and some cards up in the corner
16 table here where Mr. Brodie was sitting just a few
17 minutes ago. You can go to the next one.
18 So the prog, this program really was
19 centered around the emergency department initially
20 about five years ago when -- when it started and we
21 quickly realized that there are other environments
22 where patients with substance use disorder and mental
23 health issues exist and need to be linked to
24 treatment and an easy and efficient and our approach
25 is an electronic way without requiring any phone

1 2/8/2023 - SEMAC - Troy, New York
2 calls, waiting on hold, anything like that.
3 So the -- the referral environments
4 are on the left of the slide and -- and, as I
5 mentioned, the emergency department is where it
6 started. Referrals can also be made out of
7 correctional facilities, inpatient hot, inpatient
8 units, through telemedicine and also, of course,
9 through first response agencies, primarily, E.M.S.
10 and law enforcement across the state. You can go
11 down to the next one.
12 So here you'll see where the program
13 is active. We have a little bit of work to do in the
14 North Country. If anyone's from there and is
15 interested in chatting, please let me know. But we
16 refer out of about one hundred hospitals across the
17 state and many other organizations such as
18 correctional facilities, either county jails, or
19 state prisons, drug courts, other -- other entities
20 and we refer into a network of about two hundred
21 different treatment organizations that offer a
22 variety of substance use disorder, care, mental
23 health care.
24 We don't own any of these clinics. We
25 don't have a financial interest in any of the

1 2/8/2023 - SEMAC - Troy, New York
2 clinics. We really kind of exist in the middle space
3 that helps facilitate the linkage.
4 There -- there is one other component
5 that's a little less relevant here. But we also
6 through the course of a referral if someone doesn't
7 have insurance, we issue them a two-week voucher to
8 cover the cost of buprenorphine or suboxone was one
9 of the formulations. If they don't have insurance,
10 they get a voucher to cover medi -- their medication
11 and those vouchers can be redeemed at Walgreens,
12 Wegmans, CVS or Duane Reade and a bunch of
13 independent pharmacies across the state.
14 That's a little bit more relevant to
15 the emergency department side where a patient might
16 be getting a prescription. But that -- that is a
17 resource that's given for free to the patient through
18 the course of any referral, whether it's coming from
19 the hospital, or someone's living room, or the side
20 of the road, or the gas station bathroom. You can go
21 to the next one.
22 So really, there are two ways to make
23 -- to make a referral. I'll show you what that looks
24 like. Both of which really hinge on providers
25 downloading the free Matters App from Google Play or

1 2/8/2023 - SEMAC - Troy, New York
2 the Apple store. You can either refer a patient to
3 telemedicine or you can complete a Matters referral
4 on the web, on the app, which takes about three
5 minutes.
6 If you are in the eight counties of
7 Western New York, sorry, the rest of the state.
8 There is a third option, that is a twenty-four hour
9 hotline that are these business cards that I'll leave
10 up on the corner of the counter. So if you're from
11 one of the eight counties of Western New York, you
12 can take a stack of these. And all you have to do is
13 just give it to the -- give it to the patient.
14 So I know shuffling cards around
15 ambulances and fly cars can be a challenge. So the
16 app is really the primary base. But a real quick way
17 to do it would be to just leave the card and then the
18 patient can make the phone call. That's a little
19 less of a warm handoff as going through the app and
20 actually making them an appointment. But in some
21 cases, that might be the best we can get. You can go
22 to the next one.
23 So when you open the app up, you can
24 click on the first responder and your options are
25 listed on the -- on the second screenshot here. And

1 2/8/2023 - SEMAC - Troy, New York
2 really, the options are, re -- request a telemedicine
3 evaluation or refer a patient. And the tel -- it's
4 pretty self-explanatory. There will be some one
5 pager forms that are left up here also. And if you
6 go to the next slide, I'll show you why that becomes
7 important.
8 If you click refer a patient, you have
9 to type in an authentication code. This portion of
10 the program is in partnership with the New York State
11 Department of Health. The authentication code is on
12 all of these one-pagers. Once you see it, it's --
13 it's the same for everybody. It's not a user
14 account. It's just, one -- one other layer to get
15 in. But it's on all of these cards and also on the
16 Boardable PDF document that is on there. So go to --
17 you can go to the next one.
18 So if you type in MATTERS network on
19 either one of those, you'll get there. Or you can
20 snap the QR code on the bottom of the one pager. Go
21 to the next one, please.
22 So there's a little demographic
23 information that's collected on the patient. And
24 then based on their address, they're shown a map with
25 indicators of treatment organizations that we partner

1 2/8/2023 - SEMAC - Troy, New York
2 with. So it's not just for opioid use disorder.
3 It's also inclusive -- and also inclusive of other
4 substance use disorders and other hard to -- hard to
5 treat, or hard to link diagnoses such as HIV and
6 hepatitis.
7 This is the way it looks today. In
8 about six months, the platform will be a bit more
9 nimble. And we're -- we're excited about that. So
10 that will allow referrals for mental health as well.
11 But the patient -- you and the patient can see what
12 services are offered at the location they pick. Then
13 they just click select date. There are about two
14 thousand weekly appointments slots across the state.
15 So tons of availability. Lots of capacity. And
16 that's, you know, really it almost in every corner of
17 the state.
18 You can click the next one. So all
19 the information is sent behind the scenes. You don't
20 have to make any phone calls and -- and really all
21 this, this whole process is very fast. Go ahead.
22 So we talked a little about the
23 medication voucher. If someone needs transportation
24 assistance, it's just a question, do you need
25 transportation assistance. If they hit yes, they're

1 2/8/2023 - SEMAC - Troy, New York
2 issued instructions for an Uber voucher or a one
3 round trip Uber voucher, if they hit no, they're not.
4 We're working with other ride sharing partners to be
5 able to make that transportation assistance piece a
6 little bit more robust.
7 We also have on the website or on the
8 app, the ability to send free fentanyl test strips to
9 your organizations. I think the max is about a
10 thousand that you can request. It's free. You just
11 go on the app, enter the information and -- and we
12 will mail them to you. There's no catch. You can go
13 to the next one.
14 So just, I just wanted to acknowledge
15 if you're thinking about unseen time, I spent a fair
16 amount of time in the field and still try to, but
17 thinking about approaching this patient population
18 can be a challenge. It can be a challenge for the
19 patient. It can be a challenge for us as medical
20 directors. It's certainly challenging for our crews
21 that are out -- out -- out on the streets going to
22 calls.
23 And I think a lot of the -- the root
24 of those challenges really may be the fact that we
25 don't have much to offer. So this can, this -- this

1 2/8/2023 - SEMAC - Troy, New York
2 quick three minute time investment on scene really
3 can change the course of the relationship. Could
4 potentially change the -- the likelihood that the
5 patient -- that you'll be back at that address
6 tomorrow. It doesn't solve all the problems but it
7 certainly is a -- a way to head in the right
8 direction. So you can go to the next one.
9 That's really it. Thanks for a few
10 minutes. Sorry, it was twelve, it was thirteen
11 slides. Please accept my apologies. So the -- the
12 resource documents will be up there and their
13 business cards will be there too. Just so you know,
14 there's two stacks. A stack of papers for Western
15 New York and a stack of papers for everyone else.
16 I'll throw my cards up there too, if you have any
17 questions or want to talk offline. Thank you very
18 much.
19 **CHAIR DOYNOW:** Thank you. Anybody
20 have any questions, comments?
21 **MR. GREENBERG:** What's been the use?
22 **DR. LYNCH:** What -- what -- I'm sorry?
23 **MR. GREENBERG:** Like, what's the buy
24 in? How many people are using it on a weekly basis
25 or, you know, like, you see and can you tell if

1 2/8/2023 - SEMAC - Troy, New York
2 E.M.S. who's using it or facilitating that ...
3 **DR. LYNCH:** Yeah, so. I don't -- I
4 don't have -- I don't have that specific data with me
5 today. But we do have the ability -- we do have the
6 ability to report back either to the E.M.S. agency
7 that we can get that granular to show how much, what
8 you were referring.
9 There are several folks in the room
10 that use this program in their respective hospitals
11 and, you know, if they would like to know how many
12 patients were referred in the last quarter, we can
13 provide that information to them really easily. We
14 can also show them where the referrals were -- were
15 sent to.
16 **MR. GREENBERG:** Thanks. And I guess
17 the other question I would just have, as it tends to
18 be a hot button issue is, you spoke about it for
19 mental health as well going forward?
20 **DR. LYNCH:** Correct. So the -- the
21 current version on the app, when you click, when you,
22 when the map comes up and you click on a marker to
23 see where the treatment organization, what -- what
24 place it is, it will, also will show you what
25 services are offered there.

1 2/8/2023 - SEMAC - Troy, New York
2 So for today, you'll see if it's
3 offered mental health or not. In the -- in the new
4 version that will roll out later this year. The
5 experience will be, you enter what type of problems
6 the individual has. And then it shows you the
7 resources that treat those problems.
8 So you could potentially do a mental
9 health only referral later this year. Now, it's
10 still driven around substance use disorder but that
11 programming is in the works to kind of roll out
12 version two of this, which will be much more
13 inclusive mental health, hepatitis, HIV and really
14 all substance abuse disorders including alcohol.
15 **MR. GREENBERG:** So I guess the
16 question I have on mental health is, do you think
17 you'd be able to keep up with it? And -- and I only
18 say it from a point of view of we constantly hear the
19 issues with access to mental health care and, you
20 know, those things and I guess, how -- how do you,
21 yeah, anything?
22 **DR. LYNCH:** So we, not surprising, we
23 were asked that question a lot when we thought --
24 when we were venturing into doing this for opioid use
25 disorder and the relationships that we've made across

1 2/8/2023 - SEMAC - Troy, New York
2 the state. As far as chip, every organization kind
3 of chips in a little bit of appointment availability.
4 I think we've -- I think we've been successful in
5 proving the concept.
6 Now that we're up to two thousand
7 weekly appointment slots before we have even engaged
8 for additional re -- additional slots for mental
9 health. So I -- I would say the answer is we can
10 confidently keep up.
11 **MR. GREENBERG:** I think that's awesome
12 and the work that you're doing and thanks for
13 presenting and giving some more insight even if you
14 are more favorable to the western side, we look
15 forward to the other side as well.
16 **DR. LYNCH:** Yeah, thanks. I won't
17 comment on that second part.
18 **DR. DAILEY:** So actually from the
19 other side. So from the eastern side, I -- I, you
20 know, just to let you know, Josh and I actually
21 presented together to the Sheriffs' Association at
22 their annual meeting. And I think we were both
23 really favorably really pleased at how welcoming the
24 Sheriffs were, how much they wanted to hear about
25 other opportunities they could bring to the citizens

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1 2/8/2023 - SEMAC - Troy, New York
2 in their counties.
3 What we're seeing here is some of the
4 Sheriff's departments using this MATTERS access when
5 E.M.S. hasn't even -- even become a part of that
6 patient care. Because the Sheriff's deputies will be
7 at the scene. They'll recognize that there are
8 concerns with opioid use disorder and a couple of the
9 folks within any of these departments may end up
10 becoming specialized in dealing with this population
11 of -- of individuals.
12 And they're doing some real good
13 there. The other thing that tied into that, that
14 remains an E.M.S. initiative as well, is the lead
15 behind the ... program which I can't say enough about
16 how that, how much that's helping. So I think this
17 is just all different pieces of a comprehensive
18 approach to a really complicated problem.
19 **CHAIR DOYNOW:** Dr. Berkowitz?
20 **DR. BERKOWITZ:** Yeah, I just wanted to
21 add one part of that, other part of that problem is
22 just getting ... in the field and getting on the
23 formulary. So I don't know if there's any update on
24 where we are with that.
25 **DR. LYNCH:** So Dr. Dailey, would you

1 2/8/2023 - SEMAC - Troy, New York
2 prefer to talk about this?
3 **DR. DAILEY:** I have not gotten a
4 recent update from Bureau of Narcotics Enforcement.
5 There is commentary on it in the Governor's budget
6 proposal and I'm looking forward to my next
7 conversations with B.N.E.
8 **DR. LYNCH:** I will say that we -- we
9 have a protocol prepared for E.M.S. agencies and we
10 have no less than four agencies that are literally
11 ready to go today to provide buprenorphine in the
12 E.M.S. setting after overdose. And we -- we -- we, I
13 also look forward to further discussions with the
14 B.N.E. so we can push this forward take care of
15 patients.
16 **CHAIR DOYNOW:** Excellent. Thank you
17 for all your good work. Any other comments? Okay,
18 moving along. E.M.S. hospital wait times and
19 diversions as most of you probably know, there is a
20 meeting at the Plaza which will be starting about one
21 thirty specifically with the Health Department to
22 discuss the issue of E.M.S. wait times and diversions
23 that we are sending two representatives Dr. Cushman,
24 who's going over, and Mark Phillipy will also be
25 there.

1 2/8/2023 - SEMAC - Troy, New York
2 And I would assume anybody else that
3 would like to leave this meeting and go there.
4 You're certainly welcome to do so.
5 **MR. GREENBERG:** You can't be
6 encouraging people to leave our meeting. That
7 meeting is recorded. You can watch it later. Dr.
8 Cushman, Former Chair Phillipy, thank you for your
9 help in -- in relaying that information.
10 There's a series of presenters at the
11 PHHPC meeting on this topic. Deputy Commissioner,
12 Dr. Morley is also there, and has been working with
13 Dr. Heslan (phonetic spelling) ... the first Deputy
14 Commissioner, Deputy Director Dziura will be
15 presenting different data points from the Bureau side
16 and information. So we're really excited about this.
17 And -- and thank you to Steve Kroll for -- for
18 bringing it up to have that discussion, you know, is
19 really, I think, brought together two excellent
20 counsels.
21 I think this is, you know, one topic
22 for them to discuss. But hopefully this opens the
23 door for future conversations and future
24 collaboration. I think, especially as we see more
25 and more collaboration happening in different topics

1 2/8/2023 - SEMAC - Troy, New York
2 and, you know, I think this is -- this is excellent.
3 And so that -- that is being recorded, it should be
4 posted. I'm not sure how long it takes to get
5 posted.
6 But so for anyone who does want to
7 watch, we will -- when I find the link to that we'll
8 make sure to share it with all the members as well
9 and let them, you know, kind of see what's there.
10 But ... speaking, Greater New York is speaking, the
11 Bureau is speaking. I believe Jeremy's representing
12 ASEP. Mark Phillipy is representing the -- the State
13 Council.
14 So a number of different avenues
15 looking at it from different directions. So we're --
16 we're excited to see to start the conversation and to
17 see kind of where things go. This is, I believe,
18 today if I remember correctly, is that like their
19 equivalent of a systems committee so, you know, it's
20 a commit -- at -- at a committee level and then the
21 PHHPC will be brought up to the PHHPC meeting as a
22 report out similar to what happens here.
23 **CHAIR DOYNOW:** Excellent, thank you.
24 Moving along Suffolk County in Northwell I'm happy to
25 announce that -- that issue has been resolved. I

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1 2/8/2023 - SEMAC - Troy, New York
2 want to thank both parties for working together and
3 resolving it. New business. Senate Bill S9407B
4 that's on the agenda. Who wants to comment on that?
5 Okay, we'll move along since no one's
6 going to comment on that. It was new business.
7 **DR. WINSLOW:** Just for clarification,
8 was that the body armor thing? Didn't we handle that
9 already?
10 **CHAIR DOYNOW:** Ryan, you going to take
11 a look and see? No other announcements. Anybody
12 have anything else they want to bring up before we
13 end the meeting? And give you guys back an extra
14 half hour time. Hang on one minute while we're
15 looking at the Senate Bill that was put up. It is
16 body armor, so that's resolved. Okay. A motion to
17 adjourn.
18 **DR. MARSHALL:** So moved.
19 **CHAIR DOYNOW:** Anybody seconded?
20 **DR. LYNCH:** Second.
21 **CHAIR DOYNOW:** Second. Any -- anybody
22 against? Okay, we'll see you guys in a few months.
23 (The meeting concluded at 12:49 p.m.)
24
25

1 2/8/2023 - SEMAC - Troy, New York
2 STATE OF NEW YORK
I, DANIELLE CHRISTIAN, do hereby certify that the
3
foregoing was reported by me, in the cause, at the time
4
and place, as stated in the caption hereto, at Page
5
hereof; that the foregoing typewritten transcription
6
consisting of pages 1 through 65, is a true record of all
7
proceedings had at the hearing.
8
IN WITNESS WHEREOF, I have hereunto subscribed
9
my name, this the 23rd day of February, 2023.
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DANIELLE CHRISTIAN, Reporter
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19
20
21
22
23
24
25

A

A.E.M.T.s 25:11
A.L.S 22:10,21
a.m 1:7 3:2
A.M.T 16:11
A.M.T.s 16:20
ability 26:23,24 30:15 39:16 56:8 58:5,6
able 9:23 10:11 20:14 29:25 39:23,25 41:14 44:18,22,22 46:6,11 47:24 56:5 59:17
absolutely 11:24
abstaining 15:19 16:5
abstentions 15:3
abuse 59:14
Academy 33:25
accept 15:15 57:11
access 47:9 59:19 61:4
accessible 42:18
accessing 26:14
account 46:3 54:14
accreditation 32:4
acknowledge 56:14
action 12:10,11,12
actionable 48:10
active 35:14 51:13
actors 22:22,22
add 61:21
added 34:18
adding 49:21,21
addition 27:24 34:16
additional 20:15 34:6,12 60:8,8
address 54:24 57:5
addressed 35:18
adjourn 65:17
adjustments 27:17
administered 28:22 30:24
administering 27:11
adopt 42:9
adult 16:17
adults 16:16,23
advanced 31:2 36:22 37:19
advisement 11:19
advisory 1:5 15:23,24
age 19:16
agencies 7:10,15 21:25 23:17 32:17 39:24 40:7,13,14 42:3 42:11,11 43:6 46:8,9 47:19,22 51:9 62:9,10
agency 15:25 16:3 39:25 41:2,10 43:20 46:5,10 50:7 58:6
agency's 44:23
agency-to-agency 41:15
agenda 32:15 65:4
aggregate 31:5
agitation 33:3,22
ago 50:17,20
agreement 37:13
ahead 8:15 31:14 55:21
aid 47:7
Aidan 5:3
AIDEN 2:14
aim 50:10
airway 16:15
Albany 36:24
albuterol 19:25 20:12,12
alcohol 59:14
Alex 46:22 48:12,13,17
allegiance 3:6,7
ALLEN 2:5
alliance 42:15
allocated 7:12
allow 22:2 55:10
Alternately 19:4
alternative 16:15
ambulance 37:2
ambulances 53:15
America 3:8
amount 13:3,22 56:16
Amy 2:16 19:10,13 34:25 35:12
Amy's 35:7,16
amy.eisenhauer@health.ny.gov 19:11
analysis 25:19
analytics 45:8,14 48:16
anatomic 34:14
Ann 5:7
announce 64:25
announcements 65:11
annual 60:22
answer 60:9
answered 30:8
anybody 5:22,25,25 7:13 15:2,19 15:19 16:5,5 23:9 38:10,12 40:5 57:19 63:2 65:11,19,21
anybody's 7:6
anyone's 51:14
apologies 57:11
app 52:25 53:4,16,19,23 56:8,11

58:21
APPEARANCES 2:2
applaud 11:10
Apple 53:2
application 27:7
applications 7:20 25:14
apply 42:23
appointment 53:20 60:3,7
appointments 55:14
appreciate 50:3
approach 50:24 61:18
approaching 56:17
appropriately 3:19 7:11 35:18
approval 5:21 9:20
approve 14:19 15:22
approved 30:19 41:3,4
approves 16:3
approximately 46:15
area 36:24 37:2
areas 26:13 43:17
arm 6:21
armor 65:8,16
arose 35:19 36:15
arrest 21:17
arrests 21:24
ARTHUR 2:12
Article 37:22,23,23
ASAP 33:15
ASEP 64:12
aside 34:10
asked 19:15 28:14 32:24 37:14 39:23 59:23
asks 30:8
aspects 27:11
assist 21:10 23:24 24:11
assistance 23:22 29:6 55:24,25 56:5
assisting 37:20
associate 30:20
Association 24:3 35:14 60:21
assume 15:3,20 17:5 63:2
asterisk 16:24
Ativan 19:25
Atrovent 20:12
attend 34:24
attended 48:12
authentication 54:9,11
authority 22:15,20
auto 40:16
availability 55:15 60:3
available 18:22 24:6 30:23 35:4 35:6 40:23 41:13 42:17 44:19 45:9 47:18 48:16 50:6
avenues 64:14
aware 31:7 34:16
awesome 60:11

B

B.L.S 15:16 26:17
B.N.E 62:7,14
back 9:19 10:16 20:16 21:14,20 38:5,19 40:9 49:2 57:5 58:6 65:13
background 40:15
bad 22:22,22
Ballroom 1:12
barometer 42:6
Barzilay 5:3
base 53:16
based 10:20,23 42:5 47:5 54:24
basically 25:22
basis 36:18 45:19 57:24
bathroom 52:20
becoming 61:10
behalf 38:2
believe 12:12 50:4 64:11,17
benchmarking 22:3
benefits 22:13
Benenati 11:13
Berk 3:21
Berkowitz 2:4 3:21,22 17:7,8 61:19,20
Berry 3:23
best 53:21
beta 7:22
better 15:8 29:9 46:9
big 29:23 31:21 33:15
biggest 6:10
Bill 65:3,15
bio 40:10,16 42:18 43:22 44:12 44:20 45:3,7,11,13,13 48:17
bioscience 8:15
bit 26:18 28:4 29:9,16,20 31:7 35:9 40:11 44:12 48:11 51:13 52:14 55:8 56:6 60:3
blood 39:17 45:19 46:2 47:2
Blue 48:13
Boardable 27:9 39:4 54:16
bodies 9:14 12:22
body 14:13,21 23:23 24:12 45:17

65:8,16
bolts 40:9
Bombard 2:9 3:23,24,24 17:9,10
bottom 16:18 17:2 47:3 54:20
Branch 45:2
BRIAN 2:8
brief 6:5 38:5,25 40:21 45:15
bring 12:4,4 20:16 21:14 32:8 37:15 38:19 60:25 65:12
bringing 63:18
broader 37:8
Brodie 2:17 44:11,25 45:2 48:4 48:20 49:13 50:16
brought 16:10 50:2 63:19 64:21
buckets 6:19
budget 13:2,3,4,10,18,23 27:13 62:5
Buffalo 49:25
build 42:16
built 50:9
bunch 52:12
bundles 41:6
buprenorphine 52:8 62:11
bureau 6:2,12 27:9,18 28:14,20 28:24 29:10,25 34:2 35:9 45:2 62:4 63:15 64:11
Bureau's 29:2
Burlington 26:10
business 48:22 53:9 57:13 65:3 65:6
button 58:18
buy 57:23

C

C.F.R.s 25:10
call 3:20 8:13 14:23,25 17:6 53:18
called 25:20 28:16
calls 51:2 55:20 56:22
cannula 35:21,25 36:4,8
capacity 55:15
caption 66:4
card 53:17
cardiac 21:17,24 41:8
cards 50:15 53:9,14 54:15 57:13 57:16
care 23:2 24:15 32:16,18 33:7 36:10,17 37:22 43:11 47:13 51:22,23 59:19 61:6 62:14
CARES 21:17
CARL 2:10
cars 53:15
cases 53:21
catch 56:12
categories 49:4
cause 34:12 66:3
center 32:25 34:15 47:10,11,13
centered 50:19
centers 26:15
centralized 6:15
certainly 56:20 57:7 63:4
certificate 30:17,20
certificates 25:15
certification 28:5
certified 37:10
certify 66:2
cetera 41:9 43:18
chair 1:8 3:3 5:16,20,24 8:20 14:4,24 15:6,10,18 16:4 17:5 18:12 24:23 25:2 31:13 32:12 38:7,10,24 48:19 49:7,10,16 49:18 57:19 61:19 62:16 63:8 64:23 65:10,19,21
Chairman 48:18
challenge 53:15 56:18,18,19
challenges 13:20 56:24
challenging 56:20
chance 10:7
change 13:18 14:16,20,22 16:10 16:22 17:6 25:24 34:5 57:3,4
changed 26:7
changes 10:9 13:5,10 21:12 34:6
changing 16:16
channels 43:16
chart 39:15 46:4
charts 44:23
chatting 51:15
check 40:7
chief 11:13 45:2
child 35:10
children 33:8
chip 60:2
chips 60:3
Christian 1:16 66:2,11
circumstance 36:16
cities 15:16
citizens 60:25
clarification 17:4 20:21 65:7
class 25:17
clear 45:4

cleared 9:7
click 53:24 54:8 55:13,18 58:21 58:22
clinically 42:6
clinics 51:24 52:2
close 10:15
closed 32:20
code 54:9,11,20
collaboration 21:24 34:21 63:24 63:25
collaborative 15:15 16:13 21:13
colleagues 31:10
collected 54:23
collecting 27:6
collection 50:10
combination 20:13
combining 48:9
come 7:7 9:13,19 13:10 14:12 24:20 25:8 27:17 39:12
comes 14:19,21 15:22 58:22
coming 26:19 28:10 32:9 52:18
commenced 3:2
comment 9:11,13,16,17,18,21,22 9:22 10:2,3,12,17 12:3 23:9 23:21 48:20 60:17 65:4,6
commentary 62:5
comments 10:8 13:17 57:20 62:17
Commissioner 63:11,14
commit 64:20
committee 1:5 9:14 11:3 12:2,13 25:3 27:14 41:22 47:17 48:21 64:19,20
committees 8:4
community 11:23 12:21 33:14
complete 32:18 46:6 53:3
completed 47:23,23
complicated 37:21 61:18
complimented 24:14
component 52:4
comprehensive 26:25 47:11 61:17
comprised 29:7
computer 29:2
concept 60:5
concerned 37:18
concerns 34:12 61:8
conclude 48:4
concluded 65:23
concludes 38:4
conference 8:15,16
confidently 60:10
confirm 8:18
consider 37:14
considered 35:13
considering 45:20
consisting 66:6
constantly 59:18
contemporary 28:6
continue 6:7 7:3 23:7
continues 9:5
contract 45:10
contracts 7:3
contribution 35:16
control 40:14
conversation 11:14 43:9 64:16
conversations 36:7 62:7 63:23
Cooper 2:12 3:25 4:2 5:24 17:11 17:12 23:12 32:13,14 38:7,8 38:11,13
coordinating 16:25
Coordinator 32:19
Coordinators 32:17
copy 12:12
core 7:10,14 26:6,8,20 27:16 29:11 31:6 40:23 44:10
corner 50:15 53:10 55:16
correct 11:4 21:4 58:20
correctional 51:7,18
correctly 64:18
correspond 44:8
cost 27:10 52:8
council 11:11,11 13:13 19:6 24:13 36:25 64:13
councils 9:15
counsels 63:20
counter 53:10
counties 53:6,11 61:2
country 26:4 51:14
county 30:25 51:18 64:24
couple 14:15 49:15 61:8
course 27:5 29:12 35:7 38:8 46:16 51:8 52:6,18 57:3
courses 25:9,21,25 26:5 27:21 30:15,15
courts 51:19
cover 52:8,10
COVID 32:21
crack 37:24
create 26:25 44:4
creating 41:25
credentialing 22:10,15 24:21

crews 56:20
criteria 34:11,15,18
critical 26:23 36:10,10,17 47:9
crunching 44:19
culture 23:13,14,18
current 58:21
currently 8:12 25:2 27:7 29:17
curriculum 31:24
Cushman 2:7 4:3,4,4 17:13,14,14 62:23 63:8
cutting 24:14
CVS 52:12

D

D.I 39:24
Dailey 2:11 4:5,6,6 16:14 17:15 17:16 23:11,19,20 24:24 35:2 49:21 60:18 61:25 62:3
Dailey's 23:10
DANIEL 2:6
Danielle 1:16 66:2,11
data 8:2,6 19:15,16 20:14,15,23 27:7 31:5 39:16,16 41:12 44:5 44:17,18,23 45:2,5,11 46:4,11 46:18,21 47:5 48:8,9 58:4 63:15
date 1:6 10:20,21,23 55:13
David 2:13,16 38:24 41:23 43:2 43:21 44:25 48:5
day 6:19 48:18 66:9
days 8:5
de- 33:6
de-escalation 33:22
deal 23:5
dealing 61:10
Deborah 36:23
Decadron 20:2
December 10:22 45:18
decide 38:18
decision 14:13,21
deep 36:20
degree 30:21 34:19
demographic 54:22
demonstrate 41:3
demonstrating 35:2
demonstration 18:15
denials 25:17
denied 25:16
department 1:3 21:13 22:5,16,23 22:24 49:3 50:19 51:5 52:15 54:11 62:21
departments 32:19 61:4,9
depends 28:18
deputies 61:6
Deputy 63:11,13,14
description 18:21
Despite 26:2
details 19:10
determined 33:4
DeTraglia 3:13
develop 33:10
developed 23:24
developing 47:16
device 15:22,24 16:16
devices 16:2 18:16 35:3,7
diagnoses 55:5
Didn't 65:8
different 26:22 31:20 43:15,16 46:24 48:15 51:21 61:17 63:15 63:25 64:14,15
difficulty 26:14
dipped 26:3
direct 50:14
direction 57:8
directions 64:15
director 3:14 15:25 21:18 48:23 63:14
directors 31:18 32:2,7,8 56:20
discuss 12:4,17 48:23 62:22 63:22
discussed 7:22 18:13 35:22 37:5 39:14 45:17
discussing 14:15
discussion 14:17 15:18 16:4,11 21:10,15 22:10,17 23:6,6 24:21 28:2 30:14 38:6,11 40:21 49:8 63:18
discussions 31:19 62:13
disease 24:11
diseases 23:25 24:15
dislikes 13:17
disorder 50:22 51:22 55:2 59:10 59:25 61:8
disorders 55:4 59:14
dispatched 47:13
dispatches 47:14
display 45:14
distribute 31:6
dive 36:20
diversions 62:19,22

document 11:9 34:10 54:16
documented 19:20 20:7
documenting 20:9
documents 11:8 57:12
doing 7:5 8:2 9:5 20:9 22:13 59:24 60:12 61:12
Don 25:2
DONALD 1:8
door 63:23
doors 43:22
DOUGLAS 2:10
downloading 52:25
downstate 26:20
Doynow 1:8 3:3 4:7,8 5:16,20,24 8:20 14:4,24 15:6,10,18 16:4 17:5,17,18 18:12 24:23 31:13 32:12,14 37:12,13 38:5,7,10 38:24 48:19 49:7,10,18 57:19 61:19 62:16 64:23 65:10,19,21
Dr 1:8 2:3,4,4,6,6,7,7,8,8,9,10 2:11,11,12,13,13,14,15,17 3:12,21,21,22,23,23,24,24,25 4:2,3,4,5,6,7,9,9,10,11,11,12 4:13,14,15,15,16,17,17,18,19 4:20,21,22,23,24,25 5:6,7,9 5:23,24,25 14:5,7 15:5,10,14 15:21 16:8,13 17:3,7,9,10,11 17:12,13,14,15,16,17,19,20,21 17:22,23,25 18:2,3,4,5,6,7,8 18:9,10,25 19:13 20:18,19,22 20:25 21:4,7,9 23:10,11,12,19 23:20 24:18,23,24,25 31:14 32:12,14,14 36:23 37:12,13 38:5,7,8,11,13,14,24 41:18,19 41:20 44:7,25 48:4,6,12,19,20 49:9,11,13,14,20,20 57:22 58:3,20 59:22 60:16,18 61:19 61:20,25,25 62:3,8,23 63:7,12 63:13 65:7,18,20
driven 59:10
drop 6:13
drug 51:19
Duane 52:12
Dziura 63:14

E

E.I.I.C 32:24 33:12
E.M.S 6:11,13 9:4 11:4,6,20,21 11:22 12:9,14,17,19,21,22 13:3,7 19:20 21:20,25 23:13 24:3,6,11,13 27:22 32:17 33:25 35:15 37:10 42:7,15 45:3 46:9 48:21,23 51:9 58:2 58:6 61:5,14 62:9,12,18,22
E.M.S.C 18:22 19:4 32:13,15,23 32:25 34:20 35:6,8 37:7,16 38:2 41:8
E.M.T 25:16,21 31:2,2
E.M.T.s 25:11
earlier 14:9 34:24
early 10:10
easier 40:12
easily 42:23 58:13
eastern 60:19
easy 44:14 50:24
Ed 27:10,15 31:12,16 32:9
edge 24:14
edition 34:7
edits 10:15
educating 24:8
education 6:11,14 7:19 9:10,12 24:24 25:2 30:3 31:18,19 33:4 33:11 34:5,19
efficient 28:20 50:24
effort 42:10
Efforts 33:9
eight 8:18,19,20 25:9,10 53:6 53:11
eighteen 19:18,23
Eighteens 6:14
eighty- 45:24 46:15
eighty-nine 25:12
eighty-two 16:14,15
Eisenhauer 2:16 19:2,11 20:18 20:20,23 21:2,5,8 34:25
either 33:19 51:18 53:2 54:19 58:6
elected 12:22
electronic 26:9 28:17 50:25
eligible 30:22
email 19:10 29:14 30:4
emergency 1:5 19:5 32:16,18,19 33:14,18 36:23 50:19 51:5 52:15
encourage 6:15 9:25 12:2 23:17 29:19
encouraged 39:10
encouraging 21:20 63:6
energies 42:12
enforcement 51:10 62:4

engaged 60:7
enhance 21:18
enter 56:11 59:5
entertain 38:8
entities 51:19
environments 36:2 50:21 51:3
equipped 16:19,25
equivalent 64:19
Erie 26:11
escalation 33:7
especially 41:14 63:24
established 27:24
et 41:9 43:18
evaluated 45:21
evaluating 46:2
evaluation 54:3
everybody 6:8,16,21 9:21 11:25 12:2 15:6,7 20:17 39:23 40:24 40:25 44:22 54:13
everybody's 15:3
evidence 42:5
exact 16:22
exactly 49:3
exam 26:18,22 27:11 29:14 30:4 30:6,11
examiners 27:2
examples 34:12
exams 26:13 28:17,22
excellent 5:20 33:11,12 38:21 49:7 62:16 63:19 64:2,23
Excelsior 30:16
excited 6:18 7:23 11:8 12:5 13:15,24 55:9 63:16 64:16
excites 48:8
exciting 13:12,13 32:10 48:10
excluded 45:12
excluding 15:16
exclusions 47:6
execute 7:3
exist 26:8 43:5 50:23 52:2
existing 42:9,22
expect 44:14
expected 8:24
experience 59:5
experimental 27:7
experts 37:7
exploration 31:4
extra 65:13

F

F 13:14
facilitate 52:3
facilitating 58:2
facilities 37:21 51:7,18
facility 36:9,18,21 37:8 47:8
fact 26:2 36:8 56:24
faculty 7:24,25
fair 56:15
fairly 30:21 40:20
fall 33:23
falls 7:17
familiar 43:15
fancier 40:11
far 12:24 39:9 60:2
fast 55:21
favor 5:25 15:3,7
favorable 60:14
favorably 60:23
February 1:6 66:9
feedback 7:2 8:4 13:13,16 37:15 39:8,8 40:4
feel 7:2
felt 35:23
FEMALE 18:24
fentanyl 56:8
Ferris 1:12
field 31:21,22 32:5 56:16 61:22
fifteen 13:7 46:18
fifty 25:15
fifty-four 20:5
fifty-nine 19:19
fifty-six 25:8
final 9:19
finance 27:14,15,24 28:13
finances 27:21
financial 27:10 51:25
financially 30:22
find 30:10 64:7
finding 26:21
first 12:9,16 14:14 15:9,11 21:25 32:15 39:13 44:9 50:6 51:9 53:24 63:13
fiscal 7:18
five 19:25 45:9,25 46:16 50:20
fix 29:25
fixed 6:25
flag 3:7
Florida 42:16
flow 35:21,24 36:4,8
fly 53:15

focus 6:5 42:12 45:16
focused 34:4 36:25 43:11
focusing 35:10,15
folks 24:4 25:13 41:7 44:4 58:9 61:9
follow 40:2
following 39:11
force 12:10,11,14 36:25
foregoing 66:3,5
forget 18:23
format 31:6
formatting 34:10
Former 63:8
forming 38:13
forms 6:11,13,17 54:5
formulary 61:23
formulations 52:9
forth 10:24 49:2
forty 25:16
forward 7:7 8:3 12:4 13:21,25 14:13,19 15:22 16:10 22:4 23:7 32:9 39:11 41:23 58:19 60:15 62:6,13,14
found 19:3 30:7
four 14:11,12 21:11 38:17 62:10
fourteen 20:10
fourth 16:9
framework 42:24 44:4
free 7:2 52:17,25 56:8,10
frequency 36:9
full 13:9 30:22 32:15
funding 7:11,14 30:14,16,22,24
Funk 36:23
further 14:17 24:20 47:15 62:13
future 63:23,23

G

G.M.R 45:6,10
game 44:21
GANDOLFO 2:10
Garden 1:10
gas 52:20
general 26:21
generate 22:2
getting 6:19 29:14 52:16 61:22 61:22
give 24:10 26:12 28:15 42:6 44:13 53:13,13 65:13
given 32:21 43:20 52:17
giving 60:13
glucometry 39:17
glucose 45:19 46:2 47:2
go 6:6,12,13,18 8:14 9:11,12,15 9:23 10:16,22 25:5 31:14 38:20 40:6 43:13 50:8,8,17 51:10 52:20 53:21 54:6,16,17 54:20 55:21 56:11,12 57:8 62:11 63:3 64:17
God 3:9
goes 9:17 10:12 30:9
Gohlke 35:9
going 6:5 7:21 8:21,24 11:2 12:25 23:7,20 25:3 26:24 27:5 27:14,25 28:23 31:3,9 33:5 38:18 40:11,19 41:5,17 44:12 47:19 48:25 49:2,2,3,23 53:19 56:21 58:19 62:24 65:6,10
Gomez 4:9
good 5:4 6:4 8:3 9:5 14:7,8 22:17 23:17 24:7,21 49:22 61:12 62:17
Google 52:25
gotten 62:3
governing 9:14
Governor's 62:5
graduated 25:25
graduating 26:5
grant 9:4
granular 58:7
graph 45:23
graphic 46:20,24
graphics 49:22
great 13:22 22:10 31:19 38:23 43:25
Greater 64:10
Greenberg 2:3 6:4 21:18 31:15 34:25 48:24 57:21,23 58:16 59:15 60:11 63:5
ground 37:3
group 22:19 27:24 28:11 31:16 32:24 33:3 34:3 35:22 37:5,6 37:15 39:2,7 40:23 41:10 42:19
guess 10:13 58:16 59:15,20
guide 31:24 39:4 40:2 43:7
guidelines 34:8
guys 16:6 65:13,22

H

half 65:14

hallway 40:6
handle 65:8
handled 47:14
handoff 53:19
hands 15:7
Hang 65:14
happen 8:5,7 10:16
happened 14:11
happening 27:4 63:25
happens 29:5 64:22
happy 13:19 19:12 39:6 64:24
hard 55:4,4,5
head 57:7
health 1:3 12:9,9,14 50:23 51:23 54:11 55:10 58:19 59:3 59:9,13,16,19 60:9 62:21
hear 59:18 60:24
hearing 66:7
help 19:12 21:23 22:7 28:16 29:13,16 43:7 50:10 63:9
helped 6:22
helpful 22:4 30:12
helping 32:3 61:16
helps 52:3
hepatitis 55:6 59:13
hereof 66:5
hereto 66:4
hereunto 66:8
Heslan 63:13
high 35:13,21,24 36:4,7 37:6 38:3
Hilton 1:10
hinge 52:24
hit 55:25 56:3
HIV 55:5 59:13
hold 51:2
holding 7:13
honestly 7:16
Hoosick 1:11
hope 9:9 33:21 47:22
hoped 32:22
hopefully 10:7 12:19 13:25 40:19 49:5 63:22
hospital 21:24 47:9 52:19 62:18
hospitals 21:20 22:2 23:14 36:11,12 51:16 58:10
hot 51:7 58:18
hotline 53:9
hour 53:8 65:14
hours 25:18
house 40:9
Howard 31:9
Hudson 25:3
huge 29:24
Hughes 31:9
hundred 19:19 20:5 25:8,9,10,11 25:12,14,15,16 49:15 51:16,20

I

I'd 48:4
idea 23:17 41:6,25 42:8 43:12 44:13
identified 46:21
image 40:8,16 44:19
imbalance 25:17
implement 33:5
important 7:8 9:8 31:16 43:12 54:7
improve 11:20 12:22 13:5 39:20 44:5
improvement 32:25 39:3 42:24 44:3,4,24
include 47:8,12
included 46:4,25
including 59:14
inclusion 34:11
inclusive 41:7 55:3,3 59:13
incorporate 23:18
incorporated 27:12
incorporating 35:21
increase 20:3,6
incredible 11:24
independent 52:13
index 34:17
indicators 54:25
individual 23:4 46:10 59:6
individuals 61:11
indivisible 3:9
informatics 8:2,6 44:17 45:2
information 11:7 13:19 19:2,9 28:15 32:23 33:13,20 35:7 46:13 47:21,22 54:23 55:19 56:11 58:13 63:9,16
informative 45:15
initial 9:8
initially 50:19
initiative 31:25 61:14
initiatives 13:4
Inn 1:10
Innovation 32:25

inpatient 51:7,7
input 39:15
insight 60:13
inspections 6:9
instantaneously 27:4
instructions 56:2
instructor 27:25 28:5
instructors 26:25 28:10
insurance 52:7,9
inter 36:9,17,21 37:8 47:8
interacted 24:4
interacting 28:20
intercept 47:7
interest 48:8 51:25
interested 37:17 38:12 40:6 51:15
interesting 12:8
interface 28:25
internal 47:20
introduce 33:10,10
intubation 23:4
investment 57:2
invoices 7:9
involved 36:17
involving 37:7
ipratropium 20:13
Isaacs 2:10 4:9,10 17:19,20
issue 29:24 35:19 36:21 37:8,17 37:21 38:6 52:7 58:18 62:22 64:25
issued 25:14 56:2
issues 7:6 12:17 22:25 28:9,24 34:9 35:11 37:2,4,5 38:14 50:23 59:19
it'll 40:16
it's 15:9 55:24
item 49:17
items 18:13,22 31:20

J

jails 51:18
JASON 2:11
JEFFREY 2:6
Jenny 9:6
JEREMY 2:7
Jeremy's 64:11
job 20:9 24:7 44:16
Jobs 30:24
join 9:3
joint 27:14
Jon 2:12 5:14
JONATHAN 2:4
Josh 49:25 60:20
JOSHUA 2:8
jump 16:14
justice 3:10

K

keep 59:17 60:10
key 34:9
kind 42:2,4 44:3 50:9 52:2 59:11 60:2 64:9,17
kinds 24:16
know 6:20,24 7:8 9:25 10:4 11:2 12:5 13:21 14:11 20:16 21:22 23:2,3,4,5,13,22 30:10 32:5,5 32:6,10 33:6 36:3,3,5,13,16 36:19,21,25 37:19,21,24 39:2 42:8,11,21 43:5 44:3 51:15 53:14 55:16 57:13,25 58:11,11 59:20 60:20,20 61:23 62:19 63:18,21 64:2,9,19
knows 15:25
Kroll 2:15 5:12,13 63:17
Kugler 4:11

L

labeled 30:17
LANGSAM 2:14
large 37:2
largely 33:4 36:14
larger 41:5,10
late 33:15
law 51:10
layer 54:14
lead 61:14
leader 7:22
learn 23:17
learning 33:24
leave 53:9,17 63:3,6
led 36:24
left 51:4 54:5
legislation 13:23
legislative 12:10,12
lens 42:3
let's 14:25 15:13
letter 21:19 22:6
level 12:20 22:13 39:19 41:2,6 41:19 64:20
LEWIS 2:4

liberty 3:10
license 46:6
lies 22:15
life 36:22 37:19
light 23:10
likelihood 57:4
likes 13:17
limited 35:24
line 13:12 46:20,25 47:3
link 55:5 64:7
linkage 52:3
linked 50:23
Linstrom 15:8,11
listed 53:25
literally 6:19 62:10
little 25:24 26:4,18 28:4 29:9 29:16,20 31:7 40:11 44:12 49:16 51:13 52:5,14 53:18 54:22 55:22 56:6 60:3
live 6:12 10:22
lives 21:23
living 52:19
load 49:16
lobbying 24:4
local 8:14 22:13 47:9
location 1:10 55:12
log 44:22
long 22:9 64:4
longer 8:24
longstanding 3:13
look 6:25 10:3 16:12 19:5 21:14 23:15 27:16,25 28:8 37:8 38:13,18 39:16,23 40:7,11,22 42:20,22,22 43:3,23 44:5 46:11 60:14 62:13 65:11
looked 30:6 39:17 40:3 42:16
looking 13:6 22:5 39:10,20 40:17 41:19 44:9 45:25 46:11 62:6 64:15 65:15
looks 25:20 44:13 52:23 55:7
lose 3:12
lot 11:13 13:21 22:25 31:19 40:12 43:15 48:7 56:23 59:23
lots 8:2 9:5 55:15
Lynch 2:8 4:11,12 17:21,22 49:9 49:11,14,20,25 57:22 58:3,20 59:22 60:16 61:25 62:8 65:20

M

mail 6:19 56:12
main 49:5
mainstay 33:7
major 35:16
making 5:18 12:21 24:15 35:17 43:10 47:20 53:20
management 33:25
manager 35:8
manner 18:18
manual 27:8 39:3 40:2 44:3
map 54:24 58:22
March 47:24
Mark 5:5 62:24 64:12
marker 58:22
Markowitz 2:13 4:13,14 17:23,24
Marshall 2:4 4:15,16 5:23,25 14:6,7 15:5,14,21 16:8 17:3 17:25 18:2,25 19:13 20:18,19 20:22,25 21:4,7,9 24:18,24 65:18
Martha 35:9
Mary 5:7
materials 12:15 33:12
matters 49:8,12,14 50:5 52:25 53:3 54:18 61:4
MATTHEW 2:7
max 56:9
Maynard 4:15
MCEVORY 5:11
McEvoy 2:3 5:10 24:25,25 31:14
mean 22:12 23:5
means 7:2 22:12 39:20
measure 37:2 39:21,23 41:2 42:7 45:16
measures 40:12,18,21,23 41:7,8 41:9,10,18 42:2,4,9,15,17,20 42:23 43:3,5,20 44:8,10 47:17
mechanistic 34:15
med 14:5,9 40:14
medi 52:10
medical 1:5 3:14 15:22,24,25 16:2 24:19 32:7 34:24 40:14 48:23 56:19
medication 19:24 20:11 21:10 23:22 52:10 55:23
medications 19:25
medicine 33:14,18 36:24
medics 25:12
meet 34:14
meeting 3:2,4,18 8:8,8 9:9,10 10:11,14,18 11:8 12:10,16,18

13:2 19:14 21:15 25:4 26:17 28:3,14 31:17 32:10 33:2 35:20 38:17,19 39:11 45:17 48:14 49:5 50:3 60:22 62:20 63:3,6,7,11 64:21 65:13,23
meetings 5:21 14:15
member 3:13 35:14
members 5:2 7:25 11:5,10 12:13 64:8
membership 12:13
memorial 8:17,21,22 9:4
mental 50:22 51:22 55:10 58:19 59:3,8,13,16,19 60:8
mention 3:17 22:9 23:11 30:14
mentioned 13:3 21:19 23:12,21 38:12 43:2 51:5
mentored 32:6
menu 43:19
met 14:9 32:15 33:3 34:3
method 29:10
metrics 38:21,25 41:22 44:16 48:7
Michael 2:11,13 41:21
Midazolam 20:2,12
middle 52:2
Mike 2:3 5:10 24:25 31:14 35:2
million 15:17
mind 41:24
minute 3:12 12:25 57:2 65:14
minutes 5:22 24:19 45:8,9 50:2 50:17 53:5 57:10
misses 23:4
Mold 48:12,17
moment 3:14
money 30:23
month 45:20 50:8
months 10:23 55:8 65:22
Morley 63:12
morning 5:4 6:4 14:8,8 18:18
mother 18:17
motion 5:22 14:19 15:15,21 16:9 18:11 65:16
motions 14:10,12
move 13:21,25 15:13 39:10 41:23 49:17 65:5
moved 65:18
moves 47:8
moving 7:19 8:3 14:5 22:4 44:20 48:22 62:18 64:24
multiple 8:4
Murphy 4:17
mutual 47:7

N

name 3:17 66:9
names 8:18,19,20
Narcotics 62:4
nasal 35:21,24 36:4,8
NASEMSO 19:5,7
nation 3:9
national 24:3 34:8 35:14 42:15
nature 10:5
necessary 40:15
need 6:16 10:9,15 14:22,24 22:20,23 26:25 29:4 30:10 50:11,23 55:24
needed 34:4
needs 6:25 8:8 30:4 55:23
negative 10:5
NEMS 8:8
NEMSIS 8:8 42:17 43:6
neonatal 35:3
neonate 18:15
neonates 18:17,19 35:17
network 51:20 54:18
new 1:1,2,13 2:1 3:1 4:1 5:1 6:1,11,23 7:1,20 8:1,23 9:1 10:1 11:1 12:1 13:1,4 14:1 15:1 16:1 17:1 18:1 19:1,4 20:1 21:1 22:1 23:1,25 24:1,7 25:1,7 26:1,9,12 27:1,13 28:1 28:10 29:1 30:1,2,24 31:1 32:1 33:1 34:1 35:1,2 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1,6 46:1 47:1 48:1 49:1,25 50:1 51:1 52:1 53:1,7,11 54:1,10 55:1 56:1 57:1,15 58:1 59:1,3 60:1 61:1 62:1 63:1 64:1,10 65:1,3,6 66:1,2
newborn 18:14 20:24
newborns 18:16,19
news 33:15
newsletter 33:15
night 31:18
nimble 55:9
nine 25:10
ninety 46:16
ninety-eight 20:7
ninety-two 19:21 25:9

non-voting 5:2
North 51:14
Northwell 64:24
noted 36:7
number 8:7 20:4 26:2 31:20 64:14
numbers 25:24 26:8 44:19 46:21 47:4
nurses 36:14
nut 37:25
nuts 40:9

O

O'Connor 5:3,4
O'CONNOR 2:14
OASIS 9:4
obstacles 50:11
obviously 24:12
occur 27:5 29:8
occurring 29:22
October 8:12
odd 26:12
offer 51:21 56:25
offered 42:3 55:12 58:25 59:3
officer 31:23
official 30:19
Official's 35:15
offline 57:17
Okay 3:15 5:24 6:2,2 15:5,10,14 15:19,21 16:9 17:9 21:7 38:14 38:14,16,20 48:19,21 49:10,18 49:20 62:17 65:5,16,22
old 48:22
Olsson 2:6 4:17,18,18 18:3,4,4
Once 9:17 54:12
one's 65:5
one-pagers 54:12
ones 8:14 25:16 31:21 42:5
online 7:25 8:15
op 43:20
open 10:14 29:10 32:2 53:23
opened 26:10
opens 63:22
operations 6:7,7,11,14 9:11,12
opioid 55:2 59:24 61:8
opportunities 42:21 60:25
opportunity 9:21 32:11 33:20 34:23,25 43:23,25 50:3
opposition 9:18 10:9
opted 45:14
option 24:6,10 53:8
options 24:16 43:20 53:24 54:2
order 33:5 36:6
Oren 5:3
organization 58:23 60:2
organizations 43:10 51:17,21 54:25 56:9
out-of-state 28:10
outside 43:22
overall 12:14 37:9
overdose 62:12
overlooked 26:6
oxygen 19:25 20:11 36:5
OZGA 2:5 3:21,23,25 4:3,5,7,9 4:11,13,15,17,19,21,23 5:2,5 5:7,10,12,14,18 8:19 17:7,9 17:11,13,15,17,19,21,23,24,25 18:3,5,7,9,11

P

P.A 7:3
p.m 1:7 65:23
P.S.C 7:21,23
P.S.I 26:9
packet 11:7 12:15
page 6:12 16:12,13,14,18 19:4,6 30:2,6,8 66:4
pager 54:5,20
pagers 50:15
pages 66:6
paper 11:15,20,21
papers 57:14,15
paperwork 7:20
paramedic 30:15,25 31:17,19,25 32:7
paramedics 26:5 36:16
parking 11:13
part 6:14,22 8:16 11:12,22 12:2 12:7 13:9,14,15 32:4 42:10,10 60:17 61:5,21,21
participate 21:21
participation 21:16 22:7
particular 33:16 45:23
particularly 8:13 24:7 35:25 37:18
parties 65:2
partner 54:25
partners 56:4
partnership 54:10
passed 6:2 15:12,20

passenger 35:10
passes 15:4 18:11
passion 48:7
patient 8:25 16:17 34:13 47:3,8 52:15,17 53:2,13,18 54:3,8,23 55:11,11 56:17,19 57:5 61:6
patients 16:17,21,24 19:3,8,15 19:19 20:8,10 21:3 23:25 24:10,15 35:25 39:18 43:12 45:20 46:3 47:12 50:11,22 58:12 62:15
pay 30:25
paying 29:18
PDF 54:16
pediatric 19:3,5,7,15,19 20:4 20:10 21:2 32:16,18 33:3,22 35:3,16,21,25 36:11 37:20
pediatrics 43:18
Pennsylvania 26:11
people 11:22 24:19 27:15 28:18 29:13 43:15 57:24 63:6
people's 26:23
percent 19:21,23 20:3,8,10 28:21 29:7 45:25 46:16
period 10:8 25:21 45:20,24 46:15
permit 16:20
pertaining 27:21
Peter 2:17 44:11,24,25 48:20 49:11
pharmacies 52:13
phenomenal 19:22 20:9 44:16
PHHPC 63:11 64:21,21
Phillipy 2:15 5:5,6,6 62:24 63:8 64:12
phone 50:25 53:18 55:20
phonetic 4:23 15:11 48:13,14 63:13
physician 36:24
physicians 8:14 24:3 33:18 36:14 40:14
physiologic 34:14,18
pick 55:12
piece 40:9 56:5
pieces 61:17
place 30:12 58:24 66:4
places 26:3
planned 27:4
planning 27:13
platform 37:23 55:8
Play 52:25
Plaza 62:20
please 3:17 6:23 7:7,16 8:14,18 9:3 10:2 12:3 16:14 20:15 44:7 46:12 51:15 54:21 57:11
pleased 60:23
pleasure 48:5
pledge 3:5,7
po 42:21
point 59:18
pointed 18:18
points 46:18 63:15
policies 27:19
policy 14:16,20 15:2 21:11
populate 40:16
population 56:17 61:10
portion 54:9
Portoro 5:7
position-wise 49:4
positive 9:22 13:20 39:9 40:5
possibilities 42:21
possibility 35:20
post 30:2
posted 64:4,5
potential 37:9 39:18 47:3
potentiality 45:21
potentially 57:4 59:8
practical 26:18
pre-defined 42:19
pre-hospital 34:20
pre-hospitally 39:18
pre-register 29:11
pre-registering 29:18
predecessor 35:8
prefer 62:2
prepared 47:21 62:9
prescribed 23:22
prescription 52:16
present 4:16,25 5:6,13,15 36:19
presentation 38:25 49:8,12,14 49:22
presented 39:7 60:21
presenters 8:13 63:10
presenting 48:15 60:13 63:15
presuming 33:17
pretty 33:4 35:23 54:4
previous 5:21 22:6
primarily 25:15 28:25 51:9
primary 6:6 47:11 53:16
priorities 42:25

prisons 51:19
probably 10:14 14:25 18:19 27:5 28:8 32:22 33:24 34:9,19 62:19
problem 28:23 30:5,11 61:18,21
problems 11:23 29:6,7,22 57:6 59:5,7
proceedings 66:7
process 7:24 22:14 27:3 28:16 35:18 47:20,23 55:21
processes 9:8 23:19 29:10 48:25
productive 42:13,13
professionals 37:10
prog 50:18
program 7:10,14 21:17 22:8 25:20 30:16,17,18,20 31:23,23 31:24,25 32:2,5,7 33:23 35:8 38:5 40:13 42:11 46:8 47:19 47:21 50:5,9,18 51:12 54:10 58:10 61:15
programming 59:11
programs 43:8
progress 49:6
progressing 48:25
project 34:22 42:16
promptly 29:20
proposal 62:6
protocol 14:16,20,22 16:10 17:6 21:11,13 23:24 24:8 34:5 62:9
protocols 15:15,16 16:13
provide 7:2 40:21,23 58:13 62:11
provided 39:15
provider 34:13 39:19
providers 11:21 19:20 20:8 21:20 22:11,21 24:6,8,11 25:25 27:22 34:20 36:22 37:19 37:23 40:13 45:25 52:24
provides 45:13
providing 39:21
proving 60:5
psychological 33:6
public 9:11,12,15,17,18,20 10:12,16
publication 33:16,19
publish 10:23
published 10:21
pull 49:11
push 62:14
put 11:19,20,21 14:25 28:11 30:12 31:5,10 38:25 39:4 49:4 65:15
putting 11:15

Q

QR 54:20
qualify 45:5 47:15
quality 22:25 23:2 38:21,24 39:2,21 41:3,22 42:7,15,24 43:7 44:2,4,15,24 45:16 47:17 48:7
quarter 58:12
question 36:15 55:24 58:17 59:16,23
questions 30:7 31:11,13 38:9,11 47:15 48:2 57:17,20
quick 36:6 53:16 57:2
quickly 22:8 30:10 50:21
QuickStart 39:4 40:2
quite 24:9 35:9,23
quorum 5:16,19

R

Rabrich 2:6 5:8,9
raise 15:7
range 42:14
rare 23:25 24:10,15
rate 32:21
rates 27:18
reach 30:5
read 12:3 20:24
Reade 52:12
readily 29:3
ready 25:4,4 62:11
real 53:16 61:12
realistically 10:13
realized 50:21
really 7:8 11:8 12:19 13:15,22 13:24 16:6 19:22 22:10 24:21 36:5,5,20 44:22 50:18 52:2,22 52:24 53:16 54:2 55:16,20 56:24 57:2,9 58:13 59:13 60:23,23 61:18 63:16,19
realm 37:11
reason 15:24
receive 47:4
received 11:6 19:24 20:10 33:18 39:9 45:6
receiving 36:11,12
recertification 28:2,5

reciprocity 25:13,14,15 28:9
recognize 36:19 61:7
recommendations 11:16 12:21 13:8,17
record 66:6
recorded 63:7 64:3
red 47:3
redeemed 52:11
Redlener 2:13 41:18,19,20,21 44:7 48:6,20
reduce 8:7 50:10
refer 24:19 43:21 51:16,20 53:2 54:3,8
referral 51:3 52:6,18,23 53:3 59:9
referrals 51:6 55:10 58:14
referred 58:12
referring 58:8
refers 45:18
reg 9:20
region 23:3
region-to-region 41:15
regional 7:24,25
regions 22:3,11,20
registries 21:21
registry 21:18
regs 10:20
regular 28:23
regulations 9:7,7,10
reimbursed 27:18,20
reissuing 22:6
related 28:25 43:17,17
relates 12:20
relationship 57:3
relationships 59:25
relaying 63:9
relevant 52:5,14
remain 3:12
remainder 48:6
remains 61:14
remember 23:23 36:23 64:18
reminder 6:8
removal 16:23
REMSCO 7:4
REMSCOs 7:10,15 12:5
renewal 7:20
repetition 45:4
replacement 16:23
report 6:3 14:3 24:22 25:5 31:12 32:16 38:4 58:6 64:22
reported 1:16 22:23,24 26:16 66:3
Reporter 66:11
reporting 28:24 41:21
reports 22:2
representation 46:17,25
representatives 62:23
representing 64:11,12
republic 3:8
request 54:2 56:10
requests 20:15
require 17:6
required 33:5
requirement 40:25
requirements 28:4
requires 34:19
requiring 50:25
resolve 22:18
resolved 64:25 65:16
resolving 65:3
resource 30:12 43:7 50:6 52:17 57:12
resources 19:4 36:6 50:10 59:7
respect 36:21
respective 58:10
respiratory 43:18
responder 50:6 53:24
responders 21:25
response 32:21 51:9
responses 47:7
rest 48:17 53:7
result 28:22
review 24:20 33:20 47:20
reviewing 35:6
revising 21:19 22:6
revision 28:7
revisions 14:16 26:17 27:8
revisit 38:3
revisiting 37:17
ride 56:4
right 3:3 6:25 8:25 15:12 21:9 38:21 42:24 43:22 48:21 49:23 57:7
road 52:20
robust 32:22 33:4 56:6
role 35:8,24,24 36:8,18 37:9,19
roll 3:20 14:23,25 17:6 43:25 49:23 59:4,11
rolling 45:20 46:14
room 52:19 58:9

root 56:23
roughly 28:21 50:7
round 56:3
run 25:22 27:21 39:15 44:23
rural 12:9,9,17,23 26:13
Ryan 2:3 6:2 14:4 32:12 34:25 48:22 65:10

S

S 13:15
S.G.A 16:11,20
S9407B 65:3
safe 18:17,17 19:2,7
safely 18:20
safety 35:11
sake 49:24
save 21:23
saw 25:23
saying 29:15
says 16:15,19
scene 57:2 61:7
scenes 55:19
scheduling 29:6,9
scores 29:3
screenshot 53:25
scroll 46:12 50:8
scrolling 46:23
second 5:23 12:7 39:14 41:6 44:8 53:25 60:17 65:20,21
seconded 65:19
section 19:6
see 6:24 9:23 13:12,13,15,24 23:10 31:4 32:9 39:25 43:23 44:23 51:12 54:12 55:11 57:25 58:23 59:2 63:24 64:9,16,17 65:11,22
seeing 8:6 13:14 61:3
seen 8:22 48:3
select 55:13
self-explanatory 54:4
SEMAC 1:1 2:1 3:1,13 4:1 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1,11 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1,20 36:1 37:1,7 38:1,19 39:1 40:1 41:1,4 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1
SEMSCO 9:19 13:14 28:3 39:8,11 41:4,21
Senate 65:3,15
send 45:11 56:8
sending 62:23
sense 22:19
sent 15:23 55:19 58:15
separate 31:15 45:10
separated 6:14
September 10:18
series 36:7 63:10
serve 26:13
services 55:12 58:25
set 12:11 42:2 44:8
sets 48:15
setting 62:12
settings 12:18,23
seven 8:18,18 21:12 25:8,14
seventy-page 11:15
seventy-two 25:10
shadowing 49:21
share 9:24,25 13:19,19,20 20:16 64:8
shared 33:14
sharing 19:17 56:4
Sheriff's 61:4,6
Sheriffs 60:21,24
shipped 45:7
shock 34:17
short- 35:25
shortly 26:20
show 52:23 54:6 58:7,14,24
showing 8:23 45:24 47:3 48:15
shown 54:24
shows 46:13,24 59:6
shuffling 53:14
side 7:3,4 8:9 10:24 40:9,10 52:15,19 60:14,15,19,19 63:15
significant 11:16 20:6 37:3
significantly 26:7,22
signs 8:11 33:23 48:12
silence 3:15
similar 64:22
simple 30:21
sit 41:21
sites 26:10
sitting 48:13 50:16
six 10:23 25:11 30:7 50:4 55:8

sixty-day 10:8
skills 26:18,24
slide 43:13 44:6,7,9,10 51:4 54:6
slides 41:24 49:15 50:4 57:11
slots 55:14 60:7,8
small 29:23
snap 54:20
software 45:5
solve 57:6
somebody 30:9
someone's 52:19
soon 40:20 45:5
sorry 53:7 57:10,22
sort 34:17 37:24 40:8
space 40:8 52:2
spatial 40:10,17 42:18 43:22 44:12,20 45:3,7,11,13,13
speak 3:16 27:13
SPEAKER 18:24
speaking 3:17 37:16 64:10,10,11
special 19:6 48:17
specialized 61:10
specific 19:10 43:4 58:4
specifically 23:24 24:5 27:25 62:21
spelling 4:24 15:11 48:13,14 63:13
spending 11:14
spent 7:12 35:9 56:15
spike 26:4
spoke 37:12 58:18
spoken 11:3
sponsor 27:16
sponsored 33:25
sponsors 7:10,14 25:22 26:6,8 26:20 29:11,17 31:7
spread 33:16
STAC 34:21 41:9
stack 53:12 57:14,15
stacks 57:14
staff 6:2 25:5 27:10
staffed 36:13
stand 3:5 24:9 41:16
standard 14:9
standardized 31:22
standards 8:9 14:5 24:19 34:24
standing 3:12
stands 3:9
start 3:4,17 11:17 64:16
started 14:10 50:20 51:6
starting 11:13 62:20
state 1:2,5 9:6,15 11:11,12 15:16 19:4 22:3 23:25 24:12 24:13 25:7 26:8,12,13,14 30:24 36:25 40:24 41:3,19 42:3,4,22 43:2,3 45:7 48:23 50:7 51:10,17,19 52:13 53:7 54:10 55:14,17 60:2 64:12 66:2
stated 41:23 66:4
states 3:8 24:5,10
statewide 45:19 46:12 47:5
station 52:20
statistics 25:5
stays 46:15
STEMI 43:17
steps 47:25
Steve 5:12 63:17
STEVEN 2:15
store 53:2
stories 28:19
Street 1:11
streets 56:21
strengthen 21:24
strip 34:17
strips 56:8
stroke 39:18,18 41:8 43:17 45:22 47:2,10,11
student 30:3,4,21
students 25:8 27:2 29:12,18 32:6
study 11:5,6 12:20 13:7
stupid 30:7
style 35:13
subcommittee's 14:5
subgroup 35:5,15
submissions 7:9
submit 6:16 7:16 8:16
submitted 7:15 28:17
suboxone 52:8
subscribed 66:8
substance 50:22 51:22 55:4 59:10,14
successful 60:4
Suffolk 64:24
suggest 34:11 38:16
suggestions 27:17
SUNY 30:19
Super 16:11

support 10:3 22:7 36:22 37:19
supported 13:4
sure 5:18 6:8 7:7,8,11,16 9:24 10:2 15:25 24:5,15 31:14 35:17 43:10 47:17,20 48:24 64:4,8
surprising 59:22
survey 32:17,19
surveys 27:16
survival 21:18
sustainability 11:5,6 12:19 13:7 48:21
Syracuse 8:11,14
system 6:23 11:20 29:3 33:6,25 43:11
systems 45:3 64:19

T

T.I.A 45:22 47:2
table 50:16
tableau 25:20 48:16
take 8:24 23:12 25:3 27:16,25 28:8 29:14,15,19,20 30:4 46:3 47:24 49:15 53:12 62:14 65:10
taken 36:20
takes 53:4 64:4
Talbot 2:7 4:19,20 18:5,6
talk 8:5 12:25 13:2 28:3,18 41:18 44:12 57:17 62:2
talked 18:14 21:16 22:14,25 39:14 55:22
talking 22:22 36:15 37:22
talks 30:3
task 12:9,11,14 36:24
taskforce 38:13
team 9:6 16:9 31:18 39:24 44:16 44:17 48:7
teams 36:11,13
technician 35:11
techniques 33:23
tel 54:3
telemedicine 51:8 53:3 54:2
tell 10:11 57:25
ten 25:7,23
ten-year 25:21
tends 58:17
term 36:2
terms 40:18
test 7:22 29:15,19 56:8
testing 26:10,14,23 28:19 29:2 45:18 47:2
Texas 32:24
thank 3:15 5:20 6:21 7:4 11:25 14:4,7 15:10 17:3 18:12,25 19:13 21:7 24:17,18,22,23,24 31:13 32:12,14 38:6,7,23 44:15,24,25 48:18,19 49:20 57:17,19 62:16 63:8,17 64:23 65:2
thanks 21:8 41:20 49:24 57:9 58:16 60:12,16
that's 65:16
THERESA 2:5
they'd 32:2
thing 21:10 22:8 23:8,11 29:5 29:21 30:13 39:14 61:13 65:8
things 6:6,10 8:3,3 9:5 10:4 11:2 13:12,16,22 22:9 24:2 25:23 26:16 27:6,20 29:8,24 31:4 35:12 39:13 40:17,22 43:11 44:9 50:13 59:20 64:17
think 7:22 11:3 12:25 13:6 14:22,24 15:23 16:13 19:17 22:4,18 23:6,16 24:21 25:4 26:11 29:16 30:13 31:16 32:9 37:16 38:3 41:25 43:24 56:9 56:23 59:16 60:4,4,11,22 61:16 63:19,21,24 64:2
thinking 26:23 56:15,17
third 15:21 53:8
thirteen 57:10
thirty 62:21
thirty-eight 20:3
thought 34:4 37:4 59:23
thoughts 11:14 13:16
thousand 19:18,24 20:5 25:7,10 55:14 56:10 60:6
three 19:16 25:11 38:15 42:6 45:8,9 53:4 57:2
three-year-olds 20:24
throw 50:15 57:16
tickets 28:17
tied 61:13
TIFFANY 2:9
time 1:7 14:8 18:14 25:18,21 35:10 37:6 38:3 39:20 43:4 45:25 49:24 56:15,16 57:2 65:14 66:3
timeline 10:19
timely 7:9

times 62:18,22
timing 12:8
today 14:9 16:7 34:24 50:4 55:7 58:5 59:2 62:11 64:18
tomorrow 57:6
tons 55:15
top 16:14 19:24 46:25
topic 63:11,21
topics 63:25
tough 37:25
trained 16:19,25
training 7:25 25:2 27:9,15 30:23,25 31:2,2,12,16,22,22 31:23 32:5,9
transcribed 3:19
transcriber 3:18
transcription 66:5
transfer 29:3 34:13
transmissions 45:13
transport 18:14,16 19:3,7 35:3 35:12,16,22 36:10,11,17 37:4 37:9
transportation 55:23,25 56:5
transported 19:20 47:10
transporting 18:19
transports 20:4 37:20
trauma 34:3,8,15 43:17 45:3
treat 55:5 59:7
treatment 50:12,24 51:21 54:25 58:23
tremendous 13:22
trend 40:8,16 44:20
trends 25:20
triage 34:3,8
trial 26:19
trip 56:3
Troy 1:1,13 2:1 3:1 4:1 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1
true 66:6
try 6:5 56:16
turn 38:4,4 41:17 44:11
turned 9:20
turns 28:21 46:22
twelve 19:23 25:13 57:10
twelve- 45:19
twelve-month 45:24 46:14,14
twenty 43:5
twenty-five 11:16 13:8 20:4
twenty-four 53:8
two 6:6 7:17 8:5 11:2 19:19 22:9 25:11 26:4,9 27:6,23 28:21 29:7,8 38:15 42:5 45:8 48:9,15 50:2 51:20 52:22 55:13 57:14 59:12 60:6 62:23 63:19
two-week 52:7
type 54:9,18 59:5
typewritten 66:5

U

Uber 56:2,3
Uh-huh 17:3 20:22
unanimous 14:20 15:9,12,20 16:6
understand 11:23
understanding 10:24 46:10
UNIDENTIFIED 18:24
United 3:8
units 51:8
universally 35:23
unresponsive 16:16,20
unseen 56:15
update 19:14 26:25 27:2,2 61:23 62:4
updated 39:3
updates 7:23 8:5,7
urban 36:2
urgent 47:13
use 6:16 16:20 28:6,16 36:4 39:17 41:14 42:23 43:6,6 44:14 50:22 51:22 55:2,4 57:21 58:10 59:10,24 61:8
useful 42:6
user 54:13
uses 36:5
usually 45:7
utilizing 23:12

V

Val 5:17 8:17
Valarie 2:5 3:19
values 46:21

variances 41:14
variety 45:14 51:22
various 34:6
varying 28:19
vendor 28:19 29:2,24 45:6
venturing 59:24
verified 42:5
Vermont 26:11
version 34:17 58:21 59:4,12
versus 25:18 27:20
view 34:25 59:18
viewed 42:2
Violante 2:16 38:23,24 44:6
virtual 25:18
vital 8:11 33:23 48:12
vote 17:6
voted 10:17
voting 10:10
voucher 52:7,10 55:23 56:2,3
vouchers 52:11

W

wait 49:19 62:18,22
waiting 39:12 51:2
Walgreens 52:11
walk 6:20 50:3
Walters 2:8 4:21,22,22 18:7,8,8
want 11:10 12:24 19:9 32:8,16 34:13 38:20 40:22 41:11 44:15 48:22 57:17 64:6 65:2,12
wanted 56:14 60:24 61:20
wants 23:9 65:4
warm 53:19
Washko 2:12 5:14,15
watch 63:7 64:7
watching 21:6
way 15:2,9,12 42:13 50:25 53:16 55:7 57:7
ways 37:22 39:20 52:22
we'll 3:16 8:9,11 10:10,15 15:11,19 39:10 40:20 47:16 49:18,23,23 64:7 65:5,22
we're 5:18 7:19,23 8:25 12:25 16:8 22:21 27:6,14 28:23 31:3 36:15 37:18,22 39:6,9,12 40:17,19 41:19 44:9 47:24 49:23 55:9,9 56:4 60:6 61:3 63:16 64:15,16 65:14
we've 14:15 25:25 39:8 44:2,2 59:25 60:4,4
web 53:4
website 6:12 8:15 11:7 18:22 19:7 30:3 32:24 33:12 50:14 56:7
week 29:15
week-by-week 46:17
weekly 55:14 57:24 60:7
weeks 7:17 46:22
Wegmans 52:12
weight 19:21 20:7,9
welcome 13:16 63:4
welcoming 60:23
went 21:19
western 53:7,11 57:14 60:14
WHEREOF 66:8
white 11:15
widely 9:24
Winslow 2:11 4:24,25 18:9,10 38:14 65:7
wise 7:19
Wislinski 4:23
WITNESS 66:8
word 16:17,23,24
work 9:13 11:18 31:9 39:24 40:15 44:2 51:13 60:12 62:17
worked 39:2 43:16
workgroup 27:15 28:13
workgroups 27:23
working 8:9,23 16:8 34:22 47:16 48:5 49:17 56:4 63:12 65:2
works 59:11
worth 19:17
wound 14:10
wrong 11:4

X

Y

yeah 16:8,12,22 20:25 21:4,4 43:24 48:11 58:3 59:21 60:16 61:20
year 7:12,12,18 8:21 11:15 12:18 13:11,14,15,23 25:6 27:4 29:16 33:15 59:4,9
year's 8:16
years 25:23 26:5,6 27:6 36:22 50:20
YEDIDYAH 2:14
yesterday 12:8,17
York 1:1,2,13 2:1 3:1 4:1 5:1

6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1,4 20:1 21:1 22:1 23:1,25 24:1,7 25:1,7 26:1,12 27:1 28:1,11 29:1 30:1,24 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1,6 46:1 47:1 48:1 49:1,25 50:1 51:1 52:1 53:1,7,11 54:1,10 55:1 56:1 57:1,15 58:1 59:1 60:1 61:1 62:1 63:1 64:1,10 65:1 66:1,2
younger 33:8
Yup 49:9

Z

Zendesk 28:16
zero 14:10,10 21:11,12

0

1

1 66:6
1-1 47:7
11:32 1:7 3:2
12:49 1:7 65:23
12180 1:13
17th 8:12

2

2/8/2023 1:1 2:1 3:1 4:1 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1
2021 19:16,18
2022 19:17 20:2 45:18
2023 1:6 66:9
22nd 8:12
235 1:11
23rd 66:9
28 37:22

3

30 37:23,23
31st 10:22

4

5

6

65 66:6

7

8

8 1:6

9

9- 47:6
9-1-1 21:25 47:14