

5/8/2024 - Medical Standards - WebEx
 NEW YORK STATE
 DEPARTMENT OF HEALTH
 MEDICAL STANDARDS
 DATE: May 8, 2024
 TIME: 8:09 a.m. to 9:01 a.m.
 CHAIR: JEFFREY RABRICH
 LOCATION: Hilton Garden Inn
 235 Hoosick Street
 Troy, New York

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 2 (The meeting commenced at 8:09 am.)
 3 CHAIR RABRICH: We're just going to
 4 give it a few minutes. All right, good morning.
 5 We're going to get started. I'd like to call the
 6 meeting to order of the Protocol Med Standards
 7 Subcommittee. If we could record the attendance. Do
 8
 9 we have? It's going around, very good.
 10 Okay. So we have a couple items of
 11 old business. I think Mr. Violante, you're going to
 12 give us a report on the update on the i-gel project.
 13 Do we have new data?
 14 MR. VIOLANTE: We do, as soon as my
 15 computer boots up.
 16 CHAIR RABRICH: Okay. You're -- what
 17 --?
 18 MR. VIOLANTE: Give me one second.
 19 CHAIR RABRICH: While he's doing that,
 20 does anyone have any other old business to discuss?
 21 MR. VIOLANTE: Well, if we had a Mac.
 22 CHAIR RABRICH: Yeah, that's true. I
 23
 24 mean, that's not a Mac, is it?
 25 MR. COMMITTEE MEMBER: Yes.

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 2 APPEARANCES:
 3 AL KIM
 4 ART COOPER
 5 BRIAN CLEMENCY
 6 BRIAN WALTERS
 7 CHIEF MAGER
 8 DANIEL OLSSON
 9 DAVID KUGLER
 10 DAVID VIOLANTE
 11 DON DOYNOW
 12 DONALD DUVALL
 13 DONALD HUDSON
 14
 15 DOUGLAS ISAACS
 16 JARED KUTZIN
 17
 18 JASON WINSLOW
 19 JEREMY CUSHMAN
 20 JOE BART
 21 JOSHUA LYNCH
 22 MICHAEL DAILEY
 23 MICHELE FORENESS
 24 MIKE MCEVOY
 25 PAMELA MURPHY
 RYAN GREENBERG
 THERESA ALLEN
 TIFFANY BOMBARD
 YEDIDYAH LANGSAM

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 2 that. Okay. So we have at this point received a
 3 total of around two hundred and fifty-six i-gels
 4 confirmed on the New York State website when we get
 5 the report from them on Mondays. And of those two
 6 hundred and fifty-six, what we do is we calculate the
 7 data down and come up with numbers that -- that we
 8
 9 had sent out previously.
 10 And so these are the median numbers
 11 that I'm going to report out on this. We also have
 12 about fifty-three reports that are on Drupal. So
 13 when an agency does an i-gel, they will also send us
 14 this Drupal that says we've done one, here's the run
 15 number, here's the date and time, et cetera, so
 16 expect to see that.
 17 And we have about fifty-three of those
 18 that are not in the State report as of yet. And what
 19 we've been doing over time since our last meeting is
 20 trying to assess why those folks haven't gotten that
 21 data from their agency Drupal report into the State
 22 report. And we've been working with the data
 23 informatics team about that and the agencies with
 24 that.
 25

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 2 those things not coming across. Some of it is
 3 related to reports not meeting the Schematron at the
 4 regional or the State level. Some of them are
 5 related to not the right codes that are being
 6 transmitted and so it doesn't make the State report
 7 and such.
 8
 9 And so in each of those instances,
 10 we're continuing to work on bringing that number down
 11 and fixing those issues. And the last time we had
 12 nearly eighty Drupals that didn't make the State
 13 report, so we've -- we've cut that almost in half as
 14 to the data that's coming in.
 15 So the usual dispatch -- or sorry,
 16 median dispatch to outpatient time is about eight
 17 minutes. Outpatient to i-gel about six minutes. The
 18 i-gel size most used, not surprisingly, is the number
 19 four. We have great end-tidal CO2 values after use.
 20 About hundred and seventy-eight of
 21 these have been confirmed, meaning that someone else
 22 double checked the i-gel placement and the rest have
 23 not. And in those cases, it's because it was an
 24 arrest that was terminated in the field and so there
 25

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 2 And so out of those cases, we have two
 3 hundred and forty-one that are considered successful,
 4 fifteen that were not. And we have the Q.I. process
 5 to look into why those other ones were not
 6 successful. The responses, eighty-eight were
 7 improved, a hundred and sixty-seven unchanged. In
 8
 9 two hundred and thirty-seven of the cases, there were
 10 no adverse events.
 11 In other ones, there were some things
 12 like vomiting or it wasn't recorded. In terms of
 13 ROSC, we had a number of different ROSC scenarios.
 14 In ten, it was sustained for twenty minutes. Forty-
 15 eight, yes, prior to arrival at the E.D. Eight, yes,
 16 arrival at the E.D. And the other ones were no.
 17 In terms of outcomes, we have fifty-
 18 two expired in the E.D., ninety-two expired in the
 19 field, twenty-two ROSC in the field, fifty-two
 20 expired in the E.D., thirty-one ongoing
 21 resuscitation, and twenty-five ROSC in the E.D. In a
 22 lot of these cases, the reason it was discontinued
 23 was because it was a medical control order and that
 24 relates to some of the ones that were done in the
 25

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 2 that it was at the time where they moved the patient
 3 over.
 4 In terms of age, weight, and gender,
 5 median age is sixty-nine, median weight is eighty-
 6 six. And sorry, gents, but males outweigh females
 7 two to one in the number of uses, hundred and sixty-
 8 nine to eighty-seven. In terms of the regions,
 9 they've done a great job with this. The highest
 10 region is central New York using this, Hudson Valley,
 11 Monroe, Livingston, New York, Susquehanna follow
 12 after that.
 13 These reports will go out quarterly to
 14 the agencies and out to the program agencies and to
 15 the regional area reps. And that's about where we
 16 are with it. We're continuing to look at the
 17 process. We're continuing to see the next way
 18 forward in terms of what happens in trying to make
 19 this in the national scope of practice.
 20 And unless there's any other
 21 questions, that's the end of -- of my report.
 22
 23 CHAIR RABRICH: Thank you for the
 24 report. Are there any questions or comments on the
 25

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 2 **MR. DAILEY:** What's the end point?
 3 **MR. VIOLANTE:** So that's a great
 4 question. And I think that the end point is when
 5 we've received enough data to make the needle move at
 6 the national level, one of the things that we're
 7 really hoping to do is not take this away from folks
 8
 9 that are doing it right now because there really
 10 appears to be great success.
 11 And we also have said many times that
 12 we really don't want to move away from the national
 13 scope of practice model as well. And so that ends up
 14 being the next thing that we would really like to do.
 15 And it seems like as of the last change with the
 16 folks creating the national scope, they were really
 17 on the edge of making this something in the E.M.T.
 18 curriculum or not.
 19 And so we're really looking to present
 20 this data in addition to other national data to try
 21 and move that.
 22 **CHAIR RABRICH:** Any other comments or
 23 questions? Well, we thank you for the ongoing
 24 tremendous work and effort you're doing. And Dr.
 25

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 2 **MR. DAILEY:** I guess I would just
 3 caution us as a State in terms of trying to turn an
 4 aircraft carrier and then provide change to our
 5 patients. You know, yes, we've decided the national
 6 scope of practice model is going to be what we are
 7 going to work towards.
 8
 9 I think that is serving us quite well.
 10 I do think that this is something that has a
 11 significant number of other opportunities that we're
 12 seeing out there. You're demonstrating that it works
 13 quite well in New York.
 14 As we did with Naloxone, as we did
 15 with injectable epinephrine, I don't think that we
 16 should wait until we can change what's happening on a
 17 national level, particularly since that's basically a
 18 bunch of smart folks sitting around a table, just
 19 like what we've got in here, who ultimately change
 20 that. But every number of years rather than -- than
 21 any more frequently.
 22 I think you're demonstrating you've
 23 got something that you've brought to a population of
 24 our providers specific to some areas of the State
 25

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 2 whether or not that's something that we should
 3 advance regardless of whether or not it's in the
 4 national scope of practice model.
 5 **CHAIR RABRICH:** Right. And one
 6 doesn't preclude the other. We can do that and still
 7 work towards the national scope of practice models.
 8
 9 **MR. VIOLANTE:** I concur. I think
 10 that's great. And I'm also happy to provide this
 11 data to -- to this group on any basis as you would
 12 like or see fit.
 13 **CHAIR RABRICH:** Thank you. All right.
 14 If there's no other old business, we'll move on to
 15 new business. So the first item is the New York City
 16 protocol, which is an updated protocol for the rescue
 17 task force medical protocol. You should all have
 18 this in your packet.
 19 Most -- most of the changes to this
 20 protocol are a bunch of wordsmithing and
 21 clarification. So just for clarification, this
 22 protocol is only used by rescue task force providers
 23 in a warm zone. It's a -- it's a restricted protocol
 24 in that regard. There's been some updates to it.
 25

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 2 do you want to -- I know you were involved in the
 3 creation of this protocol. Do you want to talk about
 4 it or?
 5 **MR. ISAACS:** Sure. Just to add on to
 6 what you said, these are only people who received
 7 specialized training at FDNY with appropriate gear.
 8
 9 And it's just making some mi -- minor revisions to
 10 the existing protocol in terms of updating the
 11 equipment as well as being aligned with
 12 recommendations by the T.C.C. guidelines, such as the
 13 use of M.P.A. and recovery position.
 14 And the other big change was the
 15 extended care, wherein patients can't be rapidly
 16 extricated from the warm zone and providing some of
 17 that care until it's safe to do so.
 18 **CHAIR RABRICH:** Thanks. So really the
 19 only new part of this is the extended care, which
 20 requires physician involvement. And you'll see in
 21 that protocol there's a section under physician,
 22 which is really just kind of advisory to the
 23 physicians. Obviously not a protocol for physicians
 24 to use.
 25

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 2 It's just to provide some transparency and --
 3 **CHAIR RABRICH:** Right.
 4 **MR. ISAACS:** -- the comprehensive
 5 care being provided.
 6 **CHAIR RABRICH:** Is there any
 7 discussion on this protocol, comments? Yes?
 8
 9 **MR. OLSSON:** Dan Olsson. I just have
 10 a question on page -- excuse me, page five, item two.
 11 The -- the area deleted and what's supposed to be in
 12 there is just not clear to my reading. So if that's
 13 how it's supposed to look, that's fine. But I just
 14 have trouble understanding it.
 15 **CHAIR RABRICH:** This is the line about
 16 writing the triage category on the forehead of the
 17 patient?
 18 **MR. OLSSON:** That's the line. And if
 19 you take out the red.
 20 **MR. ISAACS:** Sorry, page five. No,
 21 the red is the edited changes. They're adding. It's
 22 not removing. I'm sorry. What -- what -- I don't
 23 understand your question about the red category or
 24 I'm not --
 25

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 2 right?
 3 **MR. ISAACS:** No. Red is the --
 4 **CHAIR RABRICH:** No, that is the --
 5 **MR. ISAACS:** -- revisions.
 6 **CHAIR RABRICH:** It's just -- it's just
 7 changed. The red just shows that that was changed --
 8
 9 MR. ISAACS: Yes, it just changed not
 10 to be removed.
 11 **CHAIR RABRICH:** -- and was deleted off
 12 to the right.
 13 **MR. OLSSON:** Okay. Thank you.
 14 **CHAIR RABRICH:** Any other questions or
 15 comments? Dr. Winslow, looks like you're about to
 16 say something.
 17 **MR. WINSLOW:** Motion to approve.
 18 **CHAIR RABRICH:** So we have a motion to
 19 approve. Is there a second?
 20 **MR. OLSSON:** I'll second.
 21 **CHAIR RABRICH:** Second. All those in
 22 favor? Any opposed? Okay, motion carries. Thank
 23 you. Next, we have some discussion items. We'll
 24 skip the first one since Dr. Dailey just walked out
 25

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 2 So we wanted to have a discussion
 3 about clinical data, its availability, its usage, and
 4 basically to help us in guiding us in answering
 5 clinical questions, right? So you know, whether
 6 that's, you know, how -- what's our first best
 7 success rate in the State? What's our, you know, you
 8 know, door to E.K.G. time?
 9
 10 You know, all the -- the performance
 11 metrics that we're looking to capture as well as some
 12 of the great work that's been going on with some of
 13 the pilot projects like the i-gel and getting good
 14 data around that.
 15 We seem to have an issue for a number
 16 of reasons, whether it's, you know, standardizing the
 17 way we input data into a P.C.R. to be able to get
 18 that data, looking at the data, analyzing it. So we
 19 want to have a discussion with the idea being to
 20 create a data integrity TAG that could kind of look
 21 at best practices in how to accurately capture data
 22 across the State and then use that data in the best
 23 possible way to answer what we really want to know,
 24 which are, you know, how are our outcomes?
 25

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 2 State? And as well as answering research questions
 3 around some of our pilot projects. So I just wanted
 4 to open that up to discussion about data and then,
 5 you know, the ultimate goal being to put together a
 6 TAG on this. So I'll open it up for discussion.
 7 Yeah, it's not designed to duplicate
 8
 9 or take over efforts of other groups that are working
 10 on data. It's really more just to ensure the
 11 integrity of data and basically best practices in
 12 data so that we're getting what the information we
 13 need to apply it clinically. So -- .
 14 **MR. WALTERS:** Dr. Rabrich?
 15 **CHAIR RABRICH:** Yes.
 16 **MR. WALTERS:** So I would agree. I
 17 think one of the issues that was brought up at the
 18 last meeting with the i-gel project was some of the
 19 data not coming in or how we're collecting it, which
 20 was, I think, concerning to a bunch of us. So if
 21 we're documenting all these things, we want to make
 22 sure we have access to it.
 23
 24 If we're running reports, we're
 25 getting the right data. And I think as some of my

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 2 Q.A., Q.I. metrics and how to implement them, and we
 3 look at their impressions list, for example, there's
 4 a lot of variability, even just amongst my agencies,
 5 what their -- what impression list they're using.
 6 It may not be NEMESIS. It may not be
 7 the New York State Data Dictionary list of
 8 impressions. And so if we're all -- if we're not
 9 requiring a certain list to pick from, that data and
 10 those impressions or, you know, the diagnoses, if you
 11 will, I know the impressions, not diagnoses, but when
 12 we start to pull data based on those, we're not
 13 getting the right data or if we're not all charting
 14 the same way or documenting the same way.
 15
 16 And what I find is not only is it
 17 people not understanding what their E.M.R. does or
 18 how to use it, but we haven't really taught our
 19 providers how we want things documented. We're not
 20 all doing it the same way, even in the same agency.
 21 And so I think that these are some of
 22 the issues that are critically important for us if we
 23 want to have good data, if it's meaningful, and if we
 24 can make medical decisions and quality standard of
 25

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 2 **CHAIR RABRICH:** Thank you. I see
 3 you're making a case to be chair of this TAG, but --
 4 **MR. WALTERS:** I am definitely not
 5 making that case, but -- but I do have a new SEMAC
 6 unvetted member who might be interested.
 7 **CHAIR RABRICH:** Okay.
 8
 9 MR. COMMITTEE MEMBER: It's okay to
 10 vote.
 11 **CHAIR RABRICH:** It's okay. You can -
 12 - you can be on a TAG and not be able to vote. Any -
 13 - any other comments on -- on this -- on data? No?
 14 **MR. DUVALL:** It seems to me from the
 15 various agencies that I have experience with, there
 16 is a huge variability of pick lists, if you will,
 17 that probably have a fairly significant impact on --
 18 on data collection.
 19 Not only patient impressions, but the
 20 discussion I had yesterday down to the use of lights
 21 and sirens and how that tends to be documented in --
 22 in terms of what NEMSIS requires, what New York State
 23 requires, and -- and even so what individual regions
 24 and individual agencies require.
 25

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 2 our charting system and compare it against
 3 disposition fields in various other agencies that
 4 I've worked with, and even patient disposition or
 5 patient outcome fields are extremely variable. And I
 6 was told that part of that was because of a tradeoff
 7 in a move to electronic charting where a region
 8 attempted to standardize those codes but still
 9 allowed agencies to utilize their own codes.
 10
 11 And at some point, if you want good,
 12 relevant, pertinent data, I -- I think some of these
 13 pick lists need to be drilled down and standardized
 14 so that providers in the field don't wind up in a
 15 position where I need to put something in a box to
 16 make this chart lock and make it advance.
 17
 18 And I found out that it doesn't really
 19 matter what I put in the box, so if I want to get my
 20 chart locked and go home, the data is probably not
 21 going to be correct. And that's an honest answer
 22 from a field provider.
 23 I -- I did a chart a couple weeks ago
 24 on a pediatric patient with roughly a half a block
 25 transport time and spent over an hour trying to

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 2 a number in the respiratory rate box.
 3 Now, by rapid pediatric assessment,
 4 breathing, respiratory rate, work of breathing was
 5 normal, color was good, I could document that, but I
 6 could not honestly put a number in that box. And --
 7 but I couldn't not put a number in the box and
 8
 9 advance the chart.
 10
 11 We really need to look at
 12 standardizing a lot of these pick lists, even across
 13 different charting platforms, and standardize them
 14 with an eye on what it is that we're trying to find.
 15 There are way too many data points that way too many
 16 entities are trying to collect that either are
 17 similar or, in some cases, non-issues that maybe we
 18 should just do away with in the interest of easier,
 19 more efficient charting.
 20 **CHAIR RABRICH:** Thank you.
 21 **MR. VIOLANTE:** Mr. Chair?
 22 **CHAIR RABRICH:** Yes.
 23 **MR. VIOLANTE:** So I can answer some of
 24 those things. There is a lot of variability of -- of
 25 data, although it all does come down to the NEMSIS

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 2 and since there's, I think it's nineteen different
 3 vendors perhaps that are out there.
 4 Some of them must meet NEMSIS
 5 requirements and do have additional other
 6 capabilities into some of those pick lists as well
 7 that some of the agencies can modify in some way, but
 8
 9 a number of them they can't. We're hoping that the
 10 move to NEMSIS three point five will make a lot of
 11 that easier in terms of pick lists and destinations
 12 especially, dispositions, et cetera, to make some of
 13 that documentation quite a bit easier as well.
 14
 15 To answer the question down here at
 16 the agency, the agency absolutely has great data of
 17 their own that they can look at, understand, chew up
 18 and figure out and move forward with.
 19
 20 Where some of the problems come into
 21 is when that data then gets transmitted up to the
 22 regional or the State level because that's where some
 23 of the variability comes in in terms of how things
 24 are identified from one vendor to another and how
 25 things actually move.
 So that's where some of the problems

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 2 been working on as well to try and make those a
 3 little bit more streamlined and accurate and make the
 4 data more relevant to where it needs to go in a
 5 timeframe that's really appropriate for physicians to
 6 be able to look at and be able to use.
 7 So hopefully the move to three point
 8
 9 five will make some of that easier, but yes, you're
 10 right, we really do need to make sure that all of the
 11 vendors are using the same language and the same data
 12 is going to the same fields and it's appropriate,
 13 it's right, it's not variable and it's not so much
 14 that it's so onerous for providers that they can't
 15 document what really needs to be done or for
 16 physicians to get that and understand what had been
 17 done as well.
 18 **CHAIR RABRICH:** Thanks. And I think
 19 that's some of the issues, right, that hopefully this
 20 tech will be able to address is the best practices
 21 around each of those steps, right, from the -- the
 22 end user inputting data correctly and having standard
 23 pick lists to, you know, what are the issues when
 24 that then goes to the regional or State level and
 25

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 2 to extract that data to answer a clinical question.
 3 So I think those are kind of the goals that we're --
 4 we're looking to --
 5 **MR. DAILEY:** Jeff?
 6 **CHAIR RABRICH:** -- accomplish. Yes,
 7 Dr. Dailey.
 8
 9 **MR. DAILEY:** So I -- I apologize for -
 10 - for jumping in. But you know, the one thing that
 11 you can't miss in taking care of patients' part,
 12 right?
 13 **CHAIR RABRICH:** Right.
 14 **MR. DAILEY:** So at the end of the day,
 15 the first reason that we document, right, isn't for
 16 billing. It's not for NEMESIS. It's not for the
 17 department, right, but it's to document the care that
 18 we have provided as Chapter 1 of a patient
 19 experience, right --
 20 **CHAIR RABRICH:** Yeah.
 21 **MR. DAILEY:** -- moving forward
 22 through a continuum of health care. Unless we make
 23 sure that the things that we accept as products here
 24 in New York, right, will ultimately serve to
 25

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 2 hospitals as well, that's all lost.
 3 There is a group that's working
 4 towards this. We haven't met in a while. We had one
 5 initial meeting. We've had some very robust email
 6 conversations. That needs to continue moving
 7 forward. It's endorsed by the STAC, has significant
 8 participation across the department, and that really
 9 needs to be the focus here.
 10
 11 How can the data both serve the people
 12 that want data, right, but more importantly and most
 13 importantly serve the people that are taking care of
 14 the patients themselves?
 15 **CHAIR RABRICH:** Absolutely, yes. And
 16 that should definitely be a part of this as well,
 17 right? Because I think we -- we all struggle on the
 18 hospital side with trying to find those reports, get
 19 those reports, being able to get the information
 20 about what happened pre-hospitally, so absolutely.
 21 And you know, just like hospital
 22 E.M.R.s, I'm not sure these systems are designed with
 23 that primarily in mind, right, there's all these
 24 other reasons that charting is created the way it is.
 25

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 2 thing to remember, too, is that E.M.S., regardless of
 3 the independence of our small agencies, right, E.M.S.
 4 is a part of a healthcare continuum, and when there's
 5 a significant amount of work that's been done within
 6 that healthcare continuum to create pathways for data
 7 to flow, we need to change and we really need to
 8 moderate the policies that we have promulgated from
 9 the department that then ultimately allow agencies to
 10 willy-nilly make decisions and change their -- their
 11 data management systems.
 12
 13 I have one local county which was
 14 entirely on one data platform until an agency
 15 randomly decided we want to have a new data
 16 management platform, didn't consult with their
 17 medical director and just went and did it. That has
 18 to stop. We have to have policies that don't allow
 19 that.
 20 I don't care what policy everybody
 21 uses within any one county, but it needs to be one so
 22 that way we have data that's all in the same language
 23 with the same data standards so we can then have a
 24 better understanding of what's happening, rather than
 25

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 2 dilutes the information that we're absorbing.
 3 **CHAIR RABRICH:** Thank you.
 4 **MR. DUVAL:** I wrote a fair share of
 5 paper charts in the early days, and I remember -- I
 6 remember the very beginning of the migration to
 7 electronic charting. And at that point, a charting
 8 platform needed State approval before it could
 9 actually go live.
 10
 11 Which meant that we -- when we started
 12 our electronic charting platform, we submitted
 13 duplicate data for thirty days with both electronic
 14 charts and paper charts. And the electronic charts
 15 were measured against the State's data format. And
 16 it required approval from the Department of Health
 17 before we could go live.
 18 I would submit that some place we've
 19 gotten soft. We -- there are tons of vendors out
 20 there, and between vendors and agencies, I think Dr.
 21 Dailey is right. They've -- the train has just kind
 22 of run away.
 23
 24 And somewhere along the way we maybe
 25 need to go back and suggest to vendors that if you

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 2 things that we expect and the things that we require
 3 as a State. How you do it is up to you. But how it
 4 comes out from your platform needs our approval or --
 5 or you're not going to sell your software here.
 6 **CHAIR RABRICH:** Thank you. Did you
 7 want to comment on anything?
 8
 9 **MR. GREENBERG:** So sorry, just dealing
 10 with an issue in the hallway at the same time. But -
 11 - so part of the problem, too, is you know, yes, they
 12 have to meet certain requirements to come in. But
 13 anybody who meets those requirements essentially
 14 would be permitted in.
 15
 16 The only other option for something of
 17 this nature to limit essentially the number of P.C.R.
 18 vendors or anything like that would be to have a
 19 regulatory set or to look into a regulatory set that
 20 would further align it and then set, hey, you, you
 21 know, have to meet additional standards or you have
 22 to be approved through this process or anything else.
 23 But right now, I think we're actually
 24 down. I think we're from twenty-one down to
 25 seventeen or sixteen. So we're doing better. But

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 2 as well. You know, it would flow better and work
 3 better for us if it was less as well.
 4 If that is a pathway that this group
 5 feels that we should go down, it is something we can
 6 look at. And it's not even -- it's things we've
 7 spoken about before, so this isn't anything new.
 8
 9 But, you know, bandwidth of everything else, you'll
 10 hear me talk about it later, there's five different
 11 regulatory sets that we're looking at.
 12
 13 But it might be the right time to look
 14 at this as well because as the technology is
 15 advancing and we're moving to three point five and we
 16 know what the problems are and some of the data
 17 coming in, maybe it's the right time to evaluate if
 18 this needs a stronger set.
 19
 20 But then the problem comes the flip
 21 side where the agency in turn says, well, the
 22 department or the SEMSCO or the REMSCO or fill in the
 23 blank, whoever, are trying to dictate what I do and
 24 how I do it. And then they get up, Al Kim is shaking
 25 his head vigorously on the other side, you know,
 becomes on the other side.

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 2 this room today, there's probably a lot of opinions
 3 at the table behind this table. Step up and say
 4 something, you know, because if this is a direction
 5 to go from a Bureau point of view, we can look into
 6 it. We just need to know direction that this group
 7 and SEMSCO would want to go.
 8
 9 **CHAIR RABRICH:** Yeah, I think everyone
 10 is very eloquently making the case for a TAG and why
 11 a TAG would be good to look at all these -- these
 12 issues and create some recommendations about how we
 13 should proceed. But other comments?
 14
 15 **MS. BOMBARD:** If you're looking for
 16 voices, Ryan, there -- there's one here. That's
 17 fine. Absolutely, I think this is in all of our best
 18 interest and first and foremost in our patient's best
 19 interest to not have this documentation lost, right?
 20 Our E.M.S. providers are generating
 21 actually better and better documentation. I get to
 22 read it about patients I've never seen because I do
 23 my agency's Q.A., right? But the physicians actually
 24 taking care of those patients never read it. It's
 25 difficult, if not impossible, to find.

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 2 anywhere for a couple of hours. And by then, nobody
 3 cares, right? We've received oral report. We've
 4 already taken care of the patient. They've been
 5 dispositioned, et cetera, et cetera. And all of that
 6 excellent work is lost. And that's a problem, right?
 7 It's a problem for our patient's
 8 safety. So absolutely we want the Bureau to be
 9 involved in this and absolutely we want to fix it.
 10 CHAIR RABRICH: All right. Thank you.
 11 So yes, so there will be -- behind me.
 12 MR. KIM: Jeff?
 13 CHAIR RABRICH: Yes, go ahead.
 14 MR. KIM: I'll speak loud. Come up.
 15 CHAIR RABRICH: Come on up.
 16 MR. GREENBERG: Al when you come up,
 17 make sure to say your full name first up front.
 18 MR. KIM: Okay, I'll speak to David.
 19 Hi, Al Kim. I just wanted to echo Dr. Dailey's
 20 comment about the disconnect between hospitals, you
 21 know, E.M.R.s and the pre-hospital cares. I mean,
 22 it's something that Ryan and I have spoken about in
 23 the past of how many E.D.s are making an issue of not
 24
 25

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 2 committee. It can cross over committees and this
 3 would probably be one that would be a --
 4 CHAIR RABRICH: Absolutely. We want a
 5 broad representation on this.
 6 MR. GREENBERG: Right.
 7 CHAIR RABRICH: Yeah. All right. The
 8 next discussion item was opiate antagonists. And --
 9 did he leave the room again?
 10 MR. GREENBERG: He left again. Maybe
 11 we should just call him. Let's try and see how long
 12 you can get the meeting to go on for.
 13 CHAIR RABRICH: Yeah, well, other new
 14 business. Yes, Dr. Isaacs?
 15 MR. ISAACS: Good morning. I'd like
 16 to propose a TAG for fetal blood transfusion. So
 17 just want to build upon the great work that Dr.
 18 Dailey's done with the legislative group, modifying
 19 or revising the Public Health Law, 2003-B. Some
 20 discussions that Director Greenberg and I have had
 21 with the blood resources program with our friends at
 22 Wadsworth.
 23 And since we're close to reality of
 24
 25

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 2 drop-off.
 3 And that's just a piece of it. I've
 4 seen multiple regions struggling with this very, very
 5 topic about, you know, small agencies to large ones
 6 using multitudes of platforms. And the fact that
 7 there has not been a regulatory component in
 8 regulating this, I think, is, you know, we put the --
 9 the horse before the -- the cart before the horse. I
 10 think it's an important piece of it.
 11 CHAIR RABRICH: Thank you, Al. All
 12 right, so --.
 13 MR. KIM: Yes, to regulatory.
 14 CHAIR RABRICH: Okay. Well, that will
 15 be another piece that the TAG can advise on.
 16 MR. GREENBERG: Just want to make sure
 17 you got that on the record, right? Okay, good. All
 18 right. That was Al Kim, Westchester region.
 19 CHAIR RABRICH: Very good. So I will
 20 send out something in the near future to collect
 21 interest in people who's interested in serving on the
 22 TAG and we will go from there. Yes, sir?
 23
 24 MR. GREENBERG: Just a reminder, so
 25

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 2 it's taken quite some time, but we're on the cusp of
 3 it, of creating a TAG where we collectively, along
 4 with other stakeholders throughout the system, from
 5 our friends at the trauma centers, blood centers and
 6 so on, working together, creating best practices,
 7 sharing training, equipment, you know, for example,
 8 how to create a protocol to validate our blood
 9 storage, which will require both bed banks.
 10 So it's a lot of work to do that, but
 11 by sharing our resources collectively, you know, can
 12 all have successful programs. Also looking at some
 13 of the research side of it as well.
 14 CHAIR RABRICH: Thanks. Discussion on
 15 this, anyone want to add? I think it would be good
 16 to have a group to kind of work on developing best
 17 practices and administering fetal transfusions, but I
 18 know there's been some work on this already. Go
 19 ahead, Ryan.
 20 MR. GREENBERG: So I think what Doug -
 21 - and I think it's important to -- to just understand
 22 the two things. So what Doug is proposing is
 23 something for best practices and moving forward in a
 24
 25

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 2 TAG.
 3 And the group that's currently
 4 wrapping up their project somewhat is the one who
 5 worked on the blood regulations --
 6 **CHAIR RABRICH:** Uh-huh.
 7 **MR. GREENBERG:** -- which we have had
 8 really good progress with. We met at Wadsworth.
 9 They gave us some pointers on that one. We're going
 10 to go back to that group. So I think what Doug's
 11 suggesting would be a separate one, kind of almost a
 12 next step.
 13 And I will say we do have blood
 14 transfusion in the field now. It's only in the air
 15 medical field, but it's getting to the field, it just
 16 only if it comes in by the air. So I think there's
 17 also that starting point, too, on starting those
 18 discussions sooner than later, because that is
 19 happening today.
 20 **MR. ISAACS:** Yes, just want to echo
 21 what Director Greenberg said. So again, we're --
 22 we're on the cusp of us working together, it's a lot
 23 to take off to kind of really implement a program.
 24
 25

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 2 along with it.
 3 So by starting that process now, I
 4 think we can work to make sure everyone has a
 5 successful program in terms of what limitation are
 6 and so on. But it's also a nice opportunity to work
 7 with other stakeholders within the system, from, you
 8 know, the trauma folks and everyone else, blood
 9 centers.
 10 So there's a lot of work to be done,
 11 and starting that process now, again, just build upon
 12 all the great work that others have made it possible
 13 to get to this point, so.
 14 **MR. GREENBERG:** I think my suggestion,
 15 Doug, let me know if it works for you, is to maybe
 16 have people, if they're interested, raise their
 17 interest between now and September, and then have
 18 that further discussion to September on who that
 19 group would be.
 20 **MR. ISAACS:** Yes, so I'll put some
 21 type of mission statement or something together, and
 22 of course it's open to anyone who wants to
 23 participate, and then look for a meeting in the
 24
 25

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 2 **CHAIR RABRICH:** Yes, I think -- I
 3 think that would be great. And as we said, to
 4 develop kind of as we roll this out, right, what are
 5 the logistical challenges and the best practices in -
 6 - in actually executing on, you know, administering
 7 the transfusions once the regulations are in place,
 8 it's kind of the next step.
 9 **MR. GREENBERG:** And I think Doug had
 10 pointed out yesterday, too, you know, the statute
 11 that is in place today that allows air medical to
 12 carry blood, carry and administer blood, there is a
 13 proposal in the Senate right now to essentially, I
 14 don't know, I didn't look at it exactly to see --
 15 **CHAIR RABRICH:** Yeah.
 16 **MR. GREENBERG:** -- if they're
 17 changing wording or adding wording or whatever it is,
 18 and ground or whatever, but --
 19 **CHAIR RABRICH:** Yes.
 20 **MR. GREENBERG:** -- it is there.
 21 **CHAIR RABRICH:** Yes, it amends it to
 22 add ground. I believe it's in assembly as well as in
 23 committee currently.
 24
 25

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 2 A.L.S. --
 3 **CHAIR RABRICH:** Yeah.
 4 **MR. ISAACS:** -- specifically that was
 5 added to it, taking out Air Medical specifically.
 6 **CHAIR RABRICH:** Right, so if your
 7 emergency is on a morning like this morning and, you
 8 know, you can't fly, you can still get the
 9 appropriate care. All right, thank you. I don't see
 10 Dr. Dailey, but he -- the next discussion item was
 11 opioid antagonist that he wanted to speak on the
 12 appropriate opioid antagonist to use in the field and
 13 continuing to use naloxone and the role of nalmefene,
 14 I don't -- is he out there? Does anyone see him?
 15 **MS. BOMBARD:** We should elect him for
 16 something while he's gone.
 17 **CHAIR RABRICH:** Go ahead.
 18 **MS. BOMBARD:** I don't have anything in
 19 mind.
 20 **CHAIR RABRICH:** Okay.
 21 **MS. BOMBARD:** Anyone -- anyone want to
 22 talk to --
 23 **CHAIR RABRICH:** Oh, he is coming now.
 24
 25

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 2 CHAIR RABRICH: Dr. Dailey, you keep
 3 walking out of the room and I want to discuss the
 4 opioid antagonist, so.
 5 MR. DAILEY: You wanted to pick an
 6 antagonist?
 7 CHAIR RABRICH: Yes. So now that
 8 you're appropriately antagonized, the floor is yours.
 9
 10 On the use of the -- the opioid antagonist and which
 11 one is appropriate for prehospital use and --.
 12 MR. DAILEY: So nice to -- to walk
 13 back into a room when I was relatively unprepared, I
 14 apologize. But so we did a -- we did a study with
 15 the State police that was published in the M.M.W.R.
 16 that looked at the difference between the four
 17 milligram and the eight milligram naloxone
 18 formulations.
 19 This was done with the Office of Drug
 20 User Health and the Office of Program Evaluation and
 21 Research at the AIDS Institute. And what we did was
 22 we took three of the eleven troops within the State
 23 and we substituted the eight milligram for the four
 24 milligram there.
 25

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 2 of what the formulations were and then allowed them
 3 just to practice for a little over a year. In the
 4 course of that time, we administered about a hundred
 5 doses of the eight milligram, around two hundred and
 6 fifty doses of the four milligram.
 7 And found out a couple of things. One
 8
 9 is, if you get eight milligram doses of naloxone, you
 10 end up with two-and-a-half times more symptoms of
 11 withdrawal, including vomiting, which as we all know
 12 has the potential to lead to aspiration.
 13 The other thing that I found very
 14 fascinating was that we actually went back and looked
 15 at all of the fatalities that we were involved with
 16 and looked at the body worn camera footage, the
 17 A.E.D. reports when they were available, and any
 18 other information that was surrounding the case.
 19 And we found that when law enforcement
 20 was called to the scene of an overdose, ninety-nine
 21 percent of them survived in both arms of that study.
 22 So I think that tells us something different, which
 23
 24 is I don't think we have a naloxone problem. I think
 25 we really need to look at what is appropriate to have

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 2 The four milligram naloxone is
 3 probably the most appropriate product we have right
 4 now. But I would caution that we still have a
 5 significant amount of withdrawal with that four
 6 milligram formulation. We probably should look to
 7 something lower rather than higher, even in this
 8 world of synthetic opioids.
 9
 10 But along the way I had -- had a
 11 chance to talk to some drug users. And people who
 12 use drugs have a slightly different approach to the
 13 idea of being reversed. There are some people that
 14 I've heard say, well, being woken up, even if it's
 15 really -- sorry.
 16 Even if it's a really rude wake up or
 17 really miserable wake up, it's still better than
 18 dying. If you actually talk to some of the drug
 19 users, they will tell you they disagree with that.
 20 Would you talk to him for me? Sorry, that's a
 21 medical control call at the same time.
 22 One of the drug users commented on a
 23 reversal that he had had of an overdose, where he had
 24 had a compassionate approach from people that he knew
 25

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 2 friends. And they woke him up actually with titrated
 3 intramuscular naloxone and rescue breaths.
 4 And he woke up, felt fine, didn't
 5 throw up, and everything was okay. The next time he
 6 overdosed, he was using with people that he didn't
 7 know. And that time, he woke up after getting
 8
 9 multiple intranasal naloxones with a firefighter and
 10 a cop both looking down at him saying, what did you
 11 take? What did you take? What did you take?
 12 And he said the experience was so bad
 13 that he then attempted to make that feeling go away
 14 by continuing to shoot drugs after signing off
 15 against medical advice for the next six hours while
 16 he waited for the naloxone to wear off. And then he
 17 used alone for the next six months.
 18 I'll point out the single most
 19 dangerous thing that any drug user can use -- can do
 20 is to use alone, particularly in this world of a
 21 completely variable drug supply.
 22 And I would suggest that what we need
 23
 24 to do is a compassionate approach to opioid
 25 antagonism, is to make sure that we're looking at the

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 2 making sure that we are taking their experience into
 3 consideration as we formulate our responses.
 4 The only data that exists is the data
 5 that we produce through the AIDS Institute and the
 6 Department of Health. Nobody else has looked at
 7 these cases. We have an ongoing fatality review that
 8 is continuing to attempt to gain data, to look at
 9 data, but they're having some of the same challenges
 10 of data acquisition that David was mentioning before.
 11 All right?
 12 But the reality is we believe that if
 13 you call 911 on a patient who is viable, they will
 14 survive. We don't need longer-acting opioid
 15 antagonists. We don't need higher doses of opioid
 16 antagonists. We need a compassionate, thoughtful
 17 response for public safety to the problem of opioid
 18 overdose.
 19 **CHAIR RABRICH:** Thank you. Any other
 20 comments or questions for Dr. Dailey? Don?
 21 **MR. DUVAL:** I find Dr. Dailey's
 22 comments interesting because it mirrors my personal
 23 experience working as a paramedic in a sort of rural
 24
 25

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 2 the reason I very rarely give Narcan to patients is
 3 because on the way to the call I get updates from the
 4 911 center, patient's received four milligrams of
 5 Narcan from law enforcement. Patient received their
 6 second dose. Patient received their third dose.
 7 We're seeing patients that are getting
 8 eight, twelve and sixteen milligrams. I think
 9 because law enforcement maybe doesn't see the
 10 expected effect where a patient instantaneously wakes
 11 up. And Dr. Dailey is right, a lot of these patients
 12 are sick.
 13 They're -- they're extremely sick.
 14 They're acutely withdrawing. They're vomiting
 15 everywhere. They're angry. When I do get the
 16 opportunity to give Narcan, I typically will do, you
 17 know, maybe that one milligram and then the second
 18 milligram.
 19 And I'm okay with bagging a patient
 20 for a few minutes until the Narcan takes effect and
 21 they -- they begin to wake up. And I -- I can see
 22 that it's much better for patients from my
 23 perspective. And it's much easier to work with
 24
 25

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 2 And I think the big problem is -- and
 3 it's great that Narcan is readily available and it's
 4 in police cars across the State, but I think in the
 5 interest of making it simple, it kind of swung that
 6 pendulum way overboard when patients are getting
 7 twelve and sixteen milligrams before the ambulance
 8 gets on scene.
 9 **MR. DAILEY:** Just -- just one thing
 10 for clarification. As we look at the total number of
 11 doses of Naloxone that folks got between the four and
 12 the eight milligram, the four milligram, they got
 13 about one point seven doses. You'll remember that
 14 these are single dose applicators. So you can't
 15 actually give a point seven, right? This is an
 16 average.
 17 And in the eight milligram, they got
 18 about one point seven doses. So exactly the same
 19 number, really done more by biomechanics, I think,
 20 than ultimate need. The other interesting thing is
 21 when we went back and we looked at the people that
 22 had received the two milligram and two M.L. you
 23 remember the one that we put together --
 24
 25

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 2 **MR. DAILEY:** -- with the mucosal
 3 atomizer device? They got one point seven too.
 4 **CHAIR RABRICH:** Any other comments?
 5 **MR. HUDSON:** Doc.
 6 **CHAIR RABRICH:** Yes?
 7 **MR. HUDSON:** So again, we all look at
 8 things from our own perspective. So from -- from an
 9 education and then I would suggest to this group
 10 medical oversight aspect, I would ask, are we using a
 11 comparable number of B.V.M.s to Narcan?
 12 **CHAIR RABRICH:** Good point.
 13 **MR. HUDSON:** And if not, perhaps we're
 14 skipping a step. And that to me speaks to medical
 15 oversight and education of our partner public safety
 16 agencies that we gave this miraculous drug to that
 17 has saved countless lives without the necessary
 18 oversight and guidance of how to properly use it.
 19 And I don't mean just initially, but I
 20 mean, you know, debriefing like, you know, I know it
 21 was stressful. I know we've all been there, but
 22 waterboarding somebody with Narcan is not best
 23 practices.
 24
 25

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 2 speaks also to, right, like what is the clinical end
 3 point they should expect with the Narcan, right? I
 4 don't know that we do a great job of making that
 5 clear as well.
 6 **MR. DAILEY:** So I think the idea of --
 7 of encouraging, right, ventilatory support is
 8 incredibly important. I think that we know that
 9 people will be relatively reticent to use the little
 10 face mask things. They will be challenged by using
 11 B.V.M.s. But I think both of -- both of those things
 12 are incredibly important.
 13 Central in the education that we're
 14 providing is the idea that what we're after here is
 15 respiration, not conversation. And that when the
 16 person's breathing is improving, that's exactly what
 17 we were going for, and that's going to continue to
 18 improve.
 19 The other thing that's in -- that's --
 20 that we should note, and certainly at this table we
 21 know, is that there is no amount of Narcan that will
 22 ultimately reverse the effects of xylazine or some of
 23 the synthetic and unapproved benzodiazepines that are
 24
 25

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 2 I saw one -- more than one tox report
 3 where I've had to go and look up all kinds of fancy
 4 medications that are approved in other countries or
 5 not approved anywhere that happen to be mixed into
 6 some of -- some of the drug supply.
 7 And currently there's an ongoing drug
 8 checking program that will yield some interesting
 9 data that hopefully we'll get here as well that's
 10 being done through the department. And I'm really
 11 enthusiastic about the opportunities there.
 12 There are also more programs looking
 13 at the crossover that many people at this table are
 14 providing, which is the crossover between public
 15 health and public safety that we really need here,
 16 right?
 17 The answer isn't just to support one
 18 or just to support the other, but how to interface
 19 the two in order to make sure that the safety net
 20 that E.M.S., law enforcement, fire provide ultimately
 21 can save the people that can't be cared for by their
 22 peers or by their family. And to continue to
 23 encourage safe consumption by people who choose to
 24
 25

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 2 **CHAIR RABRICH:** Thank you. All right.
 3 Anything else? Does anyone have any other new
 4 business they want to discuss? Dr. Dailey?
 5 **MR. DAILEY:** So I know that as a body
 6 we are not allowed to -- to lobby. However, most of
 7 the folks in here are actually also individuals, so
 8 you can keep this in mind. Assembly bill 5789 is
 9 currently moving through committee. This is
 10 Assemblywoman Warner's bill to allow blood to be
 11 administered.
 12 **CHAIR RABRICH:** Yes. This was
 13 discussed I think when you were out of the room. It
 14 was mentioned that it is in committee, so.
 15 **MR. DAILEY:** Good. It's in -- it's in
 16 committee. Support it. Thanks. Good. Bye.
 17 **CHAIR RABRICH:** There you go. Not as
 18 this body but as individuals support it.
 19 **MR. ISAACS:** Yes.
 20 **CHAIR RABRICH:** Dr. Isaacs?
 21 **MR. ISAACS:** Dr. Dailey, give you
 22 props. Thank you for the leadership on helping push
 23 that issue through, so thank you. We did go out of
 24
 25

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 2 out, so thank you.
 3 **CHAIR RABRICH:** All right. Does
 4 anyone have anything else? Any other new business?
 5 All right. Seeing none, I will entertain a motion to
 6 adjourn. Or you can sit here all morning.
 7 **MR. DOYNOW:** I'll make a motion.
 8
 9 **CHAIR RABRICH:** Oh, there's a motion.
 10 All right. Second? All in favor? Okay, we are
 11 adjourned. Thank you very much.
 12 **MR. DOYNOW:** If you're on E.C., that
 13 meeting is in sage ballroom.
 14
 15 (The meeting adjourned 9:01 a.m.)
 16
 17
 18
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 21
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2 STATE OF NEW YORK
3 I, DANIELLE CHRISTIAN, hereby certify that the foregoing
4 was reported by me, in the cause, at the time and place,
5 as stated in the caption hereto, at Page hereof; that
6 the foregoing typewritten transcription consisting of
7 pages 1 through 48, is a true record of all proceedings
8 had at the hearing.

9 IN WITNESS WHEREOF, I have hereunto subscribed
10 my name, this the 28th day of May, 2024.

11
12 DANIELLE CHRISTIAN

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22
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24
25

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