

NEW YORK STATE
DEPARTMENT OF HEALTH

NEW YORK STATE
EMERGENCY MEDICAL ADVISORY COMMITTEE
(SEMAC)

Advisory Committee Meeting

DATE: March 29, 2011

TIME: 1:35 p.m. to 3:57 p.m.

LOCATION: Ferris A - Banquet Level
The Hilton Garden Inn
235 Hoosick Street
Troy, New York 12180

1 SEMAC - 3-29-2011
 2 **ATTENDEES:**
 3 Jeremy Cushman, M.D.
 4 Pamela Murphy, M.D.
 5 Troy Johnson, M.D.
 6 Israel Miranda
 7 Daniel Blum
 8 Arthur Cooper, M.D., M.S.
 9 Michael Dailey, M.D.
 10 Mark Henry, M.D., Chair
 11 Lee Burns
 12 Tim Czapranski
 13 Robert Delagi
 14 Donald Faeth
 15 William E. Huffner, M.D.
 16 Mark Zeek
 17 Sharon Chiumento, B.S.N., E.M.T.-P.
 18 Lewis Marshall, M.D.
 19 Jack Davidoff, M.D.
 20 John DeTraglia, M.D.
 21 Carl Goodman, D.O.
 22 Timothy Haydock, M.D.
 23 Andy Johnson
 24 Bradley Kaufman, M.D.
 25 Joshua Kugler, M.D.
 August Leinhart, M.D.
 Michael Mastrianni, Jr.
 Jeffrey Myers, D.O.
 Daniel Olsson, D.O.
 Joseph Takats, III, M.D.
 Gregory E. Young, M.D.
 Rich Parrish
 Mr. Letch

Page 2

1 SEMAC - 3-29-2011
 2 **DR. KUGLER:** Here.
 3 **FROM THE FLOOR:** Dr. Leinhart?
 4 **FROM THE FLOOR:** He's here somewhere.
 5 **FROM THE FLOOR:** Dr. Marshall?
 6 **DR. MARSHALL:** Here.
 7 **FROM THE FLOOR:** Dr. Murphy?
 8 **DR. MURPHY:** Here.
 9 **FROM THE FLOOR:** Dr. Myers?
 10 **DR. MYERS:** Here.
 11 **FROM THE FLOOR:** Dr. Olsson?
 12 **DR. OLSSON:** Here.
 13 **FROM THE FLOOR:** Dr. Takats?
 14 **DR. TAKATS:** Here.
 15 **FROM THE FLOOR:** Dr. Waters? Non-voting
 16 members? Sharon Chiumento?
 17 **MS. CHIUMENTO:** Here.
 18 **FROM THE FLOOR:** Michael Mastrianni?
 19 **MR. MASTRIANNI:** Here.
 20 **FROM THE FLOOR:** Daniel Blum?
 21 **MR. BLUM:** Here.
 22 **FROM THE FLOOR:** Donald Faeth?
 23 **MR. FAETH:** Here.
 24 **FROM THE FLOOR:** Tim Czapranski?
 25 **MR. CZAPRANSKI:** Here.

Page 4

1 SEMAC - 3-29-2011
 2 (The meeting commenced at 1:35 p.m.)
 3 **DR. HENRY:** Let's call the meeting to order. We
 4 take a roll?
 5 **FROM THE FLOOR:** Dr. Broderick? Dr. Cooley?
 6 Dr. Cooper? Dr. Cushman?
 7 **DR. CUSHMAN:** Here.
 8 **FROM THE FLOOR:** Dr. Dailey?
 9 **DR. DAILEY:** Here.
 10 **FROM THE FLOOR:** Dr. Davidoff?
 11 **DR. DAVIDOFF:** Here.
 12 **FROM THE FLOOR:** Dr. Roland (phonetic spelling)?
 13 Dr. DeTraglia?
 14 **DR. DETRAGLIA:** Here.
 15 **FROM THE FLOOR:** Dr. Goodman?
 16 **DR. GOODMAN:** Present, yes.
 17 **FROM THE FLOOR:** Dr. Haydock?
 18 **DR. HAYDOCK:** Here.
 19 **FROM THE FLOOR:** Dr. Henry?
 20 **DR. HENRY:** Here.
 21 **FROM THE FLOOR:** Dr. Huffner?
 22 **DR. HUFFNER:** Here.
 23 **FROM THE FLOOR:** Dr. Kaufman?
 24 **DR. KAUFMAN:** Here.
 25 **FROM THE FLOOR:** Dr. Kugler?

Page 3

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** Robert Delagi?
 3 **MR. DELAGI:** Here.
 4 **FROM THE FLOOR:** Israel Miranda?
 5 **MR. MIRANDA:** Here.
 6 **FROM THE FLOOR:** Mark Zeek?
 7 **MR. ZEEK:** Present.
 8 **FROM THE FLOOR:** Roll call complete.
 9 **DR. HENRY:** Thank you. I just want to say a few
 10 things in opening. I was at the Center for Disease
 11 Control last week and it was a preliminary meeting to
 12 talk about their national field triage guidelines
 13 preliminary to another expert panel coming together in a
 14 month or two. And I got a chance to talk with Rick Hunt
 15 (phonetic spelling), as many of you know when he was in
 16 Syracuse, and they have the presence now of some very
 17 bright people from C.D.C. present at these meetings,
 18 Ph.D. types and others who have taken a strong interest
 19 in trauma. And what was heartening to Rick was that
 20 there's so many organizations, you know, E.M.S.
 21 organizations and different physician organizations who
 22 have embraced the topic of trauma, and it's gotten the
 23 interest now of public health and how multi-disciplinary
 24 it is.
 25 And I was thinking as we talked about the

Page 5

1 SEMAC - 3-29-2011
 2 international guidelines for heart disease and stroke and
 3 everything else that's tagged on, it's taken on a new
 4 dimension too in a sense of recognition of how important
 5 all the phases of care are for survival. You know, you
 6 just can't have one element be good; you've got to have
 7 five or six elements be good. And it's certainly taken
 8 on, in our region, that type of aura because we now have
 9 intensivists extremely interested in cardiac arrest as
 10 not only clinical, but as a research topic, and
 11 demonstrate how we can improve at all points along the
 12 curve once -- from someone's attempt -- attempted demise
 13 to perhaps pull them back to a full life.

14 So it -- it just strikes me that we are in the
 15 midst of a very important mission in terms of E.M.S. and
 16 we touch on a lot of phases of healthcare. And as we're
 17 going through our health reform, payment reform, health
 18 liberty models, we've got to play a big part in that. So
 19 that's -- that's my opening thoughts.

20 I want to commend the staff for getting us a
 21 beautiful facility here. I think however this request
 22 for proposal worked, it worked well. This is a -- this
 23 is a good meeting room, so thank you for that.

24 And then my other note -- correspondence, which
 25 I just received was a copy of a letter to Ms. Burns and

1 SEMAC - 3-29-2011
 2 this just reflects the economy, but also the need to do
 3 business, but a copy of letter from Monroe Livingston
 4 Regional Council commenting on the difficulty they're
 5 having in terms of getting timely fund transfer of what
 6 was promised so that they, in turn, can fulfill their
 7 mission, and I'm sure she'll speak about that later.

8 All right. Next topic of business is approval
 9 of the minutes from our October meeting. Are there any
 10 additions or corrections to that? All right. Hearing
 11 none, we have a motion to approve those? So moved.
 12 Second? All in favor? Aye.

13 **FROM THE FLOOR:** Aye.

14 **DR. HENRY:** Opposed? Okay. Thank you. All
 15 right. The reports of subcommittees -- is there anything
 16 from the education committee that we need to act on here
 17 today? Does anyone have any items that were able to
 18 attend there? Okay. Hearing none, I'd ask Dr. Marshall,
 19 Lou, are you able to give the medical standards report?

20 **DR. MARSHALL:** Yes, thank you. I'll do it from
 21 back here. Medical standards met this morning; it was
 22 quite lively discussion on a number of topics. We have
 23 five protocols -- or five items to bring forward for
 24 action by this committee, so I'll do those first.

25 The first item is approval of the 2010 American

1 SEMAC - 3-29-2011
 2 Heart Association A.C.L.S. guidelines for use in New York
 3 City E.M.S. systems. In 2005 we had quite long
 4 discussions about incorporation of the 2005 American
 5 Heart Association Guidelines into the New York State
 6 state and regional protocols, both at the B.L.S. and the
 7 A.C.L.S. level. This year we've done the same thing.
 8 Several -- everyone got copies of the protocols and
 9 the -- the changes that were suggested. We looked at the
 10 American Heart Association Guidelines, and there's three
 11 areas that they are incorporated into our E.M.S. systems.
 12 One is at the statewide B.L.S. protocols. One is they'll
 13 be incorporated into regional A.C.L.S. protocols.

14 And at the regional level, what we did in 2005
 15 was we asked each region to submit an updated version of
 16 their protocols incorporating the 2005 American Heart
 17 Association Guideline changes, and so this time, we're
 18 asking the same thing -- that each region incorporate the
 19 2010 American Heart Association guidelines into their
 20 regional protocols and submit a final copy from their
 21 region to the department. Those protocols will not --
 22 won't be approved because we're approving the guidelines,
 23 I hope.

24 So coming forward is a motion to approve the 2010
 25 American Heart Association A.C.L.S. guidelines for use in

1 SEMAC - 3-29-2011
 2 New York State E.M.S. systems. Again, there's three
 3 areas. One is the statewide B.L.S. protocols, which we
 4 discussed earlier; the A.C.L.S. regional protocols; and
 5 also the changes will be included in the New York
 6 statewide certification curriculum. Those items come
 7 forward as a seconded motion for your discussion.

8 **DR. HENRY:** Is there any discussion? All right.
 9 Hearing none, we'll take a vote.

10 **FROM THE FLOOR:** Dr. Cushman?

11 **DR. CUSHMAN:** Yes.

12 **FROM THE FLOOR:** Dr. Dailey?

13 **DR. DAILEY:** Yes.

14 **FROM THE FLOOR:** Dr. Davidoff?

15 **DR. DAVIDOFF:** Yes.

16 **FROM THE FLOOR:** Dr. DeTraglia?

17 **DR. DETRAGLIA:** Yes.

18 **FROM THE FLOOR:** Dr. Goodman?

19 **DR. GOODMAN:** Yes.

20 **FROM THE FLOOR:** Dr. Haydock?

21 **DR. HAYDOCK:** Yes.

22 **FROM THE FLOOR:** Dr. Henry?

23 **DR. HENRY:** Yes.

24 **FROM THE FLOOR:** Dr. Huffner?

25 **DR. HUFFNER:** Yes.

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** Dr. Kaufman?
 3 **DR. KAUFMAN:** Yes.
 4 **FROM THE FLOOR:** Dr. Kugler?
 5 **DR. KUGLER:** Yes.
 6 **FROM THE FLOOR:** Dr. Marshall?
 7 **DR. MARSHALL:** Yes.
 8 **FROM THE FLOOR:** Dr. Murphy?
 9 **DR. MURPHY:** Yes.
 10 **FROM THE FLOOR:** Dr. Myers?
 11 **DR. MYERS:** Yes.
 12 **FROM THE FLOOR:** Dr. Olsson?
 13 **DR. OLSSON:** Yes.
 14 **FROM THE FLOOR:** Dr. Takats?
 15 **DR. TAKATS:** Yes.
 16 **FROM THE FLOOR:** And is Dr. Leinhart -- Dr.
 17 Leinhart?
 18 **DR. LEINHART:** Yes.
 19 **FROM THE FLOOR:** Roll call complete.
 20 **DR. HENRY:** Thank you.
 21 **DR. MARSHALL:** The second item of business was
 22 brought up as a result of an inclusion in one of the
 23 protocols to include the use of CPAP at the intermediate
 24 E.M.T. level. After much discussion about the benefits
 25 of CPAP and the ease of use, a motion was made to include

Page 10

1 SEMAC - 3-29-2011
 2 CPAP as an advanced airway skill and to include it in
 3 protocols as appropriate. If I got that correct, that
 4 would be the motion that comes forward for discussion.
 5 **DR. HENRY:** Is there any discussion? Okay.
 6 Call -- call the question.
 7 **FROM THE FLOOR:** Dr. Cushman?
 8 **DR. CUSHMAN:** Yes.
 9 **FROM THE FLOOR:** Dr. Dailey?
 10 **DR. DAILEY:** Yes.
 11 **FROM THE FLOOR:** Dr. Davidoff?
 12 **DR. DAVIDOFF:** Yes.
 13 **FROM THE FLOOR:** Dr. DeTraglia?
 14 **DR. DETRAGLIA:** Yes.
 15 **FROM THE FLOOR:** Dr. Goodman?
 16 **DR. GOODMAN:** Yes.
 17 **FROM THE FLOOR:** Dr. Haydock?
 18 **DR. HAYDOCK:** Yes.
 19 **FROM THE FLOOR:** Dr. Henry?
 20 **DR. HENRY:** Yes.
 21 **FROM THE FLOOR:** Dr. Huffner?
 22 **DR. HUFFNER:** Yes.
 23 **FROM THE FLOOR:** Dr. Kaufman?
 24 **DR. KAUFMAN:** Yes.
 25 **FROM THE FLOOR:** Dr. Kugler?

Page 11

1 SEMAC - 3-29-2011
 2 **DR. KUGLER:** Yes.
 3 **FROM THE FLOOR:** Dr. Leinhart?
 4 **DR. LEINHART:** Yes.
 5 **FROM THE FLOOR:** Dr. Marshall?
 6 **DR. MARSHALL:** Yes.
 7 **FROM THE FLOOR:** Dr. Murphy?
 8 **DR. MURPHY:** Yes.
 9 **FROM THE FLOOR:** Dr. Myers?
 10 **DR. MYERS:** Yes.
 11 **FROM THE FLOOR:** Dr. Olsson?
 12 **DR. OLSSON:** No.
 13 **FROM THE FLOOR:** Dr. Takats?
 14 **DR. TAKATS:** Yes.
 15 **FROM THE FLOOR:** Roll call complete.
 16 **DR. HENRY:** Okay. Motion carries.
 17 **DR. MARSHALL:** Okay. The next item that comes
 18 forward, and I apologize for this, but the previous --
 19 the region previously known as REMS, which is now known
 20 as REMAC, brought forth protocols. All those protocols
 21 were approved without changes, so --.
 22 **DR. HENRY:** Okay. I'm sorry.
 23 **DR. MARSHALL:** Oh, that's okay. The REMAC
 24 protocols were approved without change. That comes
 25 forward for action.

Page 12

1 SEMAC - 3-29-2011
 2 **DR. HENRY:** Okay. Excellent. So I think we can
 3 take a hand vote on this. All in favor, please signify
 4 by raising your hand.
 5 **FROM THE FLOOR:** Yes.
 6 **DR. HENRY:** Opposed?
 7 **FROM THE FLOOR:** Yes.
 8 **DR. HENRY:** Abstentions? It carries.
 9 **FROM THE FLOOR:** Dr. Henry, I think we should
 10 take a roll call vote on that.
 11 **DR. HENRY:** Okay.
 12 **FROM THE FLOOR:** Dr. Cushman?
 13 **DR. CUSHMAN:** Yes.
 14 **FROM THE FLOOR:** Dr. Dailey?
 15 **DR. DAILEY:** Yes.
 16 **FROM THE FLOOR:** Dr. Davidoff?
 17 **DR. DAVIDOFF:** Yes.
 18 **FROM THE FLOOR:** Dr. DeTraglia?
 19 **DR. DETRAGLIA:** Yes.
 20 **FROM THE FLOOR:** Dr. Goodman?
 21 **DR. GOODMAN:** Yes.
 22 **FROM THE FLOOR:** Dr. Haydock?
 23 **DR. HAYDOCK:** Yes.
 24 **FROM THE FLOOR:** Dr. Henry?
 25 **DR. HENRY:** Yes.

Page 13

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** Dr. Huffner?
 3 **DR. HUFFNER:** Yes.
 4 **FROM THE FLOOR:** Dr. Kaufman?
 5 **DR. KAUFMAN:** Yes.
 6 **FROM THE FLOOR:** Dr. Kugler?
 7 **DR. KUGLER:** Yes.
 8 **FROM THE FLOOR:** Dr. Leinhart?
 9 **DR. LEINHART:** Yes.
 10 **FROM THE FLOOR:** Dr. Marshall?
 11 **DR. MARSHALL:** Yes.
 12 **FROM THE FLOOR:** Dr. Murphy?
 13 **DR. MURPHY:** Yes.
 14 **FROM THE FLOOR:** Dr. Myers?
 15 **DR. MYERS:** Yes.
 16 **FROM THE FLOOR:** Dr. Olsson?
 17 **DR. OLSSON:** Yes.
 18 **FROM THE FLOOR:** Dr. Takats?
 19 **DR. TAKATS:** Yes.
 20 **FROM THE FLOOR:** Roll call complete.
 21 **DR. MARSHALL:** Okay.
 22 **DR. HENRY:** Approved.
 23 **DR. MARSHALL:** Thank you. I only have two more.
 24 So we only have to do this twice more, at least for
 25 protocols.

1 SEMAC - 3-29-2011
 2 The next one is REMO. REMO presented a very
 3 nicely put together set of protocols, and I congratulate
 4 them on all their hard work. Their protocols were
 5 approved with the following changes, and Dr. Dailey,
 6 please correct me if didn't put something up there. One
 7 is removal of repeat doses of etomidate, which was in one
 8 of the protocols. A second one, after much discussion
 9 from the department and the Bureau of Narcotic
 10 Enforcement, was to remove fentanyl from standing orders
 11 for pediatric protocols. So the fentanyl will be moved
 12 to medical control options only for pediatric protocols.
 13 The third one was removal of Haldol as a
 14 restraint agent in the protocols. And also removal of
 15 the use of masks in patients with hypotension. And masks
 16 are going to be coming out of the protocols altogether.
 17 The other change that was agreed to was -- in
 18 some of the protocols, especially the diabetic protocols,
 19 the use of D-Fifty. And REMO had actually done some work
 20 and looked and found a better outcome in patients treated
 21 with D-Ten, is that correct, Dr. Dailey? So they
 22 recommended changing D-Fifty to the use of D-Ten in their
 23 diabetic protocols. And -- and that was for all levels
 24 of providers. And -- and that was approved also. So
 25 this comes forward as a seconded motion with the changes

1 SEMAC - 3-29-2011
 2 that you see here as discussed.
 3 **DR. HENRY:** Also, I want to say that this is --
 4 covers three regions, correct?
 5 **DR. MARSHALL:** Thank you.
 6 **DR. HENRY:** REMO, Adirondack Appalachian --
 7 **DR. MARSHALL:** Uh-huh.
 8 **DR. HENRY:** -- and Mountain Lakes.
 9 **DR. MARSHALL:** Yes.
 10 **DR. HENRY:** Okay. So that that's clear to
 11 everyone, it covers all three regions. Any discussion?
 12 None? We'll take a vote on this.
 13 **FROM THE FLOOR:** Dr. Cushman?
 14 **DR. CUSHMAN:** Yes.
 15 **FROM THE FLOOR:** Dr. Dailey?
 16 **DR. DAILEY:** Yes.
 17 **FROM THE FLOOR:** Dr. Davidoff?
 18 **DR. DAVIDOFF:** Yes.
 19 **FROM THE FLOOR:** Dr. DeTraglia?
 20 **DR. DETRAGLIA:** Yes.
 21 **FROM THE FLOOR:** Dr. Goodman?
 22 **DR. GOODMAN:** Yes.
 23 **FROM THE FLOOR:** Dr. Haydock?
 24 **DR. HAYDOCK:** Yes.
 25 **FROM THE FLOOR:** Dr. Henry?

1 SEMAC - 3-29-2011
 2 **DR. HENRY:** Yes.
 3 **FROM THE FLOOR:** Dr. Huffner?
 4 **DR. HUFFNER:** Yes.
 5 **FROM THE FLOOR:** Dr. Kaufman?
 6 **DR. KAUFMAN:** Yes.
 7 **FROM THE FLOOR:** Dr. Kugler?
 8 **DR. KUGLER:** Yes.
 9 **FROM THE FLOOR:** Dr. Leinhart?
 10 **DR. LEINHART:** Yes.
 11 **FROM THE FLOOR:** Dr. Marshall?
 12 **DR. MARSHALL:** Yes.
 13 **FROM THE FLOOR:** Dr. Murphy?
 14 **DR. MURPHY:** Yes.
 15 **FROM THE FLOOR:** Dr. Myers?
 16 **DR. MYERS:** Yes.
 17 **FROM THE FLOOR:** Dr. Olsson?
 18 **DR. OLSSON:** Yes.
 19 **FROM THE FLOOR:** Dr. Takats?
 20 **DR. TAKATS:** Yes.
 21 **FROM THE FLOOR:** Roll call complete.
 22 **DR. MARSHALL:** Thank you. Last one, New York
 23 City protocols. There were two protocols that were
 24 changed; one was asthma. For the A.L.S. providers, the
 25 wording was changed in the protocol to include, "Shall

1 SEMAC - 3-29-2011
 2 mix albuterol and ipratropium together and then
 3 administer the treatment." And that's under their asthma
 4 protocol.
 5 And for the burn protocol, they had wanted to look at
 6 including a rule of nines for C.F.R. and the use of dry
 7 dressings under a certain percent and what dressings
 8 above a certain percent. And going with the state
 9 curriculum for C.F.R. at the present time, we just left
 10 it as dry dressing only. And that -- that change was
 11 approved. This comes forwarded as a seconded motion.
 12 **DR. HENRY:** Is there any discussion? We have a
 13 typo? Okay.
 14 **FROM THE FLOOR:** Yes, we do.
 15 **DR. MARSHALL:** Typo, asthma. Okay. Just take
 16 the S off there.
 17 **DR. HENRY:** Okay. Then let's take a vote.
 18 **FROM THE FLOOR:** Dr. Cushman?
 19 **DR. CUSHMAN:** Yes.
 20 **FROM THE FLOOR:** Dr. Dailey?
 21 **DR. DAILEY:** Yes.
 22 **FROM THE FLOOR:** Dr. Davidoff?
 23 **DR. DAVIDOFF:** Yes.
 24 **FROM THE FLOOR:** Dr. DeTraglia?
 25 **DR. DETRAGLIA:** Yes.

Page 18

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** Dr. Goodman?
 3 **DR. GOODMAN:** Yes.
 4 **FROM THE FLOOR:** Dr. Haydock?
 5 **DR. HAYDOCK:** Yes.
 6 **FROM THE FLOOR:** Dr. Henry?
 7 **DR. HENRY:** Yes.
 8 **FROM THE FLOOR:** Dr. Huffner?
 9 **DR. HUFFNER:** Yes.
 10 **FROM THE FLOOR:** Dr. Kaufman?
 11 **DR. KAUFMAN:** Yes.
 12 **FROM THE FLOOR:** Dr. Kugler?
 13 **DR. KUGLER:** Yes.
 14 **FROM THE FLOOR:** Dr. Leinhart?
 15 **DR. LEINHART:** Yes.
 16 **FROM THE FLOOR:** Dr. Marshall?
 17 **DR. MARSHALL:** Yes.
 18 **FROM THE FLOOR:** Dr. Murphy?
 19 **DR. MURPHY:** Yes.
 20 **FROM THE FLOOR:** Dr. Myers?
 21 **DR. MYERS:** Yes.
 22 **FROM THE FLOOR:** Dr. Olsson?
 23 **DR. OLSSON:** Yes.
 24 **FROM THE FLOOR:** Dr. Takats?
 25 **DR. TAKATS:** Yes.

Page 19

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** Dr. Waters? Roll call
 3 complete.
 4 **DR. HENRY:** It carries.
 5 **DR. MARSHALL:** Thank you. Those were all the
 6 protocols that were discussed. There was other
 7 discussion this morning, including updates on
 8 hyperthermia from REMO and New York City as well as
 9 Narcan update from REMO, and those reports will continue
 10 coming. And at some point, I guess, we will need to
 11 determine when we no longer need updates and that -- the
 12 reports are completed.
 13 We also had some significant discussion again
 14 about the provision of online medical control and who
 15 should provide that online medical control to
 16 pre-hospital personnel, whether it's as our state
 17 regulation says, "It may be a physician or under the
 18 direction of a physician," and our SEMAC Policy 9501,
 19 which states that, "It must be provided by a physician."
 20 So we're looking at language to determine who can
 21 actually provide it, especially in hospitals where it may
 22 be a problem, like rural hospitals and hospitals that
 23 have under fifteen thousand visits a year that are not
 24 required to have a physician on duty in the emergency
 25 room twenty-four/seven, where they have a physician

Page 20

1 SEMAC - 3-29-2011
 2 assistant or nurse practitioner providing care as the
 3 provider in the E.R. for some portion of the day. So
 4 that will continue on.
 5 We will revise the language some more. There
 6 were some good suggestions this morning on appropriate
 7 language to use to make sure that we're very clear about
 8 who is providing online medical control and perhaps under
 9 what circumstances and in what facilities.
 10 There was also a request to look at
 11 inter-facility TAG. Medical standards has an
 12 inter-facility TAG that's been operating for time, and
 13 Dr. Funk has requested that REMAC consider making the
 14 inter-facility TAG a committee reporting to REMAC -- I
 15 mean, SEMAC, reporting to medical standards, and also to
 16 the systems committee. So there was some discussion
 17 about how that should happen. And medical standards
 18 brings it forward for further discussion as to how SEMAC
 19 would like to structure that committee. We thought it
 20 was a good idea that, based upon the inclusion of
 21 inter-facility transports in Article 30, that this TAG be
 22 a fully functional committee permanently. So it
 23 brings -- we bring that forward for your discussion
 24 and -- and action if you so choose.
 25 **DR. HENRY:** Yes, let's have a little discussion.

Page 21

1 SEMAC - 3-29-2011
 2 We had -- during a conference call with Tim and Lee and
 3 other members who are on the, I guess, executive
 4 committee or preparing for business for this meeting, the
 5 topic came up. And obviously, it has important
 6 ramifications for SEMAC. I mean, inter-facility
 7 transfers are high risk patients that we take care of.
 8 And Deb did a tremendous amount of work, and her team, in
 9 doing that report. I mean, I -- if you dust that off,
 10 it's still alive and strong. But there was so much work
 11 to do with it that we didn't finish it. And the problem
 12 didn't go away; it's -- it's still there. So I think it
 13 will upgrade care to do this. And because it touches on
 14 so many aspects of E.M.S., we thought that it should have
 15 a relationship with systems, too. And I don't know if --
 16 Tim, do you want to speak to that and share some
 17 thoughts, and then we can have some discussion?
 18 **MR. CZAPRANSKI:** Yes, I think everyone's aware
 19 of the -- of the disparity across the state in
 20 inter-facility transports. And I think that the work
 21 that was done that never really got completed should be
 22 resurrected and taken a look at, especially as we move
 23 into the new curriculum training as well.
 24 I think the systems committee has a touch into
 25 it. I think there are a lot of other committees that

Page 22

1 SEMAC - 3-29-2011
 2 touch this. But I think the medical standards is
 3 probably the place where it belongs or a TAG belongs.
 4 Now the question can be, do we make a TAG, or recreate
 5 the TAG, or do we create a separate committee to deal
 6 with this? I don't think this is going to go away. I
 7 know Mark Zeek and I have had conversations about this
 8 since our conference call, so Mark, if you have anything
 9 else you would like to say?
 10 **MR. ZEEK:** Well, I'm just glad that we're
 11 getting some serious consideration of this. And I'm not
 12 sure what the proper venue is, but I think that if -- if
 13 we could establish a committee, I think that -- that
 14 is -- it is something that will require ongoing
 15 supervision, and it's an issue that really doesn't have a
 16 lot of ownership statewide. And there are some questions
 17 about standards of training and standards of protocols,
 18 despite the fact that many regions have their own
 19 inter-facility protocols, but the standardization is
 20 lacking. So I think that we should proceed with this
 21 in -- in the way that this group and the SEMSCO thinks is
 22 the best way to go.
 23 **DR. HENRY:** Other discussion?
 24 **DR. DAILEY:** I'd actually just like to -- I'd
 25 like to express to this group that I think it's important

Page 23

1 SEMAC - 3-29-2011
 2 this become a committee. These are transports that
 3 happen every day across the state. They happen by air;
 4 they happen by ground. Some are short distances; some
 5 are long. They go between Article 30, which is us, and
 6 Article 28 facilities. This is a group of patients that
 7 has fallen between the cracks. This is a group of
 8 patients in billing situations where actually development
 9 of a curriculum and then a credential would end up
 10 leading to changes in billing environments for our
 11 partners that run E.M.S. agencies. I think this is an
 12 extremely important thing that we can't just relegate to
 13 the idea of a technical advisory group. This has got to
 14 be there forever.
 15 **DR. HENRY:** Other comments?
 16 **MR. CZAPRANSKI:** The only other comment I have
 17 is this is a little bit different than our typical 911
 18 calls in that the patients remain patients of the sending
 19 facility. So somehow we have to engage the hospitals
 20 in -- in this process as well, unlike a 911 patient who
 21 is not a hospital patient at that point.
 22 **MR. ZEEK:** Yeah, If I may. I -- that was one of
 23 Dr. Funk's concerns was getting some hospital buy-in and
 24 some possibility of observation time as part of the
 25 training curriculum for these inter-facility providers.

Page 24

1 SEMAC - 3-29-2011
 2 So that's -- I'm glad you bring that up, Tim. Thanks.
 3 **DR. MARSHALL:** There -- there was --
 4 **DR. HENRY:** I'll just remind us, we have a
 5 member from the Healthcare Association of New York. And
 6 we had -- we had HANYS members before, right? We have
 7 a -- we have a physician there. Whether that represents
 8 enough, we can -- we can then talk about, but --.
 9 **DR. MARSHALL:** Yeah, there was also a
 10 recommendation that we have some representation from STAC
 11 on this committee since there will some inter-facility
 12 transports of trauma patients.
 13 **DR. HENRY:** Okay. Well, I appreciate the
 14 comments. And we'll consider these, right --
 15 **DR. MARSHALL:** Uh-huh.
 16 **DR. HENRY:** -- when we think of the best
 17 structure for it. We'll have a conversation about it
 18 tomorrow, too, I'm sure.
 19 **DR. MARSHALL:** Yes.
 20 **DR. HENRY:** So we -- we will -- we intend to
 21 revitalize this and have it work. Whatever name we give
 22 it can be worked on, but if people have strong interests
 23 in working on the project, they should let me and Tim
 24 know.
 25 **DR. MARSHALL:** Okay. There was one other -- one

Page 25

1 SEMAC - 3-29-2011
 2 other topic from this morning, just to finish up my
 3 report. There was a lot of discussion about E.M.S.
 4 handoff at the hospital and what happens and -- and how
 5 information gets handed off from, you know, a
 6 pre-hospital to the hospital personnel and whether that
 7 handoff includes a patient care report or -- and if it
 8 does include a patient care report, how is that report
 9 formatted? Is it handwritten or electronic format?
 10 With a lot of services going to electronic
 11 records systems, handoff at the hospital, especially
 12 turning over a document in some places is posing
 13 challenges. With the different systems and E.M.R.'s that
 14 people have, they're not always compatible with like say
 15 a wireless printer in your E.R. So we had some
 16 discussion on E.M.S. hand-down. We actually looked up
 17 one of our SEMAC policies, 0801, which actually says that
 18 E.M.S. handoff and the patient care report needs to be
 19 done at the time that the patient care is transferred to
 20 the hospital personnel. Well, that doesn't specially say
 21 what the timeframe is in terms of that patient care
 22 report information. There was some discussion about how
 23 we're going to approach that. If we're going to have
 24 recommendations, what would those recommendations be? We
 25 want to make sure that patient information gets

1 SEMAC - 3-29-2011
 2 transmitted to the appropriate hospital personnel in a
 3 timely fashion. And there was -- people from around the
 4 state have different systems in their hospital. In some,
 5 the E.M.S. providers talk with the doctors. And in some,
 6 they talk with the nurse. In some, they just handed off
 7 the patient and, you know, handed in a piece of paper,
 8 and very little information was actually transmitted.
 9 So I think that's a topic that as we move more
 10 and more into electronic systems, how are we going to
 11 make sure that information is handed off appropriately?
 12 **DR. HENRY:** I don't know if you have the
 13 language from the policy available there, but I -- I'd
 14 ask Andy if he could speak to that, both the evolution of
 15 the policy, because we anticipated moving to electronic
 16 format, so the department took some pains in terms of a
 17 policy of how we would transition, but more importantly,
 18 you know, it's quite clear what the timeliness should be
 19 of a record to accompany the patient.
 20 So I was the one who brought this up, but I see
 21 this as a patient care issue. When you have a patient,
 22 the information about why they -- why E.M.S. was called
 23 and what care was rendered and what were the symptoms at
 24 the scene and -- and en route are vital in terms of
 25 treatment of that patient. And --.

1 SEMAC - 3-29-2011
 2 **DR. LEINHART:** Mark, I -- I -- I can speak to
 3 the origin of this policy because I think I prompted Ed
 4 Wronski to address it because I saw it happen. And
 5 having just refreshed everybody's memory with regard to
 6 this policy, I would say the policy is pretty clear, and
 7 it just needs to be enforced.
 8 **DR. HENRY:** Well, we're -- we're looking for
 9 that. I think part of it is because a lot of us are in
 10 beta versions of electronic records, and there's lots of
 11 vendors out there who are wanting to be of service and
 12 use, but maybe they're not aware of the policy and --
 13 and -- and what -- what -- what's required in terms of
 14 this transition.
 15 **MS. BURNS:** They're aware. We make them aware.
 16 **DR. HENRY:** They're aware? Okay. Well, then we
 17 should make us re-aware.
 18 **MS. BURNS:** As part of approving a service to
 19 utilize an electronic P.C.R., one of the -- of the points
 20 that we require them to include is the ability to
 21 transfer patient information at the time they deliver the
 22 patient. Now I'm not suggesting necessarily that they
 23 hand over a complete medical record, but there has to be
 24 a formal memorialized transfer of information.
 25 The other thing that does concern me in the

1 SEMAC - 3-29-2011
 2 bigger picture with this is with the paper P.C.R., the
 3 paper P.C.R. getting into the patient's medical record
 4 has been sketchy at best overall. And that information
 5 is very, very important in the short-term for us treating
 6 patients pre-hospitally and in the emergency department,
 7 but it's also very, very important information to be kept
 8 in the patient's medical record. And quite frankly,
 9 unfortunately, if a patient wants their medical record,
 10 the best place for them to find their pre-hospital
 11 medical record would be with the rest of their medical
 12 records. And that just overall is not happening a good
 13 way. And I -- I don't -- you know, technology is sort of
 14 in our way with regard to this. There are some
 15 interesting practices going on across the state where the
 16 transmission of pre-hospital data happens within
 17 forty-eight hours and all that kind of stuff. That's
 18 okay for a medical record in some places, but it's not
 19 good for you treating the patients in the emergency
 20 department.
 21 **DR. LEINHART:** Yeah, I would just add that
 22 the -- there may be unnecessary risks being taken. If --
 23 if the medical record is generated forty-eight hours
 24 after the event, it may or may not correlate to the --
 25 the evidence at hand on arrival. So this could be the

1 SEMAC - 3-29-2011

2 equivalent of a wet reading from an Australian
3 radiologist.

4 **DR. HENRY:** It's -- I don't know if everyone can
5 read it. Maybe you can just read it out loud for the
6 record?

7 **DR. MARSHALL:** It says, "At all times, maintain
8 the confidentiality," blah, blah, blah. "Pre-hospital
9 care reports shall be completed for each patient treated
10 when acting as part of an organized pre-hospital
11 emergency medical service, and a copy shall be provided
12 to the hospital receiving the patient and to the
13 authorized agent of the department for use in the state's
14 Q.A. program."

15 There was a -- another part of that was that it
16 had to be done at the time that the transfer of care
17 occurred.

18 **DR. HENRY:** All right. That was the section I
19 was looking for, but we'll -- we'll find that. But
20 that's -- when we do find that, we'll -- we'll clarify
21 it, okay? Do you have anything else?

22 **DR. MARSHALL:** No, that's my report.

23 **DR. HENRY:** Yes?

24 **MS. CHIUMENTO:** It's been brought to my
25 attention -- it's been brought to my attention by Donna

Page 30

1 SEMAC - 3-29-2011

2 Spink that when we voted on the A.C.L.S. protocols, we
3 did not include PALS in that. So can we just make sure
4 that it's reflected in the minutes that it -- when we
5 voted for that, we voted for both the A.C.L.S. and the
6 PALS. We had already voted for the B.L.S. separately,
7 but if we can make sure that PALS is included in that as
8 well.

9 **DR. MARSHALL:** I would -- I would make that
10 motion that we include PALS in the American Heart
11 Association Guideline update for 2010.

12 **DR. HENRY:** We certainly discussed it. I don't
13 know if we formally acknowledged it in the acronym.

14 **MS. CHIUMENTO:** Right.

15 **DR. HENRY:** But does that -- does that fit with
16 everyone's --?

17 **DR. MARSHALL:** Yeah, I'll -- I'll make that
18 motion.

19 **DR. HENRY:** Everyone affirms that? Okay. So we
20 can incorporate it as part of our discussion as a more
21 general topic, I think. But we certainly -- we certainly
22 spoke of all ages. Okay.

23 Anything else, Dr. Marshall?

24 **DR. MARSHALL:** No, that was all.

25 **DR. DAILEY:** Dr. Henry? During the discussion

Page 31

1 SEMAC - 3-29-2011

2 about the requirements for E.M.S. providers making sure
3 that their data was available to hospitals, we also
4 entered into a brief discussion on the requirements to
5 hospitals to share their data back with E.M.S. about
6 outcomes as well as imploring upon hospitals to share
7 their face sheets with the E.M.S. agencies that have
8 brought patients to them.

9 If we could make sure that that's a part of
10 the -- if -- if ultimately the Commissioner does choose
11 to send any documentation out to the agencies, if there
12 could also be included documentation to the hospitals
13 asking them to be partners with us in this process, that
14 would be very helpful.

15 **DR. HENRY:** And I don't know if -- Dr. Cushman,
16 if you would be -- add about what's happening in your
17 RHIO, that the pre-hospital reports are included in the
18 regional information system. That might be --

19 **DR. CUSHMAN:** Sure, in just as -- as --

20 **DR. HENRY:** -- something people would think
21 about.

22 **DR. CUSHMAN:** -- Dr. Leinhart was -- was
23 reminding us that -- that that transfer of information,
24 particularly from hospitals back to agencies, is done
25 under the auspices of the -- of the Q.A. and quality

Page 32

1 SEMAC - 3-29-2011

2 improvement regs that we already have in place that
3 implored them to do that anyway.

4 One of the things that I had shared to medical
5 standards was the program in -- in Rochester integrating
6 E.M.S. records with the Greater Rochester Regional Health
7 Information Organization such that those P.C.R.'s end up
8 going up to the RHIO in a -- in a common platform to
9 allow primary care users, anyone, quite frankly, with
10 access to the RHIO, to be able to see those P.C.R.'s.
11 They do not end up being in -- in electronic never land.
12 The next stage of that is assuring that E.M.S. providers
13 under certain -- certain circumstances have the ability
14 to view that information or a limited subset of
15 information from the RHIO about that patient,
16 particularly allergies, medications, main medical issues,
17 and the electronic copy of the MOLST.

18 So there are some models out there, and I would
19 encourage regions as they are looking at electronic
20 P.C.R. platforms to identify how those platforms are
21 going to interact with the healthcare system and not just
22 their own documentation, billing, and other purposes.

23 **DR. HENRY:** So as -- as you just mentioned that,
24 the ability to take a look at lists of medications, you
25 know, it's an extremely important topic that a lot of us

Page 33

1 SEMAC - 3-29-2011
 2 probably hadn't thought about the ability to merge. I
 3 mean, the fact that so many patients are vulnerable when
 4 they come in by ambulance, it's very hard to get an
 5 accurate medication list in many circumstances. And the
 6 studies show that they're notoriously inaccurate, what
 7 you get in the E.R., to what they're actually taking, for
 8 many reasons. And the power that this brings to have
 9 something more accurate is something that's maybe
 10 untapped in many areas, and it's going to evolve.

11 So I think we need to have continued discussions
 12 about this topic. I don't know the correct format, but
 13 we -- we need to revisit the -- what people are doing
 14 with this.

15 **MR. CZAPRANSKI:** Yeah, I think it would be
 16 helpful if we could get from the state a summary of RHIO
 17 projects around the state. And at the various regional
 18 councils, program agencies could work with those.

19 One of the other things that we find is that,
 20 you know, thirty percent of the patients don't get
 21 transported to the hospital, so you have seizure patients
 22 or diabetics that they're treated and released. That
 23 record goes nowhere. By depositing it in a RHIO, the
 24 primary care physician can see that, "Hey, I've got my
 25 patient seen three times and not transported to a

1 SEMAC - 3-29-2011
 2 hospital. I've got to," you know, "bring them in check
 3 their levels or do something." They can better manage
 4 that care.

5 And what we found in Rochester, a lot of the
 6 attending physicians had no idea their patient was taken
 7 to a hospital. And by having this capacity, they'll now
 8 that chart available to them so that they can review it.
 9 But if we can look at across the state and tie the E.M.S.
 10 electronic recordkeeping with the RHIO projects that are
 11 going on, I think it'll be really helpful.

12 **DR. HENRY:** Is there any other discussion on
 13 this? Okay. Thanks, Dr. Marshall.

14 **DR. MARSHALL:** You're welcome. We found the
 15 language. We found the language.

16 **DR. HENRY:** Good.

17 **DR. MARSHALL:** Which says -- where'd it go? We
 18 lost it. There it is. "The patient records have to be
 19 provided to the receiving hospital at the time the
 20 patient care is transferred or a predetermined written
 21 plan with the hospital must be in place." So you have to
 22 do at the time you drop the patient off unless you have
 23 some other arrangement.

24 **DR. HENRY:** All right. Thank you very much.
 25 Okay. I'd like to move on to the Q.I. committee, Mr.

1 SEMAC - 3-29-2011

2 Delagi and Dr. Kaufman.

3 **MR. DELAGI:** Thanks, Dr. Henry. And thanks, Dr.
 4 Dailey, for that great segue into our report because Dr.
 5 Kaufman will actually speak to the very issue of E.M.S.
 6 and hospital data sharing as we enter the second phase of
 7 a multi-phase project to do just that.

8 I just want to also, quickly, on behalf of Dr.
 9 Kaufman, thank the entire committee and the Program
 10 Agency Director's Coalition, who we worked very closely
 11 with, since it's their charge to coordinate Q.I. in their
 12 reason -- in their regions, very active with us. As you
 13 go through the report you'll hear a bunch of stuff that
 14 we've been working on through several e-mails and
 15 conference calls since our last meeting. We met today as
 16 a formal committee, and there are no motions -- seconded
 17 motions to bring forward.

18 First thing that we're working on is we
 19 completed a draft letter to ask each of the regions to
 20 submit to us their formal quality improvement plans, and
 21 that should be going out very, very shortly. And the
 22 intent of that letter is to just collect the plans that
 23 everybody is using across the state in an effort to
 24 identify best practices with the ultimate goal of trying
 25 to standardize the quality improvement process across

1 SEMAC - 3-29-2011

2 the -- the state.

3 During the staff report, we also learned about the -- the
 4 progress that's being made with the vendor, ImageTrend,
 5 and their development of the electronic bridge. You'll
 6 recall that this is part of a three or four year
 7 Governor's Traffic Safety Board grant to develop an
 8 electronic receiving platform. And we're pleased to
 9 report that that project is moving along rather quickly.
 10 The data dictionary has been complete and is currently on
 11 the website. The website is functional and -- and is
 12 actually being updated on a daily basis. And mapping is
 13 currently underway to link the data elements from each of
 14 the big electronic vendors to the now-approved NEMESIS
 15 database residing on the statewide repository.

16 And as I recall the discussion, the first one
 17 would be through the vendor, emsCharts. The second
 18 mapping to take place would be SCAN Health, which is the
 19 S.D.N.Y. E.M.S. system. And the third one to take place
 20 in mapping would be the ZOLL Data System. We expect that
 21 this will take multiple months to do, but we are
 22 nonetheless very excited at the progress that has been
 23 made so far.

24 Concurrently, the state's current P.C.R. vendor,
 25 Fedcap, will be developing a new version six, written

1 SEMAC - 3-29-2011
 2 P.C.R., which will -- will probably be some time away,
 3 probably within the next year to two. So we will have
 4 the version five for some time. But ultimately, the plan
 5 is to have ImageTrend become the New York State general
 6 repository which will include electronic data uploaded
 7 from multiple sources into ImageTrend, plus Fedcap
 8 uploading data from the version five P.C.R. into that
 9 dataset. So there is some significant progress there.

10 We're working on a project to deal with the
 11 unusual incident reports as a result of Policy Statement
 12 0606, and this is kind of tied to the safety committee's
 13 work and kind of tied to making sure that we can kind of
 14 monitor what's going on out there with regard to patient
 15 safety and provider safety.

16 For an example, it was reported that the Bureau
 17 of E.M.S. picked up a recent trend in seeing an
 18 inordinate number of stretcher tip-overs which resulted
 19 in injury to patients and providers alike. And to show
 20 you the value of this data, we would then at the regional
 21 level be able to issue situation reports to identify this
 22 trend, remind people of the need to -- to practice good
 23 ergonomics, remind people of the need to watch for curbs,
 24 you know, poor terrain topography, and -- and to get back
 25 to the basics of how to control a stretcher when you're

1 SEMAC - 3-29-2011
 2 moving down the roadway. It sounds very, very
 3 rudimentary. It sounds very, very simple, but when you
 4 pick up a trend like this, why are people dropping
 5 stretchers and why are stretchers tipping over all of a
 6 sudden? It's an interesting trend.

7 So what we've done is working with our partners
 8 in the Program Agency Director's Coalition and our
 9 committee, we identified a series of data elements from
 10 the -- the policy statement and the -- the information
 11 that's collected to decide on what kinds of canned
 12 reports that we'll be able to get by region and statewide
 13 on a regular basis. And this will be pushed out to the
 14 regions, and we'll be able to keep our providers
 15 informed.

16 And again, it will track a whole bunch of good
 17 information centering around patient safety and provider
 18 safety. And we actually are expecting a sample report to
 19 look at in May so that we can get this going as soon as
 20 possible.

21 And Dr. Kaufman, if you would?

22 **DR. KAUFMAN:** There were three other topics that
 23 we discussed at some length, the first of which was --
 24 was brought up just now about the data sharing between
 25 E.M.S. and hospitals, the bidirectional sharing of data.

1 SEMAC - 3-29-2011

2 And as Mr. Delagi mentioned, we have a -- had a
 3 multi-step plan to do this, the first being to obtain the
 4 support of the department, which was received in a letter
 5 about a year ago which demonstrated full support of, not
 6 only -- it's always happened that E.M.S. providing data
 7 to the hospitals, but of the hospitals providing data to
 8 E.M.S. We're currently in -- in step two, which is
 9 working to develop those data elements that E.M.S.
 10 systems might like to receive from the hospital.

11 So certainly in places like we just discussed
 12 where there is a RHIO, it enables the individual
 13 agencies, E.M.S. agencies, in asking specific questions
 14 or reviewing specific cases on a case-by-case basis. We
 15 found most regions are looking for a methodology to
 16 obtain data on certain cases from the hospital. So our
 17 committee is currently working to develop specific data
 18 points that regions may choose to approach to ask for
 19 from their hospitals, and I'll -- I'll quickly read some
 20 of the categories of data points that we've mentioned
 21 that we're drafting to see -- to -- to distribute to the
 22 regions, including the E.D. impression and outcomes,
 23 providing steady patients, C.V.A. patients, C.H.F. and
 24 pneumonia patients, C.O.P.D. and asthma patients,
 25 patients with major trauma, altered mental status, and

1 SEMAC - 3-29-2011
 2 then pediatric seizure patients. So that -- those were
 3 the big categories that our committee has identified, but
 4 we're going to list specific data points that regions may
 5 choose to use to receive those data from the -- from the
 6 hospitals. And certainly, we're -- we're open to hearing
 7 about other ideas if somebody has a strong opinion about
 8 something else.

9 One other data point that we would like to
 10 obtain from the hospitals, which also ties into our next
 11 discussion, is the Q.A. for capnography, which goes back
 12 to the SEMAC Advisory 0801, which requires the use of
 13 waveform capnography for intubation by A.L.S. providers.
 14 The advisory actually has a Q.A. component in it which
 15 requires the REMAC to assess the compliance with using
 16 waveform capnography and to report those results to the
 17 SEMAC. So our committee is devising questions to
 18 assess -- to help the regions assess the compliance of
 19 their agencies in using this waveform capnography. One
 20 of those Q.A. points which ties into this hospital's data
 21 sharing is confirmation from the hospital end that the
 22 tube was in place when the patient arrived at the
 23 hospital. So that crosses both of those topics.

24 And the final discussion project that we had was
 25 discussing patient care restrictions. Many regions have

1 SEMAC - 3-29-2011
 2 various methodologies by which they may choose to
 3 restrict providers' privileges in providing patient care.
 4 And we are hoping to ask the regions for any
 5 documentation they may have to be able to put together a
 6 cohesive strategy that the state may adopt for
 7 implementing patient care -- provider patient care
 8 restrictions. And that's the end of our report.

9 **DR. HENRY:** Okay. Thank you. Any discussion?
 10 All right. Thanks.
 11 Mr. Wedge, any report from the education committee?
 12 Yeah, you can take a seat over here and get a mike.
 13 There you go.

14 **MR. WEDGE:** We had two items that I think that
 15 we --.

16 **DR. HENRY:** Oh, it's not on.

17 **MR. WEDGE:** Number one, we had a rather lengthy
 18 discussion this morning concerning the piloting of the
 19 new C.O.I. program. It has been piloted a couple of
 20 times, and there have been some -- really some serious
 21 concerns about the skill level of individuals who are
 22 attempting to take the course. The skill level has not
 23 been good, so we've batted this around a number of
 24 different ways, and basically a motion was made to do
 25 away with the prescreening skills section during the

Page 42

1 SEMAC - 3-29-2011

2 **DR. OLSSON:** I -- I'm puzzled. So you have
 3 people coming into the class that don't have the skills
 4 to do that particular class, so you're going to put them
 5 through the class and then test them at the end?

6 **MR. WEDGE:** That's the proposal that came from
 7 the committee.

8 **DR. OLSSON:** So do you even want them in the
 9 class to begin with if they can't do -- am I missing
 10 something?

11 **MR. WEDGE:** Well, that -- that brings up another
 12 issue. The screening on the local level of those
 13 individuals, I'm not sure is occurring. And if it was,
 14 we probably wouldn't be dealing with this quite to the
 15 extent that we are.

16 **DR. OLSSON:** So why not re-screen them before
 17 the class starts? If they don't meet the basic criteria,
 18 they don't do the class.

19 **MR. WEDGE:** That was also discussed, but the
 20 feeling was to move these courses along to go the route
 21 that I just gave you.

22 **DR. OLSSON:** So you're going to take people that
 23 can't do something, teach them, and then hope they can do
 24 it at the end?

25 **MR. WEDGE:** Well, they know how to -- they --

Page 44

1 SEMAC - 3-29-2011
 2 class to go through all of the skills that are needed,
 3 the various pieces of equipment that are out there, and
 4 then do some sort of post-testing of those skills.

5 So that I'm bringing before you as a motion from
 6 the committee.

7 **DR. HENRY:** Is there a discussion?

8 **MR. DELAGI:** I apologize if you discussed this
 9 at the meeting. I -- I wasn't at the meeting to -- to
 10 hear if it was, but it sounds like -- that the course was
 11 piloted several times. There were concerns about the
 12 skill level of people coming into the course, meaning
 13 that want-to-be instructors were not adequately prepared
 14 to become instructors, so --.

15 **MR. WEDGE:** That is what Mr. Parrish has -- has
 16 reported in the pilot that he's -- that have been done,
 17 yes.

18 **MR. DELAGI:** Okay. So the then solution would
 19 be to just take away the requirement?

20 **MR. WEDGE:** No, you're still going to be dealing
 21 with all of that material within the course, and then
 22 there will be -- the proposal was to do a post-test
 23 thereafter, so just kind of turning it around a hundred
 24 and eighty degrees.

25 **MR. DELAGI:** Okay. Thank you.

Page 43

1 SEMAC - 3-29-2011

2 let me say, quote/unquote, at one time knew how to do
 3 this because they passed a practical exam. So this is
 4 not something that's brand new. Ms. Meggenhofen has got
 5 a comment.

6 **MS. MEGGENHOFEN:** The plan is to add back into
 7 the C.L.I. course the ability to coach and teach them how
 8 to coach and teach those skills if they don't have them.

9 **DR. HUFFNER:** If you can't do it, you can't
 10 teach it.

11 **DR. OLSSON:** Right. Do we not think there's
 12 something wrong that they don't have the skills and
 13 they're coming to learn how to -- I mean, to teach other
 14 people? I'm not -- I'm troubled.

15 **DR. HENRY:** Okay. Rich, do you have a comment
 16 for that? You're looking like you're ready.

17 **MR. PARRISH:** Rich Parrish, chair of the TAG
 18 that's been fighting this C.L.I. program now for a couple
 19 years. We did prescreenings of these folks coming in,
 20 and one session we broke four of the adjustable collars.
 21 They'd never seen it. Student were asked to demonstrate
 22 a backboarding skill, and because we didn't have spiders
 23 there, they didn't know how to do it.

24 During the prescreening, these folks are coming
 25 in; they're not prepared. We had a big discussion, you

Page 45

1 SEMAC - 3-29-2011
 2 know, who has the onus for this, is it the course
 3 sponsor, the C.I.C.'s? They're sending folks to these
 4 classes that aren't prepared. And part of what we feel
 5 is happening out there is there are C.L.I. instructors --
 6 C.I.C. instructors out there. They're teaching one skill
 7 such as traction splinting. There are four types of
 8 traction splints out there. They're teaching the splint
 9 that that agency is using and -- just to get them through
 10 the skills exam. So now we're getting these C.L.I.
 11 candidates. They only know how to do a particular skill.
 12 They don't know how to do all the skills, so now you've
 13 got some agencies out there that may be going to the new
 14 K.T.D. traction splint and nobody knows what it is.

15 So the discussion that we had at our meeting
 16 this morning was, all right, bring these folks in and go
 17 through all the skills and have them teach it back. And
 18 before they can leave the program, they have to show
 19 competency on a whole checklist. Paul Bishop helped me
 20 develop a checklist of a whole lot of skills, not just,
 21 you know, one type of traction splint, one type of
 22 bandage. We had folks on -- again, the traction splint,
 23 we -- the ankle hitch broke. They had no idea how to
 24 develop an ankle hitch from a cravat, all right?

25 It's not just the candidates coming in; it's all

Page 46

1 SEMAC - 3-29-2011

2 **MR. MASTRIANNI:** It sounded -- just from the way
 3 that you were speaking, it sounded more -- you know,
 4 obviously, when -- long ago when we went through, there
 5 was a Hare traction splint, and that was either a Thomas
 6 half-ring or a Hare traction --

7 **MR. PARRISH:** Yeah.

8 **MR. MASTRIANNI:** -- and now there are a
 9 variety --

10 **MR. PARRISH:** Uh-huh.

11 **MR. MASTRIANNI:** -- that different manufacturers
 12 have come out with.

13 **MR. PARRISH:** There's four types out there right
 14 now. Some people are still using the Thomas. You got
 15 the Sager, you got the Hare, and now the new K.T.D. is
 16 out there.

17 **MR. MASTRIANNI:** Which is just -- my point was,
 18 is it an equipment familiarity issue that needs to be
 19 trained or is it the -- is the principle of how a
 20 traction splint works, what its purpose is?

21 **MR. PARRISH:** They don't know why they're
 22 putting on a piece of equipment --

23 **MR. MASTRIANNI:** That's a problem.

24 **MR. PARRISH:** -- all right? And you can go
 25 back -- I went through all the psychomotor skills at my

Page 48

1 SEMAC - 3-29-2011
 2 our lab instructors out there are hurting skill-wise.
 3 And part of it is, we used to go out and do audits of
 4 these classes. That was a regional faculty
 5 responsibility. We don't do that anymore. There is
 6 no -- from my point of view, there is no quality audit of
 7 our instructor or our E.M.T. classes. And we're turning
 8 out students that can do just a particular skill to get
 9 through the practical exam. And part of the discussion
 10 was that, you know, even if they do fail the program or
 11 the prescreening and they don't get into the C.L.I.
 12 class, they're going back to their agencies and still
 13 being listed as skills instructors. So right now, what's
 14 happening is they're just continuing to teach the wrong
 15 stuff out there.

16 So part of the recommendation was let -- let's bring them
 17 in and start all over and teach them the skills and go
 18 over all the skills. That's where this motion came from.

19 **MR. MASTRIANNI:** Are you finding, Rich, that
 20 this is an equipment familiarity issue or a principle --
 21 not understanding the principles?

22 **MR. PARRISH:** They don't understand the
 23 principles, Mike.

24 **MR. MASTRIANNI:** Okay.

25 **MR. PARRISH:** All right?

Page 47

1 SEMAC - 3-29-2011

2 last class. You know, I brought in the O.B. mannequin.
 3 And surprisingly, a lot of the students are saying, "My
 4 classes don't have that." If you go into the E.M.T.
 5 psychomotor skills and the equipment list, you're
 6 supposed to have an O.B. mannequin. I had students not
 7 know how to drape and prepare a patient to deliver -- a
 8 simulated patient. And if you look at the psychomotor
 9 skills under that section, you're supposed to -- breech
 10 birth, arm presentation, you know, placenta previa is all
 11 supposed to be simulated. It's not being done. We have
 12 problems with our C.L.I.'s and C.I.C.'s out there.

13 **MR. MASTRIANNI:** Is this being done as a
 14 response to the lack of C.I.C.'s and C.L.I.'s that
 15 currently exist? I mean, one -- there was one mention
 16 that was made that if you can't perform it, how can you
 17 teach it? And it sounds like we're trying to make people
 18 who are not competent into teachers. And are we doing it
 19 because there is a lack of C.L.I.'s and C.I.C.'s? So if
 20 we -- if I want to be a C.I.C., you're going to -- one
 21 way or another you're going -- or C.L.I., one way or
 22 another you're going to make me a C.L.I. because I have
 23 the interest and you have such a shortage? Is that --
 24 was that the reason for this?

25 **MR. PARRISH:** There's a shortage out there, but

Page 49

1 SEMAC - 3-29-2011
 2 no, we're not rubberstamping people just to get the
 3 C.L.I.'s out there. But what we're finding is a lot of
 4 the course sponsors saying, "Hey, Mike. Yeah, you're a
 5 good guy. Why don't you go to this class?" Now you come
 6 to my class, I have a process I take you through. You
 7 come and team teach with me for one session, and then I
 8 brush you up on all your skills and then I send you off
 9 to class. We're finding that students are coming to
 10 these classes, they're not even getting that.

11 **MS. BURNS:** I -- I hate to also bring this up,
 12 but the -- the further -- when you look at the numbers of
 13 our E.M.S. providers across the state that are enrolling
 14 into the C.M.E. refresher program is increasing
 15 exponentially and steadily. And -- and when you start
 16 talking to people, one of the biggest compelling reasons
 17 to enroll in the C.M.E. refresher training program is, "I
 18 don't have to take the tests." And so in the end, what
 19 you have is that E.M.S. providers at all levels are
 20 moving further and further away from being -- being aware
 21 of and testing the basic skills of being an E.M.T. or an
 22 advanced E.M.T. at whatever level. And that -- that has
 23 become abundantly clear in a number of different ways.
 24 But -- and I think that you have to keep that in mind
 25 when you take somebody who has completed their initial

1 SEMAC - 3-29-2011
 2 training, they may -- they may have basic competency in
 3 these skills, but after a couple of recertification
 4 programs, that -- you know, in the C.M.E. program,
 5 they've not demonstrated skill competency in years.

6 **MR. PARRISH:** A large part of the people that
 7 are coming into this program, C.L.I.'s that are A.L.S.
 8 providers, they're the worst performers.

9 **DR. DAILEY:** I would actually take it a slightly
 10 different way as well, appreciating Ms. Burns' comments.
 11 I have a number of people within my squads that are
 12 extremely high performers who'd be very interested in
 13 becoming instructors, but have absolutely no interest
 14 whatsoever in sitting for another state exam. So they
 15 have been performing very well in the C.M.E.
 16 recertification. They perform well on a day-to-day
 17 basis, but because they haven't taken a state exam and
 18 scored a -- scored an eighty-five or above since they
 19 initially took the -- took the exam, they're not going to
 20 be able to become C.L.I.'s and ultimately C.I.C.'s. And
 21 I think we lose a large portion of our high performers
 22 that way as well. And we have to worry about the people
 23 that we're losing on the high end as well as the people
 24 we're keeping in at the low end with the C.M.E.
 25 recertification program.

1 SEMAC - 3-29-2011

2 **FROM THE FLOOR:** I think there are several
 3 issues here, and -- and they're all being spun together.
 4 I think we have to start out relatively simple and we
 5 have to say, "Is the program that we have today working?"
 6 Quite frankly, having studied it for five years, it's
 7 not. So this -- and it was my recommendation that we go
 8 in this direction -- or my -- so how do we fix it?

9 Thirty years ago, maybe twenty-five, we started
 10 out by saying, "Let's take a look at a crop of people.
 11 Are these people capable of teaching other people?"
 12 Some, yes; some, no. So a program was devised. We were
 13 going to select those people who we thought were high
 14 performers. We would bring them in, and we would
 15 re-educate them, fine tune them, evaluate them, and turn
 16 out a product that worked. We shouldn't have to do this
 17 if we have equity when it comes to core sponsors across
 18 the state of New York. That doesn't occur. It's just
 19 not there. If we had the pride in every one of the
 20 sponsors, we wouldn't put forth a product that needs to
 21 be re-educated, part one of the problem.

22 Part two, money's tight no matter where you go,
 23 and it's been tight for many, many years. Many places
 24 and many sponsorship don't have the equipment that they
 25 need to put on the program, so they go with one device.

1 SEMAC - 3-29-2011

2 The question becomes, should we close those core sponsors
 3 down? I doubt that because we need to continue to
 4 generate E.M.T.'s.

5 So if we were to go back, and that's where the
 6 discussion went, and said, "Okay. We can't control the
 7 student coming in because he has to be sponsored, and we
 8 can't control the level of the sponsorship because we
 9 can't police them anymore because we don't have any money
 10 and we don't have any people, how are we going to solve
 11 this problem?" We're going to solve this problem by
 12 concentrating our effort in weaning those out by
 13 attempting to educate them. The C.L.I. program or
 14 special core sponsors that were put on this material
 15 should and would have all the equipment we need. Well,
 16 we know how to use a Hare traction, but maybe we don't
 17 have the other devices. So we'll attempt to re-educate
 18 them. As a failsafe mechanism, we'll test them at the
 19 end.

20 So whether they come in incompetent or they go
 21 out incompetent, it's just a matter of how do you get to
 22 weed out the process or how do you get to weed these
 23 people out? We need core sponsors, we need C.L.I.'s, we
 24 need C.I.C.'s. We want to try a different direction, a
 25 direction that worked in the past.

1 SEMAC - 3-29-2011

2 Now we can always reverse it again, but just
3 going around and around and around does not solve a
4 problem. Thank you.

5 **DR. LEINHART:** Other than the -- the
6 motion that was offered, is the -- does the education
7 committee have a more broad recommendation to address
8 this issue?

9 **MR. WEDGE:** Again -- again, this
10 morning, we spent almost an hour discussing this, and a
11 number of proposals were put forward. This is the one
12 that was accepted by the committee. So are there other
13 potentials? I suppose. But right now, we're looking for
14 some sort of conformity, and that's just what we got.

15 **DR. LEINHART:** And it -- and it was --
16 that -- that won out because it was practical? It was
17 viewed as being practical?

18 **MR. WEDGE:** Yeah, I'm sorry. I didn't
19 hear what you said.

20 **DR. LEINHART:** Was it -- did it win out
21 because it was viewed as being the most practical,
22 expeditious, least expensive way to get to where we want
23 to get to?

24 **MR. WEDGE:** I -- I believe that's what
25 happened this morning, yes.

Page 54

1 SEMAC - 3-29-2011

2 **DR. LEINHART:** I mean, it sounds like
3 you're taking a four year college student and giving him
4 a crash course right before he graduates.

5 **MR. PARRISH:** Part of what we
6 recommended is taking -- and we're looking at the budget
7 constraints on that right now -- is taking the time that
8 was scheduled for the screening and adding that to the
9 C.L.I. program. So that'll give us another extra eight
10 hours that we can work with these students.

11 **MR. WEDGE:** And Karen Meggenhofen said
12 she would go back and look at the -- at the curriculum
13 and add those hours in where they would fit. And we have
14 another individual looking at the budget.

15 **DR. HENRY:** Don?

16 **MR. FAETH:** I'm -- I'm actually seeing
17 this in a different way. I -- I actually support what
18 Rich and his group are looking to do. A person could
19 be -- have a driver's license, be an excellent driver,
20 but may have never driven a stick shift. E.M.S. in New
21 York State and across the nation is made up of many
22 different agencies who use different vendors for their
23 equipment. So the person could be in E.M.S. for
24 twenty-five years, but have never used one of these other
25 pieces of equipment that their particular agency doesn't

Page 55

1 SEMAC - 3-29-2011

2 utilize. It wouldn't make them a bad instructor. They
3 just need exposure to that and -- and an understanding of
4 how it works for the same application.

5 So you know, at the end of the day, I see nothing wrong
6 with what they're trying to do here. You're not -- it's
7 not a crash course, and I -- I hate to hear that word
8 "incompetent." You know, the person may be a wealth of
9 experience and knowledge who would be excellent
10 instructor. They just need exposure to that piece of
11 equipment. And I don't see anything wrong with that.

12 **DR. HUFFNER:** Mr. Chairman, was there a
13 motion on the floor?

14 **DR. HENRY:** Pardon me?

15 **DR. HUFFNER:** Was there a motion the
16 floor?

17 **DR. HENRY:** The motion is from the
18 committee, yes. Karen?

19 **MS. MEGGENHOFEN:** I believe the -- the
20 main concern was -- or at least the discussion was that
21 in some instances, the time and money we're spending
22 doing a prescreening might be better spent in time in the
23 class to hone their skills or to help them learn how to
24 coach the skills they might be unfamiliar with, which is
25 what we used to do. When I started teaching C.L.I.

Page 56

1 SEMAC - 3-29-2011

2 classes, we had students come into our course that had
3 never seen anything but a cravat, had not seen a nine
4 foot strap. And that's what we did. We exposed them to
5 that, we told them how to use it, we showed them how to
6 use it, and when they left the class, they had a skill to
7 take back with them.

8 So our hope is that we can take the
9 time we've been spending on the prescreening, which the
10 concern was if they fail the prescreening, they go back
11 and teach as one of the fifty percent of the
12 non-certified people in a class. Their hope was maybe
13 we'd be better off to take that individual, put them
14 through the class, help them hone their skills, learn a
15 little more, and then again, test them at the end to make
16 sure that they are competent to go forth and teach as a
17 C.L.I. and -- and try to use that time and money as part
18 of the C.L.I. course. You know, we'll put something
19 together, try to, you know, tweak the course that Rich
20 has been working on to make sure that we have the hours
21 and so on, and we'll bring that back hopefully in May.
22 But this was our first step to try to think about at
23 least eliminating the prescreening and combining back
24 with the course. Hopefully that helps.

25 **DR. MYERS:** I -- I think the end game

Page 57

1 SEMAC - 3-29-2011
 2 here is we want C.L.I.'s who are competent to teach not
 3 only the skills, but the behaviors, attitudes, and
 4 knowledge that go along with those skills. It sounds
 5 like the education committee has looked, and it's obvious
 6 that the candidates coming in are not of the caliber that
 7 they need to be to do that -- to achieve that objective
 8 with the current system. I support changing the system
 9 so that we do take that time and spend that time to put
 10 out competent instructors, which will end up helping --
 11 helping us in the future. I think, secondarily, though,
 12 there's a larger issue that's here in terms of the
 13 quality of the current instruction that needs to be
 14 addressed separate from this venue.

15 **DR. HENRY:** Is there any other
 16 discussion?

17 **MR. ZEEK:** Yeah.

18 **DR. HENRY:** Yes?

19 **MR. ZEEK:** Oh.

20 **DR. HENRY:** Okay. Mark, and then Dr.
 21 Dailey.

22 **MR. ZEEK:** Okay. Yeah, I would -- I
 23 would agree with Dr. Myers. I could only support this
 24 interim -- as an interim measure providing we don't
 25 forget about what the real problem is -- is why these

1 SEMAC - 3-29-2011
 2 people are not competent on various types of equipment.
 3 That needs to be solved. That's the bigger problem.
 4 **DR. DAILEY:** I certainly agree with --
 5 with both of those. And the one thing that I would like
 6 to bring back to the committee is ask the committee to
 7 consider whether or not there's an alternative mechanism
 8 other than an eighty-five on your last test and needing
 9 to test every three years rather than having
 10 high-functioning people being brought in on the
 11 recommendation of their medical director to be part of
 12 the educational process. Because I think that would also
 13 increase our cache of high-qualified, active, and
 14 interested instructors, which is ultimately what our goal
 15 is.

16 **DR. HENRY:** Informative. So is there
 17 any other discussion or should we call the question? All
 18 right. So repeat the motion, please, and then we'll --
 19 we'll vote on it.

20 **MR. WEDGE:** The motion was to do away
 21 with the prescreening skill session in the C.L.I. course.
 22 Subsequently to that, to incorporate those hours into a
 23 training in the regular program.

24 **DR. HENRY:** Okay. All in favor of the
 25 motion, please raise your hands. One, two, three, four,

1 SEMAC - 3-29-2011
 2 five, six, seven, eight, nine, ten, eleven, twelve.
 3 Okay. Against? Abstentions? Okay. It carries.
 4 And you have a second motion?
 5 **MR. WEDGE:** Yes, I do.
 6 **DR. HENRY:** Equally easy?
 7 **MR. WEDGE:** I hope. Before I do that,
 8 I would like publicly to thank Rich Parrish for all the
 9 work that he's done on this program. He's been working
 10 feverishly on this for two years at least, and he's been
 11 much appreciated on our end.

12 The second motion that I have is that
 13 the committee wishes that we accept the National E.M.S.
 14 Educational Standards as they are written. We need to
 15 take this step so we can continue -- begin to develop the
 16 curriculum that we're going to be using.

17 **DR. CUSHMAN:** For -- for what levels for care?

18 **MR. WEDGE:** All.

19 **DR. CUSHMAN:** All being?

20 **MR. WEDGE:** From E.M.R. up to E.M.T. paramedic.
 21 Yeah, that's a separate program.

22 **DR. HENRY:** Jeff?

23 **DR. MYERS:** Wouldn't we need to adopt the E.M.S.
 24 scope of practice prior to adopting the E.M.S.
 25 educational standards?

1 SEMAC - 3-29-2011
 2 **MR. WEDGE:** That wasn't discussed at all, so --.
 3 **DR. MYERS:** And the only reason I say that is
 4 because the -- our current levels of provider are
 5 different than the E.M.S. scope of practice model.
 6 **MS. BURNS:** We're -- we're -- in the office,
 7 we're in the process of -- of kind of tackling our
 8 lawyers to -- the scope of practice would require a
 9 statutory change and a regulatory change. And so
 10 that's -- that's on our -- on our agenda, as it were.
 11 The other -- right now, we -- we loosely define the
 12 E.M.S. scope of practice in New York State as a
 13 combination of things: statewide and regional protocol,
 14 the training curricula, and the regulatory requirements,
 15 and -- and also, again, loosely, basic standard of care.
 16 So that -- and it's -- so far in a couple of different
 17 venues, that loosely defined scope has held up. We
 18 definitely have to move towards a scope of practice.
 19 There's no question about that.

20 But with that said, as -- as we talked about in
 21 medical standards and extensively in the education
 22 meeting, moving towards the national practice guideline
 23 really does a lot for us. First of all, most of the
 24 other states, if not all of them, are doing that, so it
 25 allows our E.M.S. community some ability to transport

1 SEMAC - 3-29-2011
 2 themselves from here to there. We always thank a state
 3 when they call and ask about, you know, reciprocity, "Oh,
 4 thank you for taking that person." So there's a
 5 portability of your certification.

6 The other thing is that I think that -- and --
 7 and this kind of brings us back to the last conversation
 8 you were just having. It may very well raise the bar on
 9 our education. It -- you know, employing this national
 10 standard, this national standard is -- is significantly
 11 more sophisticated than our current New York State
 12 curricula.

13 The other piece to this is, quite frankly, from
 14 a -- from a budgetary perspective, and that unfortunately
 15 I've become really familiar with, and that is that we --
 16 we spend a lot of time reinventing a well thought out and
 17 researched wheel. And with all due respect, New York
 18 State is -- is -- is not terribly unique in its -- in --
 19 amongst its forty-nine colleagues. And I think that, you
 20 know, we're -- we're facing a real pivotal time, and that
 21 is that all of -- of the training materials and all of
 22 the resource materials are about to adopt this standard,
 23 whether we like it or not.

24 And so our thought -- mine, probably mostly --
 25 is that I think -- it's cost effective for us to -- to

1 SEMAC - 3-29-2011
 2 move in this direction. If we receive your endorsement
 3 and the SEMSCO's endorsement now, it allows us to plot
 4 out a timeline for a number of things, not the least of
 5 which is to provide instructors with the resources
 6 necessary for them to teach. It gives us the opportunity
 7 to evaluate our examination process, both practical
 8 skills and written, and update everything that needs to
 9 be updated in a reasonable period of time.

10 **DR. HENRY:** Further discussion? Are you ready
 11 to call the question? Okay. So read the motion again,
 12 please.

13 **MR. WEDGE:** The motion is to accept the National
 14 E.M.S. Standards -- the educational standards, excuse me.

15 **DR. HENRY:** Okay. So all in favor, please raise
 16 your hands. Against? Abstentions? Okay. It carries
 17 unanimously. Do you have another item, sir?

18 **MR. WEDGE:** No, sir. That's all I have. Thank
 19 you.

20 **DR. HENRY:** Thank you. All right. E.M.S. staff
 21 report?

22 **MS. BURNS:** Okay. A couple -- actually, last
 23 week, I had the opportunity to -- to meet our new
 24 Commissioner. He seems to be very interesting. A couple
 25 of the things that we've noted so far which I think would

1 SEMAC - 3-29-2011

2 please you as the SEMAC, he is a very data driven sort of
 3 person. He's young and energetic, and he -- one of --
 4 one of his big pushes seems to be to evaluate the
 5 department's collection of data across the board and make
 6 it more available, more interconnected. And I think that
 7 is consistent with a lot of the things particularly you
 8 in evaluations are doing.

9 And so we have spent in the last, probably about
 10 a month, we across the board in the health department,
 11 identifying all of this data, providing it to him. It
 12 turns out, it's very interesting, on a piece of paper
 13 that big, front and back, fifty pages no less of
 14 databases small and huge, collected by the health
 15 department through different mechanism, whether it's
 16 researcher, surveillance, and reporting. And so he's
 17 identified a lot of things that he is interested in
 18 looking at with that data, not the least of which is
 19 research. But a big piece of it is looking at a lot of
 20 the surveillance data to identify trends and possibly
 21 look at issues of patient care -- not possibly --
 22 definitely look at issues of patient care and patient
 23 safety. So listening to him was very interesting. He --
 24 again, he's -- he's -- he's younger than most of us in
 25 this room, and he comes from New York City and seems to

1 SEMAC - 3-29-2011

2 very interested.
 3 So the other thing that we -- we in the E.M.S. bureau,
 4 we -- we like to think we fly below the radar scope and
 5 always are somewhat surprised when we aren't. But when
 6 we have a legal determination between an E.M.S. provider
 7 and the department -- Dr. Daines had reviewed all of that
 8 stuff and signed it, and so far so has Dr. Shaw (phonetic
 9 spelling), so, that was kind of a pleasant surprise.

10 I -- under the -- under the heading of budget
 11 issues, it's -- you know, I could explain to you that the
 12 state's ten billion dollars in debt, but you know that.
 13 On the brighter side, in the governor's budget proposal,
 14 the E.M.S. activities, the E.M.S. program and you all, he
 15 has left us unscathed in that we are at the same funding
 16 level as we were in the last fiscal year. That is
 17 good -- nineteen point seven million dollars for those of
 18 you who can't remember. That is -- for us, that's
 19 encouraging. I -- I liken it to think that the governor
 20 thinks E.M.S. is of value. On the other hand, I'm more
 21 realistic to think that in the big picture, out of ten
 22 billion dollars and the Medicaid stuff, we fly below the
 23 radar scope. Either way, that's okay.

24 The downside to that is that we are nestled in a
 25 hearty bureaucracy that is unable to spend money. And

1 SEMAC - 3-29-2011
 2 for those of you who work with the program agencies or
 3 the REMSCOs or core sponsors, we have had a difficult
 4 time moving contracts and vouchers and reimbursements.
 5 As -- also, because we reimburse your travel, it's
 6 been -- it's been glacially slow. And all I can do to --
 7 to -- just tell you about that and -- and I'm getting a
 8 glaring look from poor Bob back there. The bureau --
 9 we -- the bureau has -- has -- has energetically, to the
 10 point of distraction, followed up on everything from huge
 11 contracts to the smallest of vouchers. We are tenacious
 12 and dogmatic about it, and I -- I can only promise you
 13 that. From us, it goes through our department process.
 14 Karen is convinced that they move vouchers around every
 15 day on paper, then from there it goes to either the
 16 Office of the State Comptroller and/or the State Division
 17 of Budget, and we really -- I don't get a feel for that.
 18 And to -- to suggest to you that the process for
 19 contracting or paying vouchers or anything changes every
 20 day is an understatement. Every day there's a new
 21 process. Every day somebody has come up with a new form,
 22 a new tracking thing, a new, you know, acronym for
 23 something, every day. So if you work in government, you
 24 can feel my pain, but it -- it -- it's daunting. So
 25 we'll keep you posted on -- you'll know about the state

Page 66

1 SEMAC - 3-29-2011
 2 budget, but we'll keep you posted on how that affects us
 3 and E.M.S.
 4 I will tell you that I have been asked what my priorities
 5 for spending our money are. And I confess to say to you
 6 that it is training -- making sure that we are able to
 7 continue to reimburse training at all levels. I'm
 8 simple. I think that it makes a big difference to our
 9 patients, and so they sort of look at me and go, "Uh-huh,
 10 okay."
 11 So in that same vein, meetings. We -- in an
 12 effort to move all of the contracting process forward,
 13 we -- we did some creative contracting. Our meetings
 14 are -- are done in two separate contracts. The first two
 15 meetings -- this is meeting number one -- the next one
 16 will be in May for you all -- are on one contract. And
 17 then the September and January meetings are in a second.
 18 The other day, we received approval to contract for this
 19 meeting. So you sit here with water and mints. I hope
 20 you've enjoyed them. Pass the mints to the back row.
 21 They're looking hypoglycemic. Though we have permission
 22 to contract, we don't actually have a contract. So the
 23 Hilton has -- has been very amused by us so far. We hope
 24 to actually have a contract in place by our meeting in
 25 which we will feed you water and mints. So then the

Page 67

1 SEMAC - 3-29-2011
 2 second contract, we have not received permission to enter
 3 into, and those are the fall and winter meetings for next
 4 year.
 5 With that, what I would ask you to do as we
 6 progress through today and tomorrow, if you have -- if
 7 you've -- one of the things we did is, particularly with
 8 lunch, we -- we gave you -- you an hour and a half
 9 because, welcome to Troy. But if that's too long and you
 10 think that we could better arrange our schedule so that
 11 it -- it comports with better business, we'll -- we'd
 12 entertain that. Not necessarily adopt it, but certainly
 13 entertain that.
 14 So the other piece to this is in the event -- in the
 15 likely event that we're stalled a contract again, I want
 16 you all to be thinking of -- of alternatives for the
 17 continuity of business, particularly the SEMAC. I -- I
 18 started out thinking I would do this in a little amusing
 19 slide presentation, but then I thought Dr. Huffner would
 20 hurt me. But what I'm going to do -- he's going to hurt
 21 me anyway. What I'm going to do -- this little piece of
 22 paper -- and -- and indulge me for a moment -- but this
 23 piece of paper is the -- the sterilized, boiled down,
 24 statutory authority of your body. I need you to read it.
 25 And the reason for that is that quite honestly, we -- we,

Page 68

1 SEMAC - 3-29-2011
 2 the -- the bureau, particularly, are fighting. And I --
 3 you know, fighting is kind of harsh word, but it is very
 4 difficult in this fiscal atmosphere and political
 5 atmosphere to justify and work with advisory councils.
 6 You know, or you don't know, but the department
 7 was forced to eliminate the public health council and
 8 SHRPC, it is now one council called PHHPC. They are
 9 doing that -- I don't -- I'm not even really actually
 10 sure what PHHPC stands for. I think it's Public Health
 11 and Planning and on and on and on, but anyway. But as we
 12 sit here today, and I've told this to the executive
 13 committee and the committee chairs and anyone who will
 14 sit and listen, as we sit here today and tomorrow, we may
 15 not look the same as we do a year from now. It's not a
 16 threat. It's not a promise. It's honestly a reality.
 17 And I -- and why I bring this up to you is
 18 because I honestly believe that if there are changes in
 19 our structures, the E.M.S. community and the emergency
 20 medical community and the physician community need to be
 21 involved in how we look in the end. I don't want the
 22 bureaucracy to eliminate or change the -- our purpose
 23 and/or structure without input from you, who are the
 24 stakeholders. So that is why I hand this out. Tomorrow
 25 the SEMSCO gets theirs.

Page 69

1 SEMAC - 3-29-2011
 2 And with that, we've been harping on you as -- as
 3 committee chairs and participants to utilize a project
 4 management tool. There -- as awful as that is, and I
 5 apologize for that, kind of, when you actually read the
 6 form, they're not as complicated as they seem. But the
 7 reason for that is that when someone says, "Wow, you guys
 8 meet for two days." You -- and I can't -- every day I
 9 hear this from people around me and above me: "You guys
 10 manage four advisory councils? There are four E.M.S.
 11 related advisory councils?" They are stunned and amazed.
 12 And all we need is to show them that you are producing
 13 something. It -- not something ethereal. It's fine that
 14 you have discourse; we encourage discourse. But in the
 15 end, you have to make a difference to the E.M.S.
 16 community at every level. I know that you do, and in
 17 some cases, if you're not, you believe that you do, we
 18 need it memorialized.
 19 So the -- the project management tool, or I'm
 20 working on the project management weapon, is to -- is to
 21 really ratchet down on you, quite frankly. We need work
 22 plans, we need you to have attainable projects, and we
 23 need to control you, quite honestly. So with that said,
 24 and no one believed I would actually utter these words, I
 25 implore you, no new projects or TAGs. I realize you have

Page 70

1 SEMAC - 3-29-2011
 2 the critical care thing. I know that's been around for a
 3 while.
 4 I will say this again tomorrow to the -- to the SEMSCO.
 5 Please bring to closure what you're working on
 6 now so that you have -- we have something. The "we"
 7 is -- is not just the department, but it's the E.M.S.
 8 community. So I know you're very creative. I know
 9 you're all very energetic. I'm not. Please no new TAGs,
 10 no new projects until we have a grip on what we're doing
 11 now. And honestly, you have a full plate now.
 12 So blood update -- there is no blood update. We
 13 actually spoke with a blood and tissue program. The
 14 blood and tissue council approved the regulations as --
 15 as proposed to included advanced E.M.T.'s to transport
 16 blood. There is a process for doing that. We -- I --
 17 it's no wonder Andy gets all testy because those people
 18 are very interesting. We have worked with them on policy
 19 statements and paperwork in order to move this forward.
 20 We think the blood and tissue people have essentially
 21 approved of this.
 22 There's -- we -- we kind of modeled it after our P.A.D.
 23 notification. A service would notify us they're going to
 24 do this. So it's really -- we've -- we've kind of moved
 25 it to the service realm. So if the service says we're

Page 71

1 SEMAC - 3-29-2011
 2 going to do this, then we've turned to them for training,
 3 and recordkeeping is going to be at the local level.
 4 The submitted their regulations to something
 5 called the Governor's Office on Regulatory Reform, GORR.
 6 We learned the other day or -- recently that GORR has
 7 been eliminated by this governor. And so Dr. Linden
 8 (phonetic spelling) and her group are following up on
 9 where are their regulations? They are very concerned
 10 because they had some significant regulations in this
 11 package, so I'm sure that they will follow up.
 12 Do you want to comment on that, Dr. Young?
 13 **DR. YOUNG:** I think you've pretty well
 14 summarized it, Lee. We -- we weren't aware at the
 15 department level until we did some digging and -- and
 16 found out that things had been removed. So we're
 17 actively pursuing where -- where they stand and where we
 18 have to get approval because they never went out for the
 19 public comment we needed in GORR.
 20 **MS. BURNS:** Okay. Controlled substances. We --
 21 with the help of -- of a number of you, we put together a
 22 fentanyl policy -- updating fentanyl policy that would
 23 enable fentanyl on standing orders for adult patients.
 24 And we're right -- we're just finishing touches on the
 25 policy statement. And we were told -- I was told the

Page 72

1 SEMAC - 3-29-2011
 2 other day that the Commissioner's going to read it, which
 3 also is very positive. So I'll keep you posted. We'll
 4 get that out as soon as possible. I -- I -- honestly,
 5 we're -- we're right at the very end of it. I think the
 6 details, you can talk about, but I think you'll be
 7 pleased.
 8 The other thing I want to let you know is that
 9 B.N.E. and E.M.S. -- B.N.E. being the Bureau of Narcotic
 10 Enforcement -- are conducting audits of documentation at
 11 semi-annual reports and the quarterly reports. And so
 12 far, the audits have indicated dismal compliance. And
 13 because these -- the -- the Part 80 Regulations and --
 14 and Article 33 enable this to happen, we're sending out
 15 fairly draconian letters to services saying, "If you
 16 can't put together that simple useless form, perhaps you
 17 should not administer narcotic medications." So we're
 18 raising the level of awareness of some of your services.
 19 We expect they -- to come to you with their eyes glazed
 20 over in horror.
 21 The other -- the last -- well, I have a couple
 22 more items, but anyway, just to let you know that we
 23 activated our statewide mobilization plan for New York
 24 City's December 26 snowstorm. We provided -- we, you,
 25 the State of New York, and E.M.S. providers provided

Page 73

1 SEMAC - 3-29-2011

2 three operational periods of ambulances. Fifty-nine
3 ambulances responded into New York City to assist FDNY
4 and their 911 partners. That was fifty-nine agencies
5 from twenty-six counties, a hundred and seventy-two
6 E.M.S. providers.

7 **MS. BURNS:** The E.M.S. memorial. If you are not
8 aware, please be aware. The E.M.S. memorial is May 18 at
9 eleven a.m. Please, please, please come. We're
10 inducting three line of duty deaths. I -- I -- I -- the
11 memorial is one of the best things we do. I really hate
12 the memorial. I wish we didn't have to induct anybody.
13 I wish we could all stand around and say, "Oh, we didn't
14 induct anybody." We're just not that lucky. This year,
15 we're inducting two individuals who died of sudden
16 cardiac death while treating patients.

17 The -- the fire service has been dealing with
18 this for a very long time in that the general health of
19 its providers isn't that good, and then they drop dead at
20 the scene of -- of a fire. It's not something we're all
21 that used to in E.M.S., but I have to tell you that I get
22 these notifications from the listservs of line of duty
23 deaths across the country, and these numbers for
24 pre-hospital care providers are on the rise at a scary,
25 scary rate.

Page 74

1 SEMAC - 3-29-2011

2 So far, the Commissioner has acknowledged our
3 invitation, so we're pleased about that. We've invited
4 the governor. We were invited to invite the governor and
5 the legislators, and we have specifically invited the
6 legislators from the areas where the inductees come from.
7 So we have two really from -- from the southern tier and
8 one from the Glens Falls area.

9 And E.M.S. week is May 15 through the 21st. We
10 have put in a link to -- on our website to the ACEP
11 E.M.S. week package. Please pass that along. ACEP, as
12 you all know because you are members of ACEP, has always
13 put together a really excellent, excellent public
14 information packet, and our services have always used it.
15 And ACEP has provided it at no cost, but we have had to
16 pay for the mailing. And we've been invited not to pay
17 for the mailing, so the best that we can do essentially
18 is to link it to our website, so we're good with that.

19 And the last thing I have -- I don't know if you
20 have seen this, but it's very interesting. I have it
21 electronically, and I can -- I can send it to you on the
22 listserv. But the Congressional research service did a
23 look at the legislative authority for the civil
24 liabilities of volunteer health professionals in
25 emergency response. And we did share that, I think,

Page 75

1 SEMAC - 3-29-2011

2 with -- with the executive -- I don't even -- I think the
3 E.M.S. for children. And if you're interested, I have a
4 copy, but I'll -- we'll send it out on the listserv.
5 The -- the attorney who did this, the executive summary
6 is excellent, and what they -- she did is look at
7 different state laws that enable licensed health
8 professionals to volunteer in an emergency because that
9 has been an issue, both in New York and nationally.

10 And I think, Mr. Chairman -- Dr. Chairman, that
11 brings me to a close at the moment.

12 **DR. HENRY:** All right. Good. Any questions for
13 Ms. Burns or any discussion? Old business. So we we're
14 going to -- we -- last time we talked about the safety
15 advisory. We're going to issue an advisory, and I asked
16 for -- oh, I'm sorry. And I asked for the language so we
17 were accurate with it, but Interim Director Burns told me
18 that they had gotten some advice from council within the
19 department, and we're bringing it back to you here.

20 **MS. BURNS:** I -- actually, I forgot this. I
21 don't know why. Have you seen this? Can you see this
22 from where you're sitting?

23 **FROM THE FLOOR:** It looks like the MOLST to me.

24 **MS. BURNS:** Yes, we -- it's -- it's -- it's not
25 the MOLST. The -- the department is out of the safety

Page 76

1 SEMAC - 3-29-2011

2 paper that we used to print E.M.T. cards on, and so we
3 are issuing all levels of E.M.T. certificates on this
4 paper. It's important that you see this, really.

5 **MR. CZAPRANSKI:** Does -- does Dr. Bomba
6 (phonetic spelling) know?

7 **MS. BURNS:** Oh, we forgot to ask Dr. Bomba.
8 Actually, interestingly, the reason it's on this color
9 paper is very similar to the reason the MOLST form is on
10 this color paper. Andy Johnson and I did a scientific
11 test. We took all kinds of colored paper, we ran them
12 through the Xerox machine, and most colored paper comes
13 out looking white when you copy it. This offensive color
14 does not; it's grayed. And the reason we did that is
15 that we wanted to -- to be able to identify -- we wanted
16 the services, and you as medical directors, to be able to
17 identify a photocopied version of this. Even if you
18 photocopy it on this beautiful paper, it's gray. So --
19 but I -- seriously, we -- we're issuing cards on this for
20 the time being. When we get safety paper, we have
21 ordered safety paper, we have begged for safety paper, we
22 have cried, we have done 1184s, we have done everything
23 we can think of to do -- to get safety paper, we will
24 reissue all the cards we issued on this at the point we
25 get the paper. But just so you know, the department is

Page 77

1 SEMAC - 3-29-2011
 2 also out of birth certificate paper, too. So you can't
 3 have babies either.
 4 Back to the agenda. At your last meeting, Paul Bishop
 5 put together an excellent presentation on the things that
 6 you can and should not do in the back of a moving
 7 ambulance. And you all heartily supported the policy,
 8 and we -- and brought it back and basically reviewed it
 9 and realized, much to our horror, that the department
 10 cannot issue this in this way as a policy statement.
 11 I -- I said to -- in an e-mail note to Dr. Henry that you
 12 can certainly, if you wish, issue it as a SEMAC advisory
 13 and hope the Commissioner approves it. But here's the
 14 thing: I was told earlier by a doctor and an attorney
 15 that there are too many lawyers.

16 The -- when we evaluated this, the concept is
 17 excellent. And we will certainly issue a policy
 18 statement discussing the safety of operations in the back
 19 of an ambulance. But the downside to this is -- is that
 20 it's so specific that -- as to make us liable. And so,
 21 for example, if an E.M.S. provider is doing a
 22 non-lifesaving intervention in the back of an ambulance
 23 and they are involved in a crash, they have no recourse
 24 because we have said, "That's an intervention you cannot
 25 do unbelted, but you were unbelted." But conversely, if

Page 78

1 SEMAC - 3-29-2011
 2 they initiate oxygen therapy and are involved in a crash,
 3 they turn around and say, "Well, you people," the
 4 department, because it's a department policy, "said we
 5 could initiate oxygen and my loved one was killed.
 6 You're liable."

7 And so from a -- an internal control and risk
 8 issue, the department, in the way this is written, cannot
 9 issue this. With that said, we not unwilling to issue a
 10 policy statement that really does discuss the issues of
 11 safety and -- and unsafe actions in the back of an
 12 ambulance. And we will gladly work with Paul and, you
 13 know, the -- the SEMAC to do that. But the way this
 14 is -- is designed really leaves us open to a liability,
 15 really. I mean, we're liable anyway, but it leaves us
 16 open to a liability that the health department's not
 17 willing to take on.

18 **DR. HENRY:** Okay. So just to inform you of
 19 where's that at. I don't know if there's any discussion,
 20 but hopefully it'll be equally effective, just not as
 21 specific. Okay. Then the -- we had questions last time
 22 about the Vehicle and Traffic Law. We asked Ms. Burns to
 23 look further into that, and she did.

24 **MS. BURNS:** I did. There's two -- there's a
 25 couple things that have happened since -- since your last

Page 79

1 SEMAC - 3-29-2011
 2 meeting. One was you had asked us to go back to our
 3 attorneys and say, "But -- but here's the thing." And
 4 basically the attorneys said, "No, the law stands."
 5 Now with that said, though, a physician that you
 6 all know asked a question about whether or not a service
 7 could make a policy not to do blood alcohol content draws
 8 in the field. So I asked that question. And -- and
 9 basically the answer that came back to me from both our
 10 attorney and his boss, who is the deputy house counsel,
 11 was -- let me -- I'll tell you what the question is.
 12 I -- I went on and on and on about -- about the initial
 13 decision. The question I asked was, "Can an ambulance
 14 service write an internal policy prohibiting their
 15 advanced E.M.T.'s from drawing blood while
 16 working/representing an E.M.S. agency?"

17 And the second question was, "Can we presume
 18 that an E.M.T. may draw blood alcohol on his or her own
 19 time, not -- while not working?" And the response back
 20 was, "Yes and no."

21 The answer to -- the answer to both questions --
 22 well, the answer to both of my questions -- this is from
 23 the attorney -- is, "Yes. As expressed in our E.M.S.
 24 Policy 1101, the -- the change in the law permits
 25 A.E.M.T.'s to draw blood at the request of a police

Page 80

1 SEMAC - 3-29-2011
 2 officer for the purpose of alcohol and drug screening,
 3 but the E.M.T. is mandated to perform the procedure.
 4 When an E.M.T. is acting pursuant to a request of a
 5 police officer relying on B.L.T. 1194, an A.E.M.T. is
 6 acting independent of physician or medical oversight.
 7 However, an ambulance may adopt a policy prohibiting an
 8 advanced E.M.T. in its employ from drawing blood while on
 9 duty/on the job at the request of a police officer.
 10 However, it," being the ambulance service, "may not
 11 prohibit an E.M.T. employee from complying with a police
 12 officer's request off the clock."

13 So that actually is interesting. The -- the
 14 question came actually from a medical director of an
 15 ambulance service, and I've seen a couple of draft
 16 policies from services prohibiting their E.M.T.'s, while
 17 operating as E.M.T.'s for that service, from doing a
 18 blood alcohol draw. So that's -- that's an update.

19 With that said, I was invited to participate
 20 in -- I'm not really sure what they are -- but a group --
 21 I figured I was going to be murdered by a group of
 22 attorneys and police officers who work with the
 23 Department of Motor Vehicles. They got a hold of Policy
 24 Statement 1101 and -- and much to my surprise, they were
 25 very pleased with 1101. It really does speak to what --

Page 81

1 SEMAC - 3-29-2011
 2 what they had hoped for. And with that said, I have to
 3 thank a number of you for participating and working with
 4 us on that.
 5 The only thing they made comment about, and
 6 would like to move to changing it, is number eight in the
 7 policy statement, which reads, "An A.E.M.T. must confirm
 8 with the person from whom the blood sample is being
 9 requested and the supervising police officer that the
 10 person is consenting to a blood draw." They -- this is
 11 not supported by law, and they're going to provide me
 12 with the cite so that we can alter this so that it
 13 reflects current law. What they -- what the lawyers
 14 are -- the district attorneys and their district attorney
 15 lawyers are telling me is that once a police officer has
 16 placed an individual under arrest, we, the E.M.S.
 17 providers, do not have to re-consent them. What I have
 18 conversely asked them to do is work with us on
 19 documenting a blood draw. And that is a conundrum all
 20 the way around.
 21 They -- we're working with them to -- they would
 22 like to be on your agenda for the May meeting just to
 23 talk with you about education and to work with you and
 24 reach out to the REMAC so that you all are on the same
 25 page because their intention is not to take an

1 SEMAC - 3-29-2011
 2 under-informed E.M.S. provider and have them draw blood.
 3 Their intention, and they have -- they'll provide you
 4 with data. They -- they would like to make these arrests
 5 more effective and they would like to work with you to do
 6 that. And so I will be in touch with them and I will
 7 further bring this to Dr. Henry so that they can present
 8 to you and you have better information.
 9 Again, it's -- they have data that I think you
 10 would be interested in, and I think that they're not far
 11 apart from you as we think they are.
 12 **DR. HENRY:** All right. So that's an update.
 13 We've certainly got to explore this further.
 14 **MR. FAETH:** I'm sorry, Lee. Just one quick
 15 question on that. Most systems do not allow providers to
 16 accept an R.M.A. from somebody who is visibly intoxicated
 17 because that's not competent consent. How do you then be
 18 able to justify competent consent for what -- by strict
 19 letter of the law might even be deemed as a -- as an
 20 assault on an individual by drawing blood from someone.
 21 I -- I mean, that -- I think that raises a lot of legal
 22 issues for the -- for a lot of --.
 23 **MS. BURNS:** There's no question. And actually
 24 that is -- that is one of the reasons I would like them
 25 to talk with you because there are rules of custody that

1 SEMAC - 3-29-2011
 2 I, quite honestly, do not -- I don't know them. And
 3 their contention is that once under arrest, the -- the
 4 rules of consent change for the individual and that --
 5 we're not -- as I said to them, we would be glad to work
 6 with them, but I need a legal citing, and they are
 7 willing and interested in providing it. So I -- I can't
 8 answer your question, but I believe that they can.
 9 And I -- the -- again, the other piece that is a
 10 conundrum to me is how an E.M.S. provider documents a
 11 blood draw on an individual they do not have a patient
 12 relationship with, and they are working on that as well.
 13 So I think it would be very constructive for you to ask
 14 them -- them that question as opposed to me.
 15 **DR. KUGLER:** Lee, who's the "them" that you're
 16 referring to?
 17 **MS. BURNS:** I'm working with an A.D.A.,
 18 actually, from Nassau County whose first name is Maureen
 19 (phonetic spelling). But it's a -- it's a -- it's the --
 20 the -- I want to -- STOP-D.W.I. advisory committee to the
 21 Department of Motor Vehicles. They -- and it's a very
 22 interesting group of people. There are -- the state
 23 police is represented, the -- there's an association from
 24 several sheriff's department. Albany County Sheriff is
 25 represented, Steuben County Sheriff's Department is

1 SEMAC - 3-29-2011
 2 represented, and then there's a series of STOP-D.W.I.
 3 coordinators and district attorneys and the Department of
 4 Motor Vehicles. And they tell me they would be
 5 interested in working with us on an education program,
 6 and they have money. And they kept saying, "And we have
 7 money." So I'm -- you know, money.
 8 **DR. KUGLER:** It's Maureen McCormick (phonetic
 9 spelling).
 10 **DR. HUFFNER:** Lee, you mentioned that an
 11 individual service -- I'm going to assume that that's
 12 an -- well, maybe not -- I would say it's an A.L.S.
 13 service -- has the ability to create internal policy.
 14 Would a REMAC have the ability to create policy that
 15 would apply to A.L.S. agencies, either pro or con this
 16 issue?
 17 **MS. BURNS:** Quite honestly, the express answer
 18 to that is no, because the advanced E.M.T. is acting
 19 independent of physician medical control oversight. So
 20 it -- it becomes a service operating policy. Could you
 21 issue a guideline? Don't do that.
 22 **DR. HENRY:** All right. Well, this -- this begs
 23 many questions. You know, it's -- it's one -- it's one
 24 hypothetical and some answers. But I wouldn't draw large
 25 policy influences personally as a result of this.

1 SEMAC - 3-29-2011

2 Certainly it conflicts with a lot of other policies in
3 terms of blood draws for forensic purposes.

4 **MS. BURNS:** I mean, I --.

5 **DR. HENRY:** So it's -- it may be new territory,
6 but I think we'd be best, you know, exploring it a little
7 further before we jump to conclusions on this.

8 **MS. BURNS:** And I -- I see some of your minds
9 working. I would ask, honestly, that while I -- you
10 know, whatever your REMACs are going to do, that -- that
11 you allow these people to discuss it with you. You get a
12 better feel for what they know and -- and what laws they
13 are looking at before you enact, you know, regional
14 policies, because specifically the law -- the law is --
15 is described -- a relationship between the advanced
16 E.M.T. and the police officer. So consider the people in
17 May.

18 **DR. HENRY:** Thank you.

19 **DR. HUFFNER:** But -- but the individual REMAC
20 does have the authority over A.E.M.T.'s within its
21 region, yes or no?

22 **MS. BURNS:** Not in this instances, according to
23 the department's attorneys.

24 **FROM THE FLOOR:** No medical oversight?

25 **MS. BURNS:** No medical oversight.

Page 86

1 SEMAC - 3-29-2011

2 **FROM THE FLOOR:** That's -- that's crazy.

3 **MS. BURNS:** It is -- it's not. I mean, we
4 argued the -- you know, if -- if, you know, the warm and
5 fuzzy committee on open heart surgery decided that
6 outcomes would be better if -- if C.F.R.'s did open heart
7 surgery and the -- basically the -- the legislature could
8 come up with a change in the law that would enable
9 C.F.R.'s to do open heart surgery, it -- it -- it pecks
10 away at the authority that is -- that is Article 30. And
11 they told me that, "Oh, well." I was basically told,
12 "Oh, well."

13 **DR. HENRY:** Okay. I've listed demonstration
14 projects. We heard about -- we heard brief reports at
15 medical standards, but the intent was to bring the ones
16 that are outstanding to a close. That's my intent. I'm
17 searching the minutes. Well, I'm having my assistant
18 search the minutes to find out exactly what we did so we
19 can bring these to a close and move on, okay? And that's
20 why it's there.

21 There were a couple appeals. One will be
22 reported at the next meeting, and another one was
23 withdrawn. So you heard about two last week. People
24 volunteered to listen to them. We did have a couple
25 listen to one appeal, but a second one was withdrawn by

Page 87

1 SEMAC - 3-29-2011

2 the region, so -- and the one, we'll discuss as a SEMAC,
3 perhaps, at the next meeting. Any other old business?

4 **DR. KAUFMAN:** I -- just on the topic of
5 demonstration projects. I'm not sure this qualifies, but
6 I wanted to provide an update anyway.

7 Probably about a year ago, this body heard
8 information about a project -- an organ donation project
9 that's going on in New York City where there is -- where
10 we were planning at that time a special vehicle that
11 could go after a patient is pronounced dead at the scene,
12 a patient who had wanted to be an organ donor, had
13 already consented to be an organ donor, and fell within
14 the other criteria, this special unit could go and
15 transport this potential donor to Bellevue where there'd
16 be a special team waiting to place the patient on ECMO
17 until that time that the organs can be recovered and the
18 proper testing done.

19 That -- so I guess that's not a demonstration
20 project, but it's -- it's a project that's ongoing. The
21 vehicle actually hit the roads December 1st. It will
22 probably be continuing through May, and it's been very
23 successful so far. There's a vehicle that has two
24 E.M.T.'s. It's staffed with a family services specialist
25 from the New York Organ Donor Network as well as a

Page 88

1 SEMAC - 3-29-2011

2 physician from Bellevue that's on this special unit
3 called the Organ Preservation Unit. At the same time, in
4 a separate vehicle, but part of the team, is a
5 supervising police department officer. And they've been
6 working to coordinate their response to these locations
7 to see if these are candidates to -- if the person is on
8 the registry of consent, the New York State Registry of
9 Consent, they will enter the premises. They will check
10 the exclusion criteria, talk with the family.

11 To date, there have been five instances where
12 they've entered a premise, spoken with the family -- no
13 patients have met all the criteria to be transported back
14 to Bellevue, but the -- the response from the family
15 members of the places they've entered has -- has been
16 extremely positive. Also, the response from the rest of
17 the E.M.S. community and the public has been incredibly
18 positive so far.

19 So I just wanted to provide you that brief
20 update --

21 **DR. HENRY:** Thanks.

22 **DR. KAUFMAN:** -- to this body.

23 **DR. HENRY:** All right. Any other old business?
24 So we'll go to new business. Brad, did you want to speak
25 about the --

Page 89

1 SEMAC - 3-29-2011
 2 **DR. KAUFMAN:** Sure.
 3 **DR. HENRY:** -- boards?
 4 **DR. KAUFMAN:** So as most of you are aware,
 5 E.M.S. has been approved by the American Board of Medical
 6 Specialties as a sub-specialty certification under
 7 emergency medicine. This is something I know a lot of
 8 you have been involved in pushing and we're very proud
 9 of. I know a little bit about the plans as -- as do many
 10 of you, but Dr. Henry and I thought it would be worth
 11 briefly discussing.
 12 There are currently four E.M.S. fellowships throughout
 13 the state. The application process now is going to
 14 change because it's going to go through the A.C.G.M.E.
 15 We assume that those four fellowships will continue,
 16 and -- and maybe there will be others. The first
 17 A.C.G.M.E. accredited fellowship will probably start in
 18 July of 2012. So the fellows that are starting this July
 19 2011 will -- will not be still part of an A.C.G.M.E.
 20 program. The first board's exam to become certified as a
 21 E.M.S. sub-specialist will probably be in 2012 as well.
 22 There's been a committed appointed who is working on
 23 the -- the test questions now.
 24 There are three pathways to achieve board
 25 certification, the first of which is completing an

Page 90

1 SEMAC - 3-29-2011
 2 A.C.G.M.E.-accredited fellowship, of which none exist, so
 3 nobody's done that. The other two grandfather pathways
 4 involve -- well, one where somebody's done an E.M.S.
 5 fellowship and has a certain number of hours working as a
 6 medical director. And the third pathway is someone who
 7 has not done an E.M.S. fellowship, but has more hours
 8 working as a medical director. And I -- I -- I don't
 9 have those exact hour numbers, but I'm sure a lot more
 10 information will be coming out. So we just wanted to
 11 mention that.
 12 **DR. HENRY:** Two outstanding items that we have
 13 to deal with. I was remiss, but I was informed that we
 14 should have done roll call votes on the education
 15 motions. So I'm just going to ask you vote again, and
 16 we'll do it by roll call. Can you put the first motion
 17 up? All right. This is the second one we voted on, but
 18 this is fine.
 19 So this to adopt the National E.M.S. Educational
 20 Standards for training of E.M.S. providers in New York
 21 State. Any further discussion on this? Okay. Let's
 22 call the roll.
 23 **FROM THE FLOOR:** Dr. Cushman?
 24 **DR. CUSHMAN:** Yes.
 25 **FROM THE FLOOR:** Dr. Dailey?

Page 91

1 SEMAC - 3-29-2011
 2 **DR. DAILEY:** Yes.
 3 **FROM THE FLOOR:** Dr. Davidoff?
 4 **DR. DAVIDOFF:** Yes.
 5 **FROM THE FLOOR:** Dr. Delaney? Dr. DeTraglia?
 6 **DR. DETRAGLIA:** Yes.
 7 **FROM THE FLOOR:** Dr. Goodman?
 8 **DR. GOODMAN:** Yes.
 9 **FROM THE FLOOR:** Dr. Haydock? Dr. Henry?
 10 **DR. HENRY:** Yes.
 11 **FROM THE FLOOR:** Dr. Huffner?
 12 **DR. HUFFNER:** Yes.
 13 **FROM THE FLOOR:** Dr. Kaufman?
 14 **DR. KAUFMAN:** Yes.
 15 **FROM THE FLOOR:** Dr. Kugler? Dr. Leinhart?
 16 **DR. LEINHART:** Yes.
 17 **DR. COOPER:** Excuse me, was that Dr. Kugler or
 18 Dr. Cooper?
 19 **FROM THE FLOOR:** Kugler.
 20 **DR. COOPER:** Thank you.
 21 **FROM THE FLOOR:** Dr. Marshall?
 22 **DR. MARSHALL:** Yes.
 23 **FROM THE FLOOR:** Dr. Murphy?
 24 **DR. MURPHY:** Yes.
 25 **FROM THE FLOOR:** Dr. Myers?

Page 92

1 SEMAC - 3-29-2011
 2 **DR. MYERS:** Yes.
 3 **FROM THE FLOOR:** Dr. Olsson?
 4 **DR. OLSSON:** Yes.
 5 **FROM THE FLOOR:** Dr. Takats?
 6 **DR. TAKATS:** Yes.
 7 **FROM THE FLOOR:** Oh, and Dr. Cooper?
 8 **DR. COOPER:** Yes.
 9 **FROM THE FLOOR:** So that's one, two, three,
 10 four, five, six, seven, eight, nine, ten, eleven, twelve,
 11 thirteen, fourteen, fifteen for. Roll call complete.
 12 **DR. HENRY:** Thank you. Okay. How about the
 13 second motion? All right. To eliminate the skill
 14 prescreening test for the certified lab instructor
 15 courses and redirect the resources towards skill
 16 education.
 17 **FROM THE FLOOR:** Dr. Cooper?
 18 **DR. COOPER:** Yes.
 19 **FROM THE FLOOR:** Dr. Cushman?
 20 **DR. CUSHMAN:** Yes.
 21 **FROM THE FLOOR:** Dr. Dailey?
 22 **DR. DAILEY:** Yes.
 23 **FROM THE FLOOR:** Dr. Davidoff?
 24 **DR. DAVIDOFF:** Yes.
 25 **FROM THE FLOOR:** Dr. Delaney?

Page 93

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** No? Dr. DeTraglia?
 3 **DR. DETRAGLIA:** Yes.
 4 **FROM THE FLOOR:** Dr. Goodman?
 5 **DR. GOODMAN:** Abstaining.
 6 **FROM THE FLOOR:** Dr. Haydock? Dr. Henry?
 7 **DR. HENRY:** Yes.
 8 **FROM THE FLOOR:** Dr. Huffner?
 9 **DR. HUFFNER:** Yes.
 10 **FROM THE FLOOR:** Dr. Kaufman?
 11 **DR. KAUFMAN:** Yes.
 12 **FROM THE FLOOR:** Dr. Kugler? Dr. Leinhart?
 13 **DR. LEINHART:** Yes.
 14 **FROM THE FLOOR:** Dr. Marshall?
 15 **DR. MARSHALL:** Yes.
 16 **FROM THE FLOOR:** Dr. Murphy?
 17 **DR. MURPHY:** Yes.
 18 **FROM THE FLOOR:** Dr. Myers?
 19 **DR. MYERS:** Yes.
 20 **FROM THE FLOOR:** Dr. Olsson?
 21 **DR. OLSSON:** No.
 22 **FROM THE FLOOR:** Dr. Takats?
 23 **DR. TAKATS:** Yes.
 24 **FROM THE FLOOR:** One, two, three, four, five,
 25 six, seven, eight, nine, ten, eleven, twelve. That's

Page 94

1 SEMAC - 3-29-2011
 2 twelve for, one abstain, and one no -- or two no, I'm
 3 sorry.
 4 **DR. HENRY:** Okay. Thank you. Any other new
 5 business? Dr. Kaufman?
 6 **DR. KAUFMAN:** I'm sorry. I don't know if it's
 7 new business or an announcement. I just want to talk
 8 briefly -- there's a new medical school opening in -- in
 9 New York State, the Hofstra North Shore-LIJ School of
 10 Medicine. And I just thought it would be of interest to
 11 this group that the curriculum's being developed and
 12 something that the -- the E.M.S. community in downstate
 13 New York has been strongly pushing for and has --
 14 actually going to occur is that all the medical students,
 15 their very first six weeks in -- in medical school,
 16 they're going to be trained to be E.M.T.'s and be
 17 responsible for riding on ambulances as part of the
 18 medical school curriculum. And it's something we're very
 19 proud of because we strongly feel that all doctors,
 20 regardless of what specialty they end up in, should have
 21 an exposure and understanding of what E.M.S. involves.
 22 Because too often we have interactions with doctors who
 23 really have no idea.
 24 We think it will be very beneficial for these
 25 medical students to have that grounding, that

Page 95

1 SEMAC - 3-29-2011
 2 understanding that they then will carry with them
 3 throughout medical school and -- and throughout their
 4 careers as physicians. So the first class is being
 5 selected now. They start in August of 2011. Thanks.
 6 **DR. HENRY:** All right. Dr. Cooper?
 7 **DR. COOPER:** Dr. Henry, just to -- by way of
 8 another announcement. The Pediatric Disaster Coalition
 9 in New York City, with support from the Fire Department
 10 of the City of New York and the New York City Department
 11 of Health and the New York City Office of Emergency
 12 Management, will be holding a special conference on
 13 pediatric disasters in New York City on the morning of
 14 June 14th. It's going to be a very unique program. It's
 15 going to be organized around, if you will, a mock event.
 16 And national and international experts will be vetting
 17 each component of the disaster response together with
 18 participation from the audience assembled. It'll be a
 19 very, very neat program.
 20 I wanted to make you aware of it in case you had the
 21 opportunity to attend. If you wish to attend and you
 22 have not been notified of it, you can either contact me
 23 directly or contact the E.M.S. office, and they will find
 24 me and get the information to you so you know about
 25 where, when, and so on. Thank you.

Page 96

1 SEMAC - 3-29-2011
 2 **DR. HENRY:** Thank you. Okay. There's another
 3 news item that Lee brought to my attention, so -- just so
 4 we're familiar.
 5 **MS. BURNS:** Just an update on the Ryan White
 6 H.I.V. AIDS Treatment Extension Act of 2009. The C.D.C.
 7 completed the list of what they are calling potentially
 8 life threatening diseases, which the regulation required.
 9 The public comment period was completed in 2011.
 10 Actually, I have copies of the department's public
 11 comment. If you're interested, I'll leave them out on
 12 the table. And basically, the -- what they did is they
 13 listed a series of obviously life threatening diseases,
 14 so more to come.
 15 **DR. HENRY:** All right. Thanks. Any other
 16 business to be brought before the body? Dr. Cushman?
 17 **DR. CUSHMAN:** Mr. Chair, are we going to speak
 18 about the C.D.C. trauma triage?
 19 **DR. HENRY:** Sure, if you want to speak about it.
 20 **DR. CUSHMAN:** We -- we had -- we had an e-mail
 21 discussion earlier indicating that you wanted to revisit
 22 it at this meeting, given that the STAC considered it
 23 last week, and whether or not this body should adopt the
 24 C.D.C. trauma triage algorithm as it is written or with
 25 certain modifications.

Page 97

1 SEMAC - 3-29-2011
 2 **DR. HENRY:** Right. Well, at the -- there was
 3 a -- well, I guess you all got the -- you're all on the
 4 listserv, so Andy sent out the protocol and you responded
 5 and Mike responded --
 6 **DR. CUSHMAN:** Uh-huh.
 7 **DR. HENRY:** -- and I responded.
 8 **DR. CUSHMAN:** Uh-huh.
 9 **DR. HENRY:** So there was interest. So yeah,
 10 if -- if -- that item, we can bring up at the table here.
 11 So you had suggested --
 12 **DR. CUSHMAN:** Well --.
 13 **DR. HENRY:** -- dropping pulse, correct?
 14 **DR. CUSHMAN:** Yes.
 15 **DR. HENRY:** Okay.
 16 **DR. CUSHMAN:** So -- so I -- I would -- I would
 17 suggest that the SEMAC endorse the C.D.C. trauma triage
 18 algorithm. And the -- the reason for this is that
 19 it's -- it's not about pulse; it's about process. We
 20 should agree to embrace the C.D.C. guidelines as well as
 21 any revisions that come down in the future since they use
 22 a rigorous process to review that literature and come up
 23 with expert consensus when literature is not available,
 24 just as we recently adopted the H.A. guidelines with
 25 remarkably little discussion.

1 SEMAC - 3-29-2011
 2 that captured what we had.
 3 So they're revisiting, now, it because A.C.S. is
 4 coming out with the, quote, new green book in a year or
 5 so, so they decided to meet, looking at the literature
 6 from 2006 up to now and spiriting a discussion. So also
 7 something they're going to consider in a debate at the
 8 next meeting. And I'd sent around, in response to that,
 9 the literature that we had used in New York where we
 10 chose to retain pulse as a criteria. And so everyone's
 11 clear, that was a look from the hospital outside. That
 12 did not have the universe of injured parties who were
 13 brought by ambulance to a hospital, many of whom -- most
 14 of whom are sent home. It had just the collection of
 15 people who were admitted to the hospital with an I.S.S.
 16 greater than nine, injury severity score greater than
 17 nine.
 18 So looking back out from that and attaching
 19 whatever pre-hospital values they had, if you wanted to
 20 capture more people who had need for a major operation,
 21 you picked up another hundred and twenty-eight who had
 22 pulse as the only criteria for physiologic and anatomic,
 23 and that was the rationale. It was a move towards
 24 sensitivity. So no one knows the answer really to
 25 specificity, you know, unless you picked up a different

1 SEMAC - 3-29-2011
 2 The C.D.C. is committed to doing this on a
 3 regular basis, and if they recommend inclusion of heart
 4 rate or any other variables that, as you and I have
 5 discussed in -- in side conversations, then I'm all for
 6 it. But the C.D.C. provides the infrastructure for
 7 regular updates and provides the educational materials
 8 for distribution to our E.M.S. providers. And our state
 9 cannot even come close to this level of ongoing
 10 commitment. Therefore, we should adopt that which is
 11 adopted in all other forty-nine states. And you know, if
 12 the motion is amended to adopt any further revisions,
 13 that would allow us to respond very proactively to future
 14 revisions which, as we all know, are likely going to
 15 happen in the next year, so that we can implement them
 16 quickly and not years after they are released.
 17 **DR. HENRY:** Okay. I -- my response to the
 18 process, though, is that actually we had probably the
 19 most rigorous process when we considered our trauma
 20 triage guidelines. We met on several occasions along the
 21 New York City, and we -- at the last C.D.C., we probably
 22 had the richest database of anyone in the country. And
 23 they defaulted to expert opinion because they didn't have
 24 it. That's one reason they funded the study that you
 25 were investigator in, because no -- data did not exist

1 SEMAC - 3-29-2011
 2 study. But that was the basis for it.
 3 I mean, I think there's a compelling argument to
 4 make for having educational materials available. But --
 5 but that's why when this discussion came up, since we had
 6 embraced it so much, I said to someone, you know, I
 7 suggested to you because Mark Gestring said, "Let's use
 8 the C.D.C. material." Mark Gestring's a trauma surgeon
 9 in Rochester, and he brought it up to STAC to use the
 10 C.D.C. materials. So I suggested they discuss it, and I
 11 really don't know what they discussed. I wasn't able to
 12 make the meeting. But it's -- you know, it's the -- it's
 13 a motion of the SEMAC.
 14 **DR. DAILEY:** Actually, what the STAC did do was
 15 they discussed a motion which Jeremy's commentary here
 16 mirrors, and they then passed and endorsed that motion to
 17 adopt the C.D.C. criteria and then to update it along
 18 with subsequent updates from the C.D.C. for a number of
 19 different reasons. And -- and quite a few people spoke
 20 on both sides. Dr. Cooper spoke eloquently, of course,
 21 supporting the inclusion of heart rate. And a number of
 22 us looked for the fiscal prudence of using a significant
 23 amount of educational material that's already been
 24 developed on behalf of -- of your tax dollars. And we
 25 commented as well and discussed the paper that you had

1 SEMAC - 3-29-2011

2 written that was in P.E.C. increasing the inclusion, I
3 guess, of trauma patients by two percent. And many
4 people were troubled by the fact that we don't have a
5 denominator for the total number of patients that have a
6 heart rate of greater than a hundred and twenty. In
7 particular, being concerned that these patients, because
8 of their heart rate alone, would bypass the community
9 hospital and overwhelm trauma centers.
10 I think at this point we would be very well served by the
11 adoption of the C.D.C. criteria, having the continual
12 updates to that as the national -- this national expert
13 body, which includes yourself, does come together and
14 develop new guidelines. And we continue to use our tax
15 dollars to fund a single training program through the
16 federal -- federal tax base, if you will, rather than
17 using Ms. Burns' nineteen point seven million dollars to
18 begin to develop alternative materials.

19 These materials have also been already
20 developed -- and already been developed. They're been
21 disseminated to most of your ambulance agencies. Most of
22 mine have approached me already to say, "What are these?
23 Do we use them?" And I can only say, "Stand by." And
24 this is the -- what they are standing by for. So I would
25 urge this body to adopt the C.D.C. triage guidelines.

Page 102

1 SEMAC - 3-29-2011

2 **DR. HENRY:** Art?

3 **DR. COOPER:** I would speak against this motion
4 at this particular time for a variety of reasons. First,
5 I wanted to respond to Dr. Dailey's suggestion that we
6 allow the federal tax base to support this issue rather
7 than our own. The -- the fact is that the data that was
8 used to generate the heart rate recommendation in the
9 first place is data that's primarily collected by the New
10 York State Trauma Registry for purposes of -- of risk
11 adjusted to quality improvement in trauma centers. That
12 money will be spent or not spent depending upon the need
13 of the department to continue to conduct analysis of
14 trauma center performance. The data on the pre-hospital
15 triage criteria was a secondary analysis of that dataset.
16 And -- and my presumption is that even if we did not do
17 such secondary analyses on that dataset, that that
18 dataset would continue to be bought and paid for by the
19 department.

20 So but setting aside that issue, yes, the
21 criticism has been made that -- that, as Dr. Henry
22 indicated, that the database from which these numbers
23 were derived reflects a subset of all injured patients
24 who are most seriously injured. However, you know,
25 that -- that is, in many ways, precisely the point. You

Page 103

1 SEMAC - 3-29-2011

2 know, we -- we know that patients who are severely
3 injured, and particularly those who are injured by
4 penetrating injuries who are young and strong, often have
5 pulse rate as their only sign of significant injury.
6 Our -- our data has informed us about this fact, data
7 from our own population-based trauma registry. Very,
8 very few other states have that kind of data. That kind
9 of data was not presented to the C.D.C. workgroup that --
10 that -- that looked at this issue. And to me, keeping
11 pulse rate in the -- the -- the field triage criteria in
12 New York State for that reason is very important.

13 Second, that is the only way in which our New
14 York State field triage criteria differ from the national
15 field triage criteria. It's not a deletion of anything
16 from the C.D.C. criteria; it's inclusion of a point that
17 identifies a subset of patients who we know are likely to
18 be seriously injured and therefore deserve the benefit of
19 trauma center care, in my opinion.

20 Last, the -- the fact of the matter is that the
21 educational materials that have been provided by the
22 C.D.C., which are outstanding, I -- I certainly agree,
23 the -- those educational materials can still be used.
24 There's no barrier to using them at the present time.
25 All we have to do is simply say in -- in addition, in New

Page 104

1 SEMAC - 3-29-2011

2 York State, we're adding pulse rate to the -- to the
3 field triage criteria because our own population-based
4 New York State data says that we should.

5 So for all those reasons, I would -- I would be
6 against this motion at this time. What I suggested at
7 SEMAC was that we delay consideration of this until the
8 C.D.C. finishes its process of re-looking at the data,
9 which is -- which is ongoing at the present time, and
10 revisit this in the fall after the C.D.C. has done that
11 reconsideration. If after a more extensive literature
12 review at that time it turns out that the -- that -- that
13 it looks as though the algorithm is going to change and
14 pulse rate is shown by subsequent data analysis to be
15 less useful than we had previously thought here, well,
16 fine. But there's a process ongoing at the present time
17 to look at that data once again. It's analogous in my
18 view to what we've always done here, which is wait for
19 the Heart Association standards to come out, you know,
20 before we change things here.

21 I -- I -- I just think that there's -- you know,
22 that there's every reason for us to continue doing what
23 we're doing. It's based on sound data from our own
24 population-based registry. And no reason to rush if the
25 C.D.C. is going to be looking at this issue over the next

Page 105

1 SEMAC - 3-29-2011
 2 few months and will probably come to some kind of closure
 3 before we next meet.
 4 **DR. HENRY:** I -- I just want to add, too, that
 5 they presented at our meeting last week, examples of
 6 North Carolina and Colorado, which both had tweaked the
 7 algorithm, you know? They had run it into trees when
 8 they were skiing in Colorado, and they changed the --
 9 they changed some of the algorithm in North Carolina, and
 10 they talked about what does it mean to constitute, quote,
 11 adoption of this vehicle? But -- so just in terms of
 12 process.
 13 **MS. BURNS:** I just wanted to remind you that --
 14 in -- at your October meeting, you voted to approve the
 15 C.D.C. guideline with the inclusion of pulse criteria.
 16 So we're waiting to release that or not.
 17 **DR. HENRY:** So was your -- was your -- did you
 18 make a motion?
 19 **DR. CUSHMAN:** I did a motion to accept the
 20 C.D.C. --
 21 **DR. HENRY:** Okay.
 22 **DR. CUSHMAN:** -- trauma triage algorithm as it's
 23 currently defined, and all subsequent revisions --
 24 **DR. HENRY:** Right.
 25 **DR. CUSHMAN:** -- so that Dr. Cooper's

Page 106

1 SEMAC - 3-29-2011
 2 **FROM THE FLOOR:** Dr. Kaufman?
 3 **DR. KAUFMAN:** Yes.
 4 **FROM THE FLOOR:** Dr. Kugler? Dr. Leinhart?
 5 **DR. LEINHART:** Yes.
 6 **FROM THE FLOOR:** Dr. Marshall? Dr. Murphy?
 7 **DR. MURPHY:** Yes.
 8 **FROM THE FLOOR:** Dr. Myers?
 9 **DR. MYERS:** Yes.
 10 **FROM THE FLOOR:** Dr. Olsson?
 11 **DR. OLSSON:** No.
 12 **FROM THE FLOOR:** Dr. Takats? One, two, three,
 13 four, five, six -- one, two -- that would be eight yeses
 14 and three nos. The motion passed.
 15 **DR. COOPER:** Mr. Chairman, do we still have a
 16 quorum?
 17 **DR. HENRY:** I would have to check if it's a
 18 majority of those voting once we've had a quorum or a
 19 majority of the -- of the body. I think it's a majority
 20 of the people. Okay. Any other discussion? All right.
 21 The next meeting is May 24th, 2011.
 22 (The meeting concluded at 3:57 p.m.)
 23
 24
 25

Page 108

1 SEMAC - 3-29-2011
 2 concerns -- and mine as well -- I'm eager to see what --
 3 what changes can be acted upon and implemented in a
 4 timely fashion for the folks in the state.
 5 **DR. HENRY:** Is there a second?
 6 **FROM THE FLOOR:** Seconded.
 7 **DR. HENRY:** Okay. So we got a motion on the
 8 floor. Is there any further discussion or debate? All
 9 right. All right. So let's call the question then.
 10 We'll do a roll call vote.
 11 **FROM THE FLOOR:** Dr. Cooper?
 12 **DR. COOPER:** No. No.
 13 **FROM THE FLOOR:** Dr. Cushman?
 14 **DR. CUSHMAN:** Yes.
 15 **FROM THE FLOOR:** Dr. Dailey?
 16 **DR. DAILEY:** Yes.
 17 **FROM THE FLOOR:** Dr. Davidoff?
 18 **DR. DAVIDOFF:** Yes.
 19 **FROM THE FLOOR:** Dr. Delaney? Oh, not -- okay.
 20 Dr. DeTraglia?
 21 **DR. DETRAGLIA:** Yes.
 22 **FROM THE FLOOR:** Dr. Goodman? Okay. Dr. Henry?
 23 **DR. HENRY:** No.
 24 **FROM THE FLOOR:** Dr. Huffner?
 25 **DR. HUFFNER:** Yes.

Page 107

1 SEMAC - 3-29-2011
 2 I, Howard Hubbard, do hereby certify that the
 3 foregoing was taken by me, in the cause, at the time
 4 and place, as stated in the caption hereto, that the
 5 foregoing typewritten transcription, consisting of
 6 pages number 1 to 108, inclusive, is a true record
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Howard Hubbard, Reporter_____
Date

Page 109

A	
ability 28:20 33:13,24 34:2 45:7 61:25 85:13,14	adult 72:23
able 7:17,19 33:10 38:21 39:12 39:14 42:5 51:20 67:6 77:15 77:16 83:18 101:11	advanced 11:2 50:22 71:15 80:15 81:8 85:18 86:15
absolutely 51:13	advice 76:18
abstain 95:2	advisory 1:5,7 24:13 41:12,14 69:5 70:10,11 76:15,15 78:12 84:20
Abstaining 94:5	affirms 31:19
Abstentions 13:8 60:3 63:16	agencies 24:11 32:7,11,24 34:18 40:13,13 41:19 46:13 47:12 55:22 66:2 74:4 85:15 102:21
abundantly 50:23	agency 36:10 39:8 46:9 55:25 80:16
accept 60:13 63:13 83:16 106:19	agenda 61:10 78:4 82:22
accepted 54:12	agent 15:14 30:13
access 33:10	ages 31:22
accompany 27:19	ago 40:5 48:4 52:9 88:7
accredited 90:17 91:2	agree 58:23 59:4 98:20 104:22
accurate 34:5,9 76:17	agreed 15:17
ACEP 75:10,11,12,15	AIDS 97:6
achieve 58:7 90:24	air 24:3
acknowledged 31:13 75:2	airway 11:2
acronym 31:13 66:22	Albany 84:24
act 7:16 97:6	albuterol 18:2
acted 107:3	alcohol 80:7,18 81:2,18
acting 30:10 81:4,6 85:18	algorithm 97:24 98:18 105:13 106:7,9,22
action 7:24 12:25 21:24	alike 38:19
actions 79:11	alive 22:10
activated 73:23	allergies 33:16
active 36:12 59:13	allow 33:9 83:15 86:11 99:13 103:6
actively 72:17	allows 61:25 63:3
activities 65:14	alter 82:12
add 29:21 32:16 45:6 55:13 106:4	altered 40:25
adding 55:8 105:2	alternative 59:7 102:18
addition 104:25	alternatives 68:16
additions 7:10	altogether 15:16
address 28:4 54:7	amazed 70:11
addressed 58:14	ambulance 34:4 78:7,19,22 79:12 80:13 81:7,10,15 100:13 102:21
adequately 43:13	ambulances 74:2,3 95:17
Adirondack 16:6	amended 99:12
adjustable 45:20	American 7:25 8:4,10,16,19,25 31:10 90:5
adjusted 103:11	amount 22:8 101:23
administer 18:3 73:17	amused 67:23
admitted 100:15	amusing 68:18
adopt 42:6 60:23 62:22 68:12 81:7 91:19 97:23 99:10,12 101:17 102:25	analogous 105:17
adopted 98:24 99:11	
adopting 60:24	
adoption 102:11 106:11	

<p> analyses 103:17 analysis 103:13,15 105:14 anatomic 100:22 Andy 2:13 27:14 71:17 77:10 98:4 and/or 66:16 69:23 ankle 46:23,24 announcement 95:7 96:8 answer 80:9,21,21,22 84:8 85:17 100:24 answers 85:24 anticipated 27:15 anybody 74:12,14 anymore 47:5 53:9 anyway 33:3 68:21 69:11 73:22 79:15 88:6 apart 83:11 apologize 12:18 43:8 70:5 Appalachian 16:6 appeal 87:25 appeals 87:21 application 56:4 90:13 apply 85:15 appointed 90:22 appreciate 25:13 appreciated 60:11 appreciating 51:10 approach 26:23 40:18 approached 102:22 appropriate 11:3 21:6 27:2 appropriately 27:11 approval 7:8,25 67:18 72:18 approve 7:11 8:24 106:14 approved 8:22 12:21,24 14:22 15:5,24 18:11 71:14,21 90:5 approves 78:13 approving 8:22 28:18 area 75:8 areas 8:11 9:3 34:10 75:6 argued 87:4 argument 101:3 arm 49:10 arrange 68:10 arrangement 35:23 arrest 6:9 82:16 84:3 arrests 83:4 arrival 29:25 arrived 41:22 Art 103:2 Arthur 2:5 </p>	<p> Article 21:21 24:5,6 73:14 87:10 aside 103:20 asked 8:15 45:21 67:4 76:15,16 79:22 80:2,6,8,13 82:18 asking 8:18 32:13 40:13 aspects 22:14 assault 83:20 assembled 96:18 assess 41:15,18,18 assist 74:3 assistant 21:2 87:17 Associated 109:7 association 8:2,5,10,17,19,25 25:5 31:11 84:23 105:19 assume 85:11 90:15 assuring 33:12 asthma 17:24 18:3,15 40:24 atmosphere 69:4,5 attaching 100:18 attainable 70:22 attempt 6:12 53:17 attempted 6:12 attempting 42:22 53:13 attend 7:18 96:21,21 ATTENDEES 2:2 attending 35:6 attention 30:25,25 97:3 attitudes 58:3 attorney 76:5 78:14 80:10,23 82:14 attorneys 80:3,4 81:22 82:14 85:3 86:23 audience 96:18 audit 47:6 audits 47:3 73:10,12 August 2:14 96:5 aura 6:8 auspices 32:25 Australian 30:2 authority 68:24 75:23 86:20 87:10 authorized 30:13 available 27:13 32:3 35:8 64:6 98:23 101:4 aware 22:18 28:12,15,15,16 50:20 72:14 74:8,8 90:4 96:20 awareness 73:18 awful 70:4 Aye 7:12,13 </p>
--	---

A.C.G.M.E 90:14,17,19 91:2	bidirectional 39:25
A.C.L.S 8:2,7,13,25 9:4 31:2,5	big 6:18 37:14 41:3 45:25 64:4 64:13,19 65:21 67:8
A.C.S 100:3	bigger 29:2 59:3
A.D.A 84:17	biggest 50:16
A.E.M.T 80:25 81:5 82:7 86:20	billing 24:8,10 33:22
A.L.S 17:24 41:13 51:7 85:12,15	billion 65:12,22
a.m 74:9	birth 49:10 78:2
B	
babies 78:3	Bishop 46:19 78:4
back 6:13 7:21 32:5,24 38:24 41:11 45:6 46:17 47:12 48:25 53:5 55:12 57:7,10,21,23 59:6 62:7 64:13 66:8 67:20 76:19 78:4,6,8,18,22 79:11 80:2,9 80:19 89:13 100:18	bit 24:17 90:9
backboarding 45:22	blah 30:8,8,8
bad 56:2	blood 71:12,12,13,14,16,20 80:7 80:15,18,25 81:8,18 82:8,10 82:19 83:2,20 84:11 86:3
bandage 46:22	Blum 2:5 4:20,21
Banquet 1:12	board 37:7 64:5,10 90:5,24
bar 62:8	boards 90:3
barrier 104:24	board's 90:20
base 102:16 103:6	Bob 66:8
based 21:20 105:23	body 68:24 88:7 89:22 97:16,23 102:13,25 108:19
basic 44:17 50:21 51:2 61:15	boiled 68:23
basically 42:24 78:8 80:4,9 87:7,11 97:12	Bomba 77:5,7
basics 38:25	book 100:4
basis 37:12 39:13 40:14 51:17 99:3 101:2	boss 80:10
batted 42:23	bought 103:18
beautiful 6:21 77:18	Brad 89:24
becoming 51:13	Bradley 2:13
begged 77:21	brand 45:4
begs 85:22	breech 49:9
behalf 36:8 101:24	bridge 37:5
behaviors 58:3	brief 32:4 87:14 89:19
believe 54:24 56:19 69:18 70:17 84:8	briefly 90:11 95:8
believed 70:24	bright 5:17
Bellevue 88:15 89:2,14	brighter 65:13
belongs 23:3,3	bring 7:23 21:23 25:2 35:2 36:17 46:16 47:16 50:11 52:14 57:21 59:6 69:17 71:5 83:7 87:15,19 98:10
beneficial 95:24	bringing 43:5 76:19
benefit 104:18	brings 21:18,23 34:8 44:11 62:7 76:11
benefits 10:24	broad 54:7
best 23:22 25:16 29:4,10 36:24 74:11 75:17 86:6	Broderick 3:5
beta 28:10	broke 45:20 46:23
better 15:20 35:3 56:22 57:13 68:10,11 83:8 86:12 87:6	brought 10:22 12:20 27:20 30:24 30:25 32:8 39:24 49:2 59:10 78:8 97:3,16 100:13 101:9
	brush 50:8
	budget 55:6,14 65:10,13 66:17

67:2	carries 12:16 13:8 20:4 60:3
budgetary 62:14	63:16
bunch 36:13 39:16	carry 96:2
bureau 15:9 38:16 65:3 66:8,9	case 96:20
69:2 73:9	cases 40:14,16 70:17
bureaucracy 65:25 69:22	case-by-case 40:14
burn 18:5	categories 40:20 41:3
Burns 2:7 6:25 28:15,18 50:11	cause 109:3
51:10 61:6 63:22 72:20 74:7	center 5:10 103:14 104:19
76:13,17,20,24 77:7 79:22,24	centering 39:17
83:23 84:17 85:17 86:4,8,22	centers 102:9 103:11
86:25 87:3 97:5 102:17 106:13	certain 18:7,8 33:13,13 40:16
business 7:3,8 10:21 22:4 68:11	91:5 97:25
68:17 76:13 88:3 89:23,24	certainly 6:7 31:12,21,21 40:11
95:5,7 97:16	41:6 59:4 68:12 78:12,17
buy-in 24:23	83:13 86:2 104:22
bypass 102:8	certificate 78:2
B.L.S 8:6,12 9:3 31:6	certificates 77:3
B.L.T 81:5	certification 9:6 62:5 90:6,25
B.N.E 73:9,9	certified 90:20 93:14
B.S.N 2:10	certify 109:2
	chair 2:6 45:17 97:17
C	Chairman 56:12 76:10,10 108:15
cache 59:13	chairs 69:13 70:3
caliber 58:6	challenges 26:13
call 3:3 5:8 10:19 11:6,6 12:15	chance 5:14
13:10 14:20 17:21 20:2 22:2	change 12:24 15:17 18:10 61:9,9
23:8 59:17 62:3 63:11 91:14	69:22 80:24 84:4 87:8 90:14
91:16,22 93:11 107:9,10	105:13,20
called 27:22 69:8 72:5 89:3	changed 17:24,25 106:8,9
calling 97:7	changes 8:9,17 9:5 12:21 15:5
calls 24:18 36:15	15:25 24:10 66:19 69:18 107:3
candidates 46:11,25 58:6 89:7	changing 15:22 58:8 82:6
canned 39:11	charge 36:11
capable 52:11	chart 35:8
capacity 35:7	check 35:2 89:9 108:17
capnography 41:11,13,16,19	checklist 46:19,20
caption 109:4	children 76:3
capture 100:20	Chiumento 2:10 4:16,17 30:24
captured 100:2	31:14
cardiac 6:9 74:16	choose 21:24 32:10 40:18 41:5
cards 77:2,19,24	42:2
care 6:5 21:2 22:7,13 26:7,8,18	chose 100:10
26:19,21 27:21,23 30:9,16	circumstances 21:9 33:13 34:5
33:9 34:24 35:4,20 41:25 42:3	cite 82:12
42:7,7 60:17 61:15 64:21,22	citing 84:6
71:2 74:24 104:19	City 8:3 17:23 20:8 64:25 74:3
careers 96:4	88:9 96:9,10,10,11,13 99:21
Carl 2:12	City's 73:24
Carolina 106:6,9	civil 75:23

<p>clarify 30:20</p> <p>class 43:2 44:3,4,5,9,17,18 47:12 49:2 50:5,6,9 56:23 57:6,12,14 96:4</p> <p>classes 46:4 47:4,7 49:4 50:10 57:2</p> <p>clear 16:10 21:7 27:18 28:6 50:23 100:11</p> <p>clinical 6:10</p> <p>clock 81:12</p> <p>close 53:2 76:11 87:16,19 99:9</p> <p>closely 36:10</p> <p>closure 71:5 106:2</p> <p>coach 45:7,8 56:24</p> <p>Coalition 36:10 39:8 96:8</p> <p>cohesive 42:6</p> <p>collars 45:20</p> <p>colleagues 62:19</p> <p>collect 36:22</p> <p>collected 39:11 64:14 103:9</p> <p>collection 64:5 100:14</p> <p>college 55:3</p> <p>color 77:8,10,13</p> <p>Colorado 106:6,8</p> <p>colored 77:11,12</p> <p>combination 61:13</p> <p>combining 57:23</p> <p>come 9:6 34:4 48:12 50:5,7 53:20 57:2 66:21 73:19 74:9 75:6 87:8 97:14 98:21,22 99:9 102:13 105:19 106:2</p> <p>comes 11:4 12:17,24 15:25 18:11 52:17 64:25 77:12</p> <p>coming 5:13 8:24 15:16 20:10 43:12 44:3 45:13,19,24 46:25 50:9 51:7 53:7 58:6 91:10 100:4</p> <p>commenced 3:2</p> <p>commend 6:20</p> <p>comment 24:16 45:5,15 72:12,19 82:5 97:9,11</p> <p>commentary 101:15</p> <p>commented 101:25</p> <p>commenting 7:4</p> <p>comments 24:15 25:14 51:10</p> <p>Commissioner 32:10 63:24 75:2 78:13</p> <p>Commissioner's 73:2</p> <p>commitment 99:10</p> <p>committed 90:22 99:2</p>	<p>committee 1:5,7 7:16,24 21:14 21:16,19,22 22:4,24 23:5,13 24:2 25:11 35:25 36:9,16 39:9 40:17 41:3,17 42:11 43:6 44:7 54:7,12 56:18 58:5 59:6,6 60:13 69:13,13 70:3 84:20 87:5</p> <p>committees 22:25</p> <p>committee's 38:12</p> <p>common 33:8</p> <p>community 61:25 69:19,20,20 70:16 71:8 89:17 95:12 102:8</p> <p>compatible 26:14</p> <p>compelling 50:16 101:3</p> <p>competency 46:19 51:2,5</p> <p>competent 49:18 57:16 58:2,10 59:2 83:17,18</p> <p>complete 5:8 10:19 12:15 14:20 17:21 20:3 28:23 37:10 93:11</p> <p>completed 20:12 22:21 30:9 36:19 50:25 97:7,9 109:7</p> <p>completing 90:25</p> <p>compliance 41:15,18 73:12</p> <p>complicated 70:6</p> <p>complying 81:11</p> <p>component 41:14 96:17</p> <p>comports 68:11</p> <p>Comptroller 66:16</p> <p>con 85:15</p> <p>concentrating 53:12</p> <p>concept 78:16</p> <p>concern 28:25 56:20 57:10</p> <p>concerned 72:9 102:7</p> <p>concerning 42:18</p> <p>concerns 24:23 42:21 43:11 107:2</p> <p>concluded 108:22</p> <p>conclusions 86:7</p> <p>Concurrently 37:24</p> <p>conduct 103:13</p> <p>conducting 73:10</p> <p>conference 22:2 23:8 36:15 96:12</p> <p>confess 67:5</p> <p>confidentiality 30:8</p> <p>confirm 82:7</p> <p>confirmation 41:21</p> <p>conflicts 86:2</p> <p>conformity 54:14</p> <p>congratulate 15:3</p>
--	--

<p>Congressional 75:22 consensus 98:23 consent 83:17,18 84:4 89:8,9 consented 88:13 consenting 82:10 consider 21:13 25:14 59:7 86:16 100:7 consideration 23:11 105:7 considered 97:22 99:19 consistent 64:7 consisting 109:5 constitute 106:10 constraints 55:7 constructive 84:13 contact 96:22,23 content 80:7 contention 84:3 continual 102:11 continue 20:9 21:4 53:3 60:15 67:7 90:15 102:14 103:13,18 105:22 continued 34:11 continuing 47:14 88:22 continuity 68:17 contract 67:16,18,22,22,24 68:2 68:15 contracting 66:19 67:12,13 contracts 66:4,11 67:14 control 5:11 15:12 20:14,15 21:8 38:25 53:6,8 70:23 79:7 85:19 Controlled 72:20 conundrum 82:19 84:10 conversation 25:17 62:7 conversations 23:7 99:5 conversely 78:25 82:18 convinced 66:14 Cooley 3:5 Cooper 2:5 3:6 92:17,18,20 93:7 93:8,17,18 96:6,7 101:20 103:3 107:11,12 108:15 Cooper's 106:25 coordinate 36:11 89:6 coordinators 85:3 copies 8:8 97:10 copy 6:25 7:3 8:20 30:11 33:17 76:4 77:13 core 52:17 53:2,14,23 66:3 correct 11:3 15:6,21 16:4 34:12 98:13</p>	<p>corrections 7:10 correlate 29:24 correspondence 6:24 cost 62:25 75:15 council 7:4 69:7,8 71:14 76:18 councils 34:18 69:5 70:10,11 counsel 80:10 counties 74:5 country 74:23 99:22 County 84:18,24,25 couple 42:19 45:18 51:3 61:16 63:22,24 73:21 79:25 81:15 87:21,24 course 42:22 43:10,12,21 45:7 46:2 50:4 55:4 56:7 57:2,18 57:19,24 59:21 101:20 courses 44:20 93:15 covers 16:4,11 CPAP 10:23,25 11:2 cracks 24:7 crash 55:4 56:7 78:23 79:2 cravat 46:24 57:3 crazy 87:2 create 23:5 85:13,14 creative 67:13 71:8 credential 24:9 cried 77:22 criteria 44:17 88:14 89:10,13 100:10,22 101:17 102:11 103:15 104:11,14,15,16 105:3 106:15 critical 71:2 criticism 103:21 crop 52:10 crosses 41:23 curbs 38:23 current 37:24 58:8,13 61:4 62:11 82:13 currently 37:10,13 40:8,17 49:15 90:12 106:23 curricula 61:14 62:12 curriculum 9:6 18:9 22:23 24:9 24:25 55:12 60:16 95:18 curriculum's 95:11 curve 6:12 Cushman 2:3 3:6,7 9:10,11 11:7 11:8 13:12,13 16:13,14 18:18 18:19 32:15,19,22 60:17,19 91:23,24 93:19,20 97:16,17,20 98:6,8,12,14,16 106:19,22,25</p>
--	---

<p>107:13,14 custody 83:25 Czapranski 2:7 4:24,25 22:18 24:16 34:15 77:5 C.D.C 5:17 97:6,18,24 98:17,20 99:2,6,21 101:8,10,17,18 102:11,25 104:9,16,22 105:8 105:10,25 106:15,20 C.F.R 18:6,9 87:6,9 C.H.F 40:23 C.I.C 46:3,6 49:12,14,19,20 51:20 53:24 C.L.I 45:7,18 46:5,10 47:11 49:12,14,19,21,22 50:3 51:7 51:20 53:13,23 55:9 56:25 57:17,18 58:2 59:21 C.M.E 50:14,17 51:4,15,24 C.O.I 42:19 C.O.P.D 40:24 C.V.A 40:23</p> <hr/> <p style="text-align: center;">D</p> <hr/> <p>Dailey 2:6 3:8,9 9:12,13 11:9 11:10 13:14,15 15:5,21 16:15 16:16 18:20,21 23:24 31:25 36:4 51:9 58:21 59:4 91:25 92:2 93:21,22 101:14 107:15 107:16 Dailey's 103:5 daily 37:12 Daines 65:7 Daniel 2:5,16 4:20 data 29:16 32:3,5 36:6 37:10,13 37:20 38:6,8,20 39:9,24,25 40:6,7,9,16,17,20 41:4,5,9,20 64:2,5,11,18,20 83:4,9 99:25 103:7,9,14 104:6,6,8,9 105:4 105:8,14,17,23 database 37:15 99:22 103:22 databases 64:14 dataset 38:9 103:15,17,18 date 1:10 89:11 109:11 daunting 66:24 Davidoff 2:11 3:10,11 9:14,15 11:11,12 13:16,17 16:17,18 18:22,23 92:3,4 93:23,24 107:17,18 day 21:3 24:3 56:5 66:15,20,20 66:21,23 67:18 70:8 72:6 73:2 days 70:8</p>	<p>day-to-day 51:16 dead 74:19 88:11 deal 23:5 38:10 91:13 dealing 43:20 44:14 74:17 death 74:16 deaths 74:10,23 Deb 22:8 debate 100:7 107:8 debt 65:12 December 73:24 88:21 decide 39:11 decided 87:5 100:5 decision 80:13 deemed 83:19 defaulted 99:23 define 61:11 defined 61:17 106:23 definitely 61:18 64:22 degrees 43:24 Delagi 2:8 5:2,3 36:2,3 40:2 43:8,18,25 Delaney 92:5 93:25 107:19 delay 105:7 deletion 104:15 deliver 28:21 49:7 demise 6:12 demonstrate 6:11 45:21 demonstrated 40:5 51:5 demonstration 87:13 88:5,19 denominator 102:5 department 1:2 8:21 15:9 27:16 29:6,20 30:13 40:4 64:10,15 65:7 66:13 69:6 71:7 72:15 76:19,25 77:25 78:9 79:4,4,8 81:23 84:21,24,25 85:3 89:5 96:9,10 103:13,19 department's 64:5 79:16 86:23 97:10 depending 103:12 depositing 34:23 deputy 80:10 derived 103:23 described 86:15 deserve 104:18 designed 79:14 despite 23:18 details 73:6 determination 65:6 determine 20:11,20 DeTraglia 2:11 3:13,14 9:16,17</p>
---	---

11:13,14 13:18,19 16:19,20 18:24,25 92:5,6 94:2,3 107:20 107:21	76:13 79:19 91:21 97:21 98:25 100:6 101:5 107:8 108:20
develop 37:7 40:9,17 46:20,24 60:15 102:14,18	discussions 8:4 34:11
developed 95:11 101:24 102:20 102:20	disease 5:10 6:2
developing 37:25	diseases 97:8,13
development 24:8 37:5	dismal 73:12
device 52:25	disparity 22:19
devices 53:17	disseminated 102:21
devised 52:12	distances 24:4
devising 41:17	distraction 66:10
diabetic 15:18,23	distribute 40:21
diabetics 34:22	distribution 99:8
dictionary 37:10	district 82:14,14 85:3
died 74:15	Division 66:16
differ 104:14	doctor 78:14
difference 67:8 70:15	doctors 27:5 95:19,22
different 5:21 24:17 26:13 27:4 42:24 48:11 50:23 51:10 53:24 55:17,22,22 61:5,16 64:15 76:7 100:25 101:19	document 26:12
difficult 66:3 69:4	documentation 32:11,12 33:22 42:5 73:10
difficulty 7:4	documenting 82:19
digging 72:15	documents 84:10
dimension 6:4	dogmatic 66:12
direction 20:18 52:8 53:24,25 63:2	doing 22:9 34:13 49:18 56:22 61:24 64:8 69:9 71:10,16 78:21 81:17 99:2 105:22,23
directly 96:23	dollars 65:12,17,22 101:24 102:15,17
director 59:11 76:17 81:14 91:6 91:8	Don 55:15
directors 77:16	Donald 2:8 4:22
Director's 36:10 39:8	donation 88:8
disaster 96:8,17	Donna 30:25
disasters 96:13	donor 88:12,13,15,25
discourse 70:14,14	doses 15:7
discuss 79:10 86:11 88:2 101:10	doubt 53:3
discussed 9:4 16:2 20:6 31:12 39:23 40:11 43:8 44:19 61:2 99:5 101:11,15,25	downside 65:24 78:19
discussing 41:25 54:10 78:18 90:11	downstate 95:12
discussion 7:22 9:7,8 10:24 11:4,5 15:8 16:11 18:12 20:7 20:13 21:16,18,23,25 22:17 23:23 26:3,16,22 31:20,25 32:4 35:12 37:16 41:11,24 42:9,18 43:7 45:25 46:15 47:9 53:6 56:20 58:16 59:17 63:10	Dr 3:3,5,5,6,6,7,8,9,10,11,12 3:13,14,15,16,17,18,19,20,21 3:22,23,24,25 4:2,3,5,6,7,8,9 4:10,11,12,13,14,15 5:9 7:14 7:18,20 9:8,10,11,12,13,14,15 9:16,17,18,19,20,21,22,23,24 9:25 10:2,3,4,5,6,7,8,9,10,11 10:12,13,14,15,16,16,18,20,21 11:5,7,8,9,10,11,12,13,14,15 11:16,17,18,19,20,21,22,23,24 11:25 12:2,3,4,5,6,7,8,9,10 12:11,12,13,14,16,17,22,23 13:2,6,8,9,11,12,13,14,15,16 13:17,18,19,20,21,22,23,24,25

14:2,3,4,5,6,7,8,9,10,11,12	drawing 80:15 81:8 83:20
14:13,14,15,16,17,18,19,21,22	draws 80:7 86:3
14:23 15:5,21 16:3,5,6,7,8,9	dress 18:10
16:10,13,14,15,16,17,18,19,20	dressings 18:7,7
16:21,22,23,24,25 17:2,3,4,5	driven 55:20 64:2
17:6,7,8,9,10,11,12,13,14,15	driver 55:19
17:16,17,18,19,20,22 18:12,15	driver's 55:19
18:17,18,19,20,21,22,23,24,25	drop 35:22 74:19
19:2,3,4,5,6,7,8,9,10,11,12	dropping 39:4 98:13
19:13,14,15,16,17,18,19,20,21	drug 81:2
19:22,23,24,25 20:2,4,5 21:13	dry 18:6,10
21:25 23:23,24 24:15,23 25:3	due 62:17
25:4,9,13,15,16,19,20,25	dust 22:9
27:12 28:2,8,16 29:21 30:4,7	duty 20:24 74:10,22
30:18,22,23 31:9,12,15,17,19	duty/on 81:9
31:23,24,25,25 32:15,15,19,20	D-Fifty 15:19,22
32:22,22 33:23 35:12,13,14,16	D-Ten 15:21,22
35:17,24 36:2,3,3,4,8 39:21	D.O 2:12,15,16
39:22 42:9,16 43:7 44:2,8,16	
44:22 45:9,11,15 51:9 54:5,15	<hr/> E <hr/>
54:20 55:2,15 56:12,14,15,17	E 2:9,17
57:25 58:15,18,20,20,23 59:4	eager 107:2
59:16,24 60:6,17,19,22,23	earlier 9:4 78:14 97:21
61:3 63:10,15,20 65:7,8 68:19	ease 10:25
72:7,12,13 76:10,12 77:5,7	easy 60:6
78:11 79:18 83:7,12 84:15	ECMO 88:16
85:8,10,22 86:5,18,19 87:13	economy 7:2
88:4 89:21,22,23 90:2,3,4,10	Ed 28:3
91:12,23,24,25 92:2,3,4,5,5,6	educate 53:13
92:7,8,9,9,10,11,12,13,14,15	education 7:16 42:11 54:6 58:5
92:15,16,17,17,18,20,21,22,23	61:21 62:9 82:23 85:5 91:14
92:24,25 93:2,3,4,5,6,7,8,12	93:16
93:17,18,19,20,21,22,23,24,25	educational 59:12 60:14,25
94:2,3,4,5,6,6,7,8,9,10,11,12	63:14 91:19 99:7 101:4,23
94:12,13,14,15,16,17,18,19,20	104:21,23
94:21,22,23 95:4,5,6 96:6,6,7	effective 62:25 79:20 83:5
96:7 97:2,15,16,17,19,20 98:2	effort 36:23 53:12 67:12
98:6,7,8,9,12,13,14,15,16	eight 55:9 60:2 82:6 93:10
99:17 101:14,20 103:2,3,5,21	94:25 108:13
106:4,17,19,21,22,24,25,25	eighty 43:24
107:5,7,11,12,13,14,15,16,17	eighty-five 51:18 59:8
107:18,19,20,21,22,22,23,24	either 48:5 65:23 66:15 78:3
107:25 108:2,3,4,4,5,6,6,7,8	85:15 96:22
108:9,10,11,12,15,17	electronic 26:9,10 27:10,15
draconian 73:15	28:10,19 33:11,17,19 35:10
draft 36:19 81:15	37:5,8,14 38:6
drafting 40:21	electronically 75:21
drape 49:7	element 6:6
draw 80:18,25 81:18 82:10,19	elements 6:7 37:13 39:9 40:9
83:2 84:11 85:24	eleven 60:2 74:9 93:10 94:25

eliminate 69:7,22 93:13	evaluations 64:8
eliminated 72:7	event 29:24 68:14,15 96:15
eliminating 57:23	everybody 36:23
eloquently 101:20	everybody's 28:5
embrace 98:20	everyone's 22:18 31:16 100:10
embraced 5:22 101:6	evidence 29:25
emergency 1:5 20:24 29:6,19	evolution 27:14
30:11 69:19 75:25 76:8 90:7	evolve 34:10
96:11	exact 91:9
employ 81:8	exactly 87:18
employee 81:11	exam 45:3 46:10 47:9 51:14,17
employing 62:9	51:19 90:20
emsCharts 37:17	examination 63:7
en 27:24	example 38:16 78:21
enable 72:23 73:14 76:7 87:8	examples 106:5
enables 40:12	excellent 13:2 55:19 56:9 75:13
enact 86:13	75:13 76:6 78:5,17
encourage 33:19 70:14	excited 37:22
encouraging 65:19	exclusion 89:10
endorse 98:17	excuse 63:14 92:17
endorsed 101:16	executive 22:3 69:12 76:2,5
endorsement 63:2,3	exist 49:15 91:2 99:25
energetic 64:3 71:9	expect 37:20 73:19
energetically 66:9	expecting 39:18
enforced 28:7	expeditious 54:22
Enforcement 15:10 73:10	expensive 54:22
engage 24:19	experience 56:9
enjoyed 67:20	expert 5:13 98:23 99:23 102:12
enroll 50:17	experts 96:16
enrolling 50:13	explain 65:11
enter 36:6 68:2 89:9	explore 83:13
entered 32:4 89:12,15	exploring 86:6
entertain 68:12,13	exponentially 50:15
entire 36:9	exposed 57:4
environments 24:10	exposure 56:3,10 95:21
equally 60:6 79:20	express 23:25 85:17
equipment 43:3 47:20 48:18,22	expressed 80:23
49:5 52:24 53:15 55:23,25	Extension 97:6
56:11 59:2	extensive 105:11
equity 52:17	extensively 61:21
equivalent 30:2	extent 44:15
ergonomics 38:23	extra 55:9
especially 15:18 20:21 22:22	extremely 6:9 24:12 33:25 51:12
26:11	89:16
essentially 71:20 75:17	eyes 73:19
establish 23:13	e-mail 78:11 97:20
ethereal 70:13	e-mails 36:14
etomidate 15:7	E.D 40:22
evaluate 52:15 63:7 64:4	E.M.R 26:13 60:20
evaluated 78:16	E.M.S 5:20 6:15 8:3,11 9:2

<p>22:14 24:11 26:3,16,18 27:5 27:22 32:2,5,7 33:6,12 35:9 36:5 37:19 38:17 39:25 40:6,8 40:9,13 50:13,19 55:20,23 60:13,23,24 61:5,12,25 63:14 63:20 65:3,6,14,14,20 67:3 69:19 70:10,15 71:7 73:9,25 74:6,7,8,21 75:9,11 76:3 78:21 80:16,23 82:16 83:2 84:10 89:17 90:5,12,21 91:4,7 91:19,20 95:12,21 96:23 99:8 E.M.T 2:10 10:24 47:7 49:4 50:21,22 53:4 60:20 71:15 77:2,3 80:15,18 81:3,4,8,11 81:16,17 85:18 86:16 88:24 95:16 E.R 21:3 26:15 34:7</p> <hr/> <p style="text-align: center;">F</p> <hr/> <p>face 32:7 facilities 21:9 24:6 facility 6:21 24:19 facing 62:20 fact 23:18 34:3 102:4 103:7 104:6,20 faculty 47:4 Faeth 2:8 4:22,23 55:16 83:14 fail 47:10 57:10 failsafe 53:18 fairly 73:15 fall 68:3 105:10 fallen 24:7 Falls 75:8 familiar 62:15 97:4 familiarity 47:20 48:18 family 88:24 89:10,12,14 far 37:23 61:16 63:25 65:8 67:23 73:12 75:2 83:10 88:23 89:18 fashion 27:3 107:4 favor 7:12 13:3 59:24 63:15 FDNY 74:3 Fedcap 37:25 38:7 federal 102:16,16 103:6 feed 67:25 feel 46:4 66:17,24 86:12 95:19 feeling 44:20 fell 88:13 fellows 90:18 fellowship 90:17 91:2,5,7</p>	<p>fellowships 90:12,15 fantanyl 15:10,11 72:22,22,23 Ferris 1:12 feverishly 60:10 field 5:12 80:8 104:11,14,15 105:3 fifteen 20:23 93:11 fifty 57:11 64:13 fifty-nine 74:2,4 fighting 45:18 69:2,3 figured 81:21 final 8:20 41:24 find 29:10 30:19,20 34:19 87:18 96:23 finding 47:19 50:3,9 fine 52:15 70:13 91:18 105:16 finish 22:11 26:2 finishes 105:8 finishing 72:24 fire 74:17,20 96:9 first 7:24,25 36:18 37:16 39:23 40:3 57:22 61:23 67:14 84:18 90:16,20,25 91:16 95:15 96:4 103:4,9 fiscal 65:16 69:4 101:22 fit 31:15 55:13 five 6:7 7:23,23 38:4,8 52:6 60:2 89:11 93:10 94:24 108:13 fix 52:8 floor 3:5,8,10,12,15,17,19,21 3:23,25 4:3,4,5,7,9,11,13,15 4:18,20,22,24 5:2,4,6,8 7:13 9:10,12,14,16,18,20,22,24 10:2,4,6,8,10,12,14,16,19 11:7,9,11,13,15,17,19,21,23 11:25 12:3,5,7,9,11,13,15 13:5,7,9,12,14,16,18,20,22,24 14:2,4,6,8,10,12,14,16,18,20 16:13,15,17,19,21,23,25 17:3 17:5,7,9,11,13,15,17,19,21 18:14,18,20,22,24 19:2,4,6,8 19:10,12,14,16,18,20,22,24 20:2 52:2 56:13,16 76:23 86:24 87:2 91:23,25 92:3,5,7 92:9,11,13,15,19,21,23,25 93:3,5,7,9,17,19,21,23,25 94:2,4,6,8,10,12,14,16,18,20 94:22,24 107:6,8,11,13,15,17 107:19,22,24 108:2,4,6,8,10 108:12</p>
---	---

fly 65:4,22	Garden 1:13
folks 45:19,24 46:3,16,22 107:4	general 31:21 38:5 74:18
follow 72:11	generate 53:4 103:8
followed 66:10	generated 29:23
following 15:5 72:8	Gestring 101:7
foot 57:4	Gestring's 101:8
forced 69:7	getting 6:20 7:5 23:11 24:23 29:3 46:10 50:10 66:7
foregoing 109:3,5	give 7:19 25:21 55:9
forensic 86:3	given 97:22
forever 24:14	gives 63:6
forget 58:25	giving 55:3
forgot 76:20 77:7	glacially 66:6
form 66:21 70:6 73:16 77:9	glad 23:10 25:2 84:5
formal 28:24 36:16,20	gladly 79:12
formally 31:13	glaring 66:8
format 26:9 27:16 34:12	glazed 73:19
formatted 26:9	Glens 75:8
forth 12:20 52:20 57:16	go 22:12 23:6,22 24:5 35:17 36:13 42:13 43:2 44:20 46:16 47:3,17 48:24 49:4 50:5 52:7 52:22,25 53:5,20 55:12 57:10 57:16 58:4 67:9 80:2 88:11,14 89:24 90:14
forty-eight 29:17,23	goal 36:24 59:14
forty-nine 62:19 99:11	goes 34:23 41:11 66:13,15
forward 7:23 8:24 9:7 11:4 12:18,25 15:25 21:18,23 36:17 54:11 67:12 71:19	going 6:17 15:16 18:8 23:6 26:10,23,23 27:10 29:15 33:8 33:21 34:10 35:11 36:21 38:14 39:19 41:4 43:20 44:4,22 46:13 47:12 49:20,21,22 51:19 52:13 53:10,11 54:3 60:16 68:20,20,21 71:23 72:2,3 73:2 76:14,15 81:21 82:11 85:11 86:10 88:9 90:13,14 91:15 95:14,16 96:14,15 97:17 99:14 100:7 105:13,25
forwarded 18:11	good 6:6,7,23 21:6,20 29:12,19 35:16 38:22 39:16 42:23 50:5 65:17 74:19 75:18 76:12
found 15:20 35:5,14,15 40:15 72:16	Goodman 2:12 3:15,16 9:18,19 11:15,16 13:20,21 16:21,22 19:2,3 92:7,8 94:4,5 107:22
four 37:6 45:20 46:7 48:13 55:3 59:25 70:10,10 90:12,15 93:10 94:24 108:13	GORR 72:5,6,19
fourteen 93:11	gotten 5:22 76:18
frankly 29:8 33:9 52:6 62:13 70:21	government 66:23
front 64:13	governor 65:19 72:7 75:4,4
fulfill 7:6	governor's 37:7 65:13 72:5
full 6:13 40:5 71:11	graduates 55:4
fully 21:22	grandfather 91:3
functional 21:22 37:11	
fund 7:5 102:15	
funded 99:24	
funding 65:15	
Funk 21:13	
Funk's 24:23	
further 21:18 50:12,20,20 63:10 79:23 83:7,13 86:7 91:21 99:12 107:8	
future 58:11 98:21 99:13	
fuzzy 87:5	
<hr/> G <hr/>	
game 57:25	

grant 37:7	37:18 64:10,14 69:7,10 74:18
gray 77:18	75:24 76:7 79:16 96:11
grayed 77:14	healthcare 6:16 25:5 33:21
great 36:4	hear 36:13 43:10 54:19 56:7
greater 33:6 100:16,16 102:6	70:9
green 100:4	heard 87:14,14,23 88:7
Gregory 2:17	hearing 7:10,18 9:9 41:6
grip 71:10	heart 6:2 8:2,5,10,16,19,25
ground 24:4	31:10 87:5,6,9 99:3 101:21
grounding 95:25	102:6,8 103:8 105:19
group 23:21,25 24:6,7,13 55:18	heartening 5:19
72:8 81:20,21 84:22 95:11	heartily 78:7
guess 20:10 22:3 88:19 98:3	hearty 65:25
102:3	held 61:17
guideline 8:17 31:11 61:22	help 41:18 56:23 57:14 72:21
85:21 106:15	helped 46:19
guidelines 5:12 6:2 8:2,5,10,19	helpful 32:14 34:16 35:11
8:22,25 98:20,24 99:20 102:14	helping 58:10,11
102:25	helps 57:24
guy 50:5	Henry 2:6 3:3,19,20 5:9 7:14
guys 70:7,9	9:8,22,23 10:20 11:5,19,20
	12:16,22 13:2,6,8,9,11,24,25
H	14:22 16:3,6,8,10,25 17:2
Haldol 15:13	18:12,17 19:6,7 20:4 21:25
half 68:8	23:23 24:15 25:4,13,16,20
half-ring 48:6	27:12 28:8,16 30:4,18,23
hand 13:3,4 28:23 29:25 65:20	31:12,15,19,25 32:15,20 33:23
69:24	35:12,16,24 36:3 42:9,16 43:7
handed 26:5 27:6,7,11	45:15 55:15 56:14,17 58:15,18
handoff 26:4,7,11,18	58:20 59:16,24 60:6,22 63:10
hands 59:25 63:16	63:15,20 76:12 78:11 79:18
handwritten 26:9	83:7,12 85:22 86:5,18 87:13
hand-down 26:16	89:21,23 90:3,10 91:12 92:9
HANYS 25:6	92:10 93:12 94:6,7 95:4 96:6
happen 21:17 24:3,3,4 28:4	96:7 97:2,15,19 98:2,7,9,13
73:14 99:15	98:15 99:17 103:2,21 106:4,17
happened 40:6 54:25 79:25	106:21,24 107:5,7,22,23
happening 29:12 32:16 46:5	108:17
47:14	hereto 109:4
happens 26:4 29:16	Hey 34:24 50:4
hard 15:4 34:4	high 22:7 51:12,21,23 52:13
Hare 48:5,6,15 53:16	high-functioning 59:10
harping 70:2	high-qualified 59:13
harsh 69:3	Hilton 1:13 67:23
hate 50:11 56:7 74:11	hit 88:21
Haydock 2:12 3:17,18 9:20,21	hitch 46:23,24
11:17,18 13:22,23 16:23,24	Hofstra 95:9
19:4,5 92:9 94:6	hold 81:23
heading 65:10	holding 96:12
health 1:2 5:23 6:17,17 33:6	home 100:14

<p>hone 56:23 57:14 honestly 68:25 69:16,18 70:23 71:11 73:4 84:2 85:17 86:9 Hoosick 1:13 hope 8:23 44:23 57:8,12 60:7 67:19,23 78:13 hoped 82:2 hopefully 57:21,24 79:20 hoping 42:4 horror 73:20 78:9 hospital 24:21,23 26:4,6,11,20 27:2,4 30:12 34:21 35:2,7,19 35:21 36:6 40:10,16 41:21,23 100:11,13,15 102:9 hospitals 20:21,22,22 24:19 32:3,5,6,12,24 39:25 40:7,7 40:19 41:6,10 hospital's 41:20 hour 54:10 68:8 91:9 hours 29:17,23 55:10,13 57:20 59:22 91:5,7 house 80:10 Howard 109:2,10 Hubbard 109:2,10 Huffner 2:9 3:21,22 9:24,25 11:21,22 14:2,3 17:3,4 19:8,9 45:9 56:12,15 68:19 85:10 86:19 92:11,12 94:8,9 107:24 107:25 huge 64:14 66:10 hundred 43:23 74:5 100:21 102:6 Hunt 5:14 hurt 68:20,20 hurting 47:2 hyperthermia 20:8 hypoglycemic 67:21 hypotension 15:15 hypothetical 85:24 H.A 98:24 H.I.V 97:6</p> <hr/> <p style="text-align: center;">I</p> <hr/> <p>idea 21:20 24:13 35:6 46:23 95:23 ideas 41:7 identified 39:9 41:3 64:17 identifies 104:17 identify 33:20 36:24 38:21 64:20 77:15,17 identifying 64:11</p>	<p>III 2:16 ImageTrend 37:4 38:5,7 implement 99:15 implemented 107:3 implementing 42:7 implore 70:25 implored 33:3 imploring 32:6 important 6:4,15 22:5 23:25 24:12 29:5,7 33:25 77:4 104:12 importantly 27:17 impression 40:22 improve 6:11 improvement 33:2 36:20,25 103:11 inaccurate 34:6 incident 38:11 include 10:23,25 11:2 17:25 26:8 28:20 31:3,10 38:6 included 9:5 31:7 32:12,17 71:15 includes 26:7 102:13 including 18:6 20:7 40:22 inclusion 10:22 21:20 99:3 101:21 102:2 104:16 106:15 inclusive 109:6 incompetent 53:20,21 56:8 incorporate 8:18 31:20 59:22 incorporated 8:11,13 incorporating 8:16 incorporation 8:4 increase 59:13 increasing 50:14 102:2 incredibly 89:17 independent 81:6 85:19 indicated 73:12 103:22 indicating 97:21 individual 40:12 55:14 57:13 82:16 83:20 84:4,11 85:11 86:19 individuals 42:21 44:13 74:15 induct 74:12,14 inductees 75:6 inducting 74:10,15 indulge 68:22 influences 85:25 inform 79:18 information 26:5,22,25 27:8,11 27:22 28:21,24 29:4,7 32:18</p>
---	---

<p>32:23 33:7,14,15 39:10,17 75:14 83:8 88:8 91:10 96:24 Informative 59:16 informed 39:15 91:13 104:6 infrastructure 99:6 initial 50:25 80:12 initially 51:19 initiate 79:2,5 injured 100:12 103:23,24 104:3 104:3,18 injuries 104:4 injury 38:19 100:16 104:5 Inn 1:13 inordinate 38:18 input 69:23 instances 56:21 86:22 89:11 instruction 58:13 instructor 47:7 56:2,10 93:14 instructors 43:13,14 46:5,6 47:2,13 51:13 58:10 59:14 63:5 integrating 33:5 intend 25:20 intensivists 6:9 intent 36:22 87:15,16 intention 82:25 83:3 interact 33:21 interactions 95:22 interconnected 64:6 interest 5:18,23 49:23 51:13 95:10 98:9 interested 6:9 51:12 59:14 64:17 65:2 76:3 83:10 84:7 85:5 97:11 interesting 29:15 39:6 63:24 64:12,23 71:18 75:20 81:13 84:22 interestingly 77:8 interests 25:22 interim 58:24,24 76:17 intermediate 10:23 internal 79:7 80:14 85:13 international 6:2 96:16 intervention 78:22,24 inter-facility 21:11,12,14,21 22:6,20 23:19 24:25 25:11 intoxicated 83:16 intubation 41:13 Int'l 109:8 investigator 99:25</p>	<p>invitation 75:3 invite 75:4 invited 75:3,4,5,16 81:19 involve 91:4 involved 69:21 78:23 79:2 90:8 involves 95:21 ipratropium 18:2 Israel 2:4 5:4 issue 23:15 27:21 36:5 38:21 44:12 47:20 48:18 54:8 58:12 76:9,15 78:10,12,17 79:8,9,9 85:16,21 103:6,20 104:10 105:25 issued 77:24 issues 33:16 52:3 64:21,22 65:11 79:10 83:22 issuing 77:3,19 item 7:25 10:21 12:17 63:17 97:3 98:10 items 7:17,23 9:6 42:14 73:22 91:12 it'll 35:11 79:20 96:18 I.S.S 100:15</p> <hr/> <p style="text-align: center;">J</p> <hr/> <p>Jack 2:11 January 67:17 Jeff 60:22 Jeffrey 2:15 Jeremy 2:3 Jeremy's 101:15 job 81:9 John 2:11 Johnson 2:4,13 77:10 Joseph 2:16 Joshua 2:14 Jr 2:15 July 90:18,18 jump 86:7 June 96:14 justify 69:5 83:18</p> <hr/> <p style="text-align: center;">K</p> <hr/> <p>Karen 55:11 56:18 66:14 Kaufman 2:13 3:23,24 10:2,3 11:23,24 14:4,5 17:5,6 19:10 19:11 36:2,5,9 39:21,22 88:4 89:22 90:2,4 92:13,14 94:10 94:11 95:5,6 108:2,3 keep 39:14 50:24 66:25 67:2</p>
---	--

<p>73:3 keeping 51:24 104:10 kept 29:7 85:6 killed 79:5 kind 29:17 38:12,13,13 43:23 61:7 62:7 65:9 69:3 70:5 71:22,24 104:8,8 106:2 kinds 39:11 77:11 knew 45:2 know 5:15,20 6:5 22:15 23:7 25:24 26:5 27:7,12,18 29:13 30:4 31:13 32:15 33:25 34:12 34:20 35:2 38:24 44:25 45:23 46:2,11,12,21 47:10 48:3,21 49:2,7,10 51:4 53:16 56:5,8 57:18,19 62:3,9,20 65:11,12 66:22,25 69:3,6,6 70:16 71:2 71:8,8 73:8,22 75:12,19 76:21 77:6,25 79:13,19 80:6 84:2 85:7,23 86:6,10,12,13 87:4,4 90:7,9 95:6 96:24 99:11,14 100:25 101:6,11,12 103:24 104:2,2,17 105:19,21 106:7 knowledge 56:9 58:4 known 12:19,19 knows 46:14 100:24 Kugler 2:14 3:25 4:2 10:4,5 11:25 12:2 14:6,7 17:7,8 19:12,13 84:15 85:8 92:15,17 92:19 94:12 108:4 K.T.D 46:14 48:15</p> <hr/> <p style="text-align: center;">L</p> <hr/> <p>lab 47:2 93:14 lack 49:14,19 lacking 23:20 Lakes 16:8 land 33:11 language 20:20 21:5,7 27:13 35:15,15 76:16 large 51:6,21 85:24 larger 58:12 law 79:22 80:4,24 82:11,13 83:19 86:14,14 87:8 laws 76:7 86:12 lawyers 61:8 78:15 82:13,15 leading 24:10 learn 45:13 56:23 57:14 learned 37:3 72:6 leave 46:18 97:11</p>	<p>leaves 79:14,15 Lee 2:7 22:2 72:14 83:14 84:15 85:10 97:3 left 18:9 57:6 65:15 legal 65:6 83:21 84:6 legislative 75:23 legislators 75:5,6 legislature 87:7 Leinhart 2:14 4:3 10:16,17,18 12:3,4 14:8,9 17:9,10 19:14 19:15 28:2 29:21 32:22 54:5 54:15,20 55:2 92:15,16 94:12 94:13 108:4,5 length 39:23 lengthy 42:17 Letch 2:18 letter 6:25 7:3 36:19,22 40:4 83:19 letters 73:15 let's 3:3 18:17 21:25 47:16 52:10 91:21 101:7 107:9 level 1:12 8:7,14 10:24 38:21 42:21,22 43:12 44:12 50:22 53:8 65:16 70:16 72:3,15 73:18 99:9 levels 15:23 35:3 50:19 60:17 61:4 67:7 77:3 Lewis 2:10 liabilities 75:24 liability 79:14,16 liable 78:20 79:6,15 liberty 6:18 license 55:19 licensed 76:7 life 6:13 97:8,13 liken 65:19 limited 33:14 Linden 72:7 line 74:10,22 link 37:13 75:10,18 list 34:5 41:4 49:5 97:7 listed 47:13 87:13 97:13 listen 69:14 87:24,25 listening 64:23 lists 33:24 listserv 75:22 76:4 98:4 listservs 74:22 literature 98:22,23 100:5,9 105:11 little 21:25 24:17 27:8 57:15</p>
---	---

68:18,21 86:6 90:9 98:25	March 1:10
lively 7:22	Mark 2:6,9 5:6 23:7,8 28:2
Livingston 7:3	58:20 101:7,8
local 44:12 72:3	Marshall 2:10 4:5,6 7:18,20
LOCATION 1:12	10:6,7,21 12:5,6,17,23 14:10
locations 89:6	14:11,21,23 16:5,7,9 17:11,12
long 8:3 24:5 48:4 68:9 74:18	17:22 18:15 19:16,17 20:5
longer 20:11	25:3,9,15,19,25 30:7,22 31:9
look 18:5 21:10 22:22 33:24	31:17,23,24 35:13,14,17 92:21
35:9 39:19 49:8 50:12 52:10	92:22 94:14,15 108:6
55:12 64:21,22 66:8 67:9	masks 15:15,15
69:15,21 75:23 76:6 79:23	Mastrianni 2:15 4:18,19 47:19
100:11 105:17	47:24 48:2,8,11,17,23 49:13
looked 8:9 15:20 26:16 58:5	material 43:21 53:14 101:8,23
101:22 104:10	materials 62:21,22 99:7 101:4
looking 20:20 28:8 30:19 33:19	101:10 102:18,19 104:21,23
40:15 45:16 54:13 55:6,14,18	109:8
64:18,19 67:21 77:13 86:13	matter 52:22 53:21 104:20
100:5,18 105:25	Maureen 84:18 85:8
looks 76:23 105:13	McCormick 85:8
loosely 61:11,15,17	mean 21:15 22:6,9 34:3 45:13
lose 51:21	49:15 55:2 79:15 83:21 86:4
losing 51:23	87:3 101:3 106:10
lost 35:18	meaning 43:12
lot 6:16 22:25 23:16 26:3,10	measure 58:24
28:9 33:25 35:5 46:20 49:3	mechanism 53:18 59:7 64:15
50:3 61:23 62:16 64:7,17,19	Medicaid 65:22
83:21,22 86:2 90:7 91:9	medical 1:5 7:19,21 15:12 20:14
lots 28:10	20:15 21:8,11,15,17 23:2
Lou 7:19	28:23 29:3,8,9,11,11,18,23
loud 30:5	30:11 33:4,16 59:11 61:21
loved 79:5	69:20 77:16 81:6,14 85:19
low 51:24	86:24,25 87:15 90:5 91:6,8
lucky 74:14	95:8,14,15,18,25 96:3
lunch 68:8	medication 34:5
	medications 33:16,24 73:17
M	medicine 90:7 95:10
machine 77:12	meet 44:17 63:23 70:8 100:5
mailing 75:16,17	106:3
main 33:16 56:20	meeting 1:7 3:2,3 5:11 6:23 7:9
maintain 30:7	22:4 36:15 43:9,9 46:15 61:22
major 40:25 100:20	67:15,19,24 78:4 80:2 82:22
majority 108:18,19,19	87:22 88:3 97:22 100:8 101:12
making 21:13 32:2 38:13 67:6	106:5,14 108:21,22
manage 35:3 70:10	meetings 5:17 67:11,13,15,17
management 70:4,19,20 96:12	68:3
mandated 81:3	Meggenhofen 45:4,6 55:11 56:19
mannequin 49:2,6	member 25:5
manufacturers 48:11	members 4:16 22:3 25:6 75:12
mapping 37:12,18,20	89:15

<p>memorial 74:7, 8, 11, 12 memorialized 28:24 70:18 memory 28:5 mental 40:25 mention 49:15 91:11 mentioned 33:23 40:2, 20 85:10 merge 34:2 met 7:21 36:15 89:13 99:20 methodologies 42:2 methodology 40:15 Michael 2:6, 15 4:18 midst 6:15 mike 42:12 47:23 50:4 98:5 million 65:17 102:17 mind 50:24 minds 86:8 mine 62:24 102:22 107:2 mints 67:19, 20, 25 minutes 7:9 31:4 87:17, 18 Miranda 2:4 5:4, 5 mirrors 101:16 missing 44:9 mission 6:15 7:7 mix 18:2 mobilization 73:23 mock 96:15 model 61:5 modeled 71:22 models 6:18 33:18 modifications 97:25 MOLST 33:17 76:23, 25 77:9 moment 68:22 76:11 money 53:9 56:21 57:17 65:25 67:5 85:6, 7, 7 103:12 money's 52:22 monitor 38:14 Monroe 7:3 month 5:14 64:10 months 37:21 106:2 morning 7:21 20:7 21:6 26:2 42:18 46:16 54:10, 25 96:13 motion 7:11 8:24 9:7 10:25 11:4 12:16 15:25 18:11 31:10, 18 42:24 43:5 47:18 54:6 56:13 56:15, 17 59:18, 20, 25 60:4, 12 63:11, 13 91:16 93:13 99:12 101:13, 15, 16 103:3 105:6 106:18, 19 107:7 108:14 motions 36:16, 17 91:15 Motor 81:23 84:21 85:4</p>	<p>Mountain 16:8 move 22:22 27:9 35:25 44:20 61:18 63:2 66:14 67:12 71:19 82:6 87:19 100:23 moved 7:11 15:11 71:24 moving 27:15 37:9 39:2 50:20 61:22 66:4 78:6 multiple 37:21 38:7 multi-disciplinary 5:23 multi-phase 36:7 multi-step 40:3 murdered 81:21 Murphy 2:3 4:7, 8 10:8, 9 12:7, 8 14:12, 13 17:13, 14 19:18, 19 92:23, 24 94:16, 17 108:6, 7 Myers 2:15 4:9, 10 10:10, 11 12:9 12:10 14:14, 15 17:15, 16 19:20 19:21 57:25 58:23 60:23 61:3 92:25 93:2 94:18, 19 108:8, 9 M.D 2:3, 3, 4, 5, 6, 6, 9, 10, 11, 11, 12 2:13, 14, 14, 16, 17 M.S 2:5</p> <hr/> <p style="text-align: center;">N</p> <hr/> <p>name 25:21 84:18 Narcan 20:9 narcotic 15:9 73:9, 17 Nassau 84:18 nation 55:21 national 5:12 60:13 61:22 62:9 62:10 63:13 91:19 96:16 102:12, 12 104:14 nationally 76:9 neat 96:19 necessarily 28:22 68:12 necessary 63:6 need 7:2, 16 20:10, 11 34:11, 13 38:22, 23 52:25 53:3, 15, 23, 23 53:24 56:3, 10 58:7 60:14, 23 68:24 69:20 70:12, 18, 21, 22, 23 84:6 100:20 103:12 needed 43:2 72:19 needing 59:8 needs 26:18 28:7 48:18 52:20 58:13 59:3 63:8 NEMSIS 37:14 nestled 65:24 Network 88:25 never 22:21 33:11 45:21 55:20 55:24 57:3 72:18</p>
---	--

<p>new 1:2,5,14 6:3 8:2,5 9:2,5 17:22 20:8 22:23 25:5 37:25 38:5 42:19 45:4 46:13 48:15 52:18 55:20 61:12 62:11,17 63:23 64:25 66:20,21,22,22 70:25 71:9,10 73:23,25 74:3 76:9 86:5 88:9,25 89:8,24 91:20 95:4,7,8,9,13 96:9,10 96:10,11,13 99:21 100:4,9 102:14 103:9 104:12,13,25 105:4 news 97:3 nicely 15:3 nine 57:3 60:2 93:10 94:25 100:16,17 nines 18:6 nineteen 65:17 102:17 nobody's 91:3 non-certified 57:12 non-lifesaving 78:22 Non-voting 4:15 North 95:9 106:6,9 nos 108:14 note 6:24 78:11 noted 63:25 notification 71:23 notifications 74:22 notified 96:22 notify 71:23 notoriously 34:6 now-approved 37:14 number 7:22 38:18 42:17,23 50:23 51:11 54:11 63:4 67:15 72:21 82:3,6 91:5 101:18,21 102:5 109:6 numbers 50:12 74:23 91:9 103:22 nurse 21:2 27:6</p> <hr/> <p style="text-align: center;">O</p> <hr/> <p>objective 58:7 observation 24:24 obtain 40:3,16 41:10 obvious 58:5 obviously 22:5 48:4 97:13 occasions 99:20 occur 52:18 95:14 occurred 30:17 occurring 44:13 October 7:9 106:14 offensive 77:13</p>	<p>offered 54:6 office 61:6 66:16 72:5 96:11,23 officer 81:2,5,9 82:9,15 86:16 89:5 officers 81:22 officer's 81:12 oh 12:23 42:16 58:19 62:3 74:13 76:16 77:7 87:11,12 93:7 107:19 okay 7:14,18 11:5 12:16,17,22 12:23 13:2,11 14:21 16:10 18:13,15,17 25:13,25 28:16 29:18 30:21 31:19,22 35:13,25 42:9 43:18,25 45:15 47:24 53:6 58:20,22 59:24 60:3,3 63:11,15,16,22 65:23 67:10 72:20 79:18,21 87:13,19 91:21 93:12 95:4 97:2 98:15 99:17 106:21 107:7,19,22 108:20 old 76:13 88:3 89:23 Olsson 2:16 4:11,12 10:12,13 12:11,12 14:16,17 17:17,18 19:22,23 44:2,8,16,22 45:11 93:3,4 94:20,21 108:10,11 once 6:12 82:15 84:3 105:17 108:18 ones 87:15 ongoing 23:14 88:20 99:9 105:9 105:16 online 20:14,15 21:8 onus 46:2 open 41:6 79:14,16 87:5,6,9 opening 5:10 6:19 95:8 operating 21:12 81:17 85:20 operation 100:20 operational 74:2 operations 78:18 opinion 41:7 99:23 104:19 opportunity 63:6,23 96:21 opposed 7:14 13:6 84:14 options 15:12 order 3:3 71:19 ordered 77:21 orders 15:10 72:23 organ 88:8,12,13,25 89:3 Organization 33:7 organizations 5:20,21,21 organized 30:10 96:15 organs 88:17 origin 28:3</p>
---	---

<p>outcome 15:20 outcomes 32:6 40:22 87:6 outside 100:11 outstanding 87:16 91:12 104:22 overall 29:4,12 oversight 81:6 85:19 86:24,25 overwhelm 102:9 ownership 23:16 oxygen 79:2,5 O.B 49:2,6</p> <hr/> <p style="text-align: center;">P</p> <hr/> <p>P 2:10 package 72:11 75:11 packet 75:14 page 82:25 pages 64:13 109:6 paid 103:18 pain 66:24 pains 27:16 PALS 31:3,6,7,10 Pamela 2:3 panel 5:13 paper 27:7 29:2,3 64:12 66:15 68:22,23 77:2,4,9,10,11,12,18 77:20,21,21,23,25 78:2 101:25 paperwork 71:19 paramedic 60:20 Pardon 56:14 Parrish 2:17 43:15 45:17,17 47:22,25 48:7,10,13,21,24 49:25 51:6 55:5 60:8 part 6:18 24:24 28:9,18 30:10 30:15 31:20 32:9 37:6 46:4 47:3,9,16 51:6 52:21,22 55:5 57:17 59:11 73:13 89:4 90:19 95:17 participants 70:3 participate 81:19 participating 82:3 participation 96:18 particular 44:4 46:11 47:8 55:25 102:7 103:4 particularly 32:24 33:16 64:7 68:7,17 69:2 104:3 parties 100:12 partners 24:11 32:13 39:7 74:4 pass 67:20 75:11 passed 45:3 101:16 108:14 pathway 91:6</p>	<p>pathways 90:24 91:3 patient 24:20,21 26:7,8,18,19 26:21,25 27:7,19,21,21,25 28:21,22 29:9 30:9,12 33:15 34:25 35:6,18,20,22 38:14 39:17 41:22,25 42:3,7,7 49:7 49:8 64:21,22,22 84:11 88:11 88:12,16 patients 15:15,20 22:7 24:6,8 24:18,18 25:12 29:6,19 32:8 34:3,20,21 38:19 40:23,23,24 40:24,25 41:2 67:9 72:23 74:16 89:13 102:3,5,7 103:23 104:2,17 patient's 29:3,8 Paul 46:19 78:4 79:12 pay 75:16,16 paying 66:19 payment 6:17 pecks 87:9 pediatric 15:11,12 41:2 96:8,13 penetrating 104:4 people 5:17 25:22 26:14 27:3 32:20 34:13 38:22,23 39:4 43:12 44:3,22 45:14 48:14 49:17 50:2,16 51:6,11,22,23 52:10,11,11,13 53:10,23 57:12 59:2,10 70:9 71:17,20 79:3 84:22 86:11,16 87:23 100:15 100:20 101:19 102:4 108:20 percent 18:7,8 34:20 57:11 102:3 perform 49:16 51:16 81:3 performance 103:14 performers 51:8,12,21 52:14 performing 51:15 period 63:9 97:9 periods 74:2 permanently 21:22 permission 67:21 68:2 permits 80:24 person 55:18,23 56:8 62:4 64:3 82:8,10 89:7 personally 85:25 personnel 20:16 26:6,20 27:2 perspective 62:14 phase 36:6 phases 6:5,16 PHHPC 69:8,10 phonetic 3:12 5:15 65:8 72:8</p>
--	--

<p>77:6 84:19 85:8 photocopied 77:17 photocopy 77:18 physician 5:21 20:17,18,19,24 20:25 25:7 34:24 69:20 80:5 81:6 85:19 89:2 physicians 35:6 96:4 physiologic 100:22 Ph.D 5:18 pick 39:4 picked 38:17 100:21,25 picture 29:2 65:21 piece 27:7 48:22 56:10 62:13 64:12,19 68:14,21,23 84:9 pieces 43:3 55:25 pilot 43:16 piloted 42:19 43:11 piloting 42:18 pivotal 62:20 place 23:3 29:10 33:2 35:21 37:18,19 41:22 67:24 88:16 103:9 109:4 placed 82:16 placenta 49:10 places 26:12 29:18 40:11 52:23 89:15 plan 35:21 38:4 40:3 45:6 73:23 planning 69:11 88:10 plans 36:20,22 70:22 90:9 plate 71:11 platform 33:8 37:8 platforms 33:20,20 play 6:18 pleasant 65:9 please 13:3 15:6 59:18,25 63:12 63:15 64:2 71:5,9 74:8,9,9,9 75:11 pleased 37:8 73:7 75:3 81:25 plot 63:3 plus 38:7 pneumonia 40:24 point 20:10 24:21 41:9 47:6 48:17 65:17 66:10 77:24 102:10,17 103:25 104:16 points 6:11 28:19 40:18,20 41:4 41:20 police 53:9 80:25 81:5,9,11,22 82:9,15 84:23 86:16 89:5 policies 26:17 81:16 86:2,14 policy 20:18 27:13,15,17 28:3,6</p>	<p>28:6,12 38:11 39:10 71:18 72:22,22,25 78:7,10,17 79:4 79:10 80:7,14,24 81:7,23 82:7 85:13,14,20,25 political 69:4 poor 38:24 66:8 population-based 104:7 105:3,24 portability 62:5 portion 21:3 51:21 posing 26:12 positive 73:3 89:16,18 possibility 24:24 possible 39:20 73:4 possibly 64:20,21 posted 66:25 67:2 73:3 post-test 43:22 post-testing 43:4 potential 88:15 potentially 97:7 potentials 54:13 power 34:8 practical 45:3 47:9 54:16,17,21 63:7 practice 38:22 60:24 61:5,8,12 61:18,22 practices 29:15 36:24 practitioner 21:2 precisely 103:25 predetermined 35:20 preliminary 5:11,13 premise 89:12 premises 89:9 prepare 49:7 prepared 43:13 45:25 46:4 109:7 preparing 22:4 prescreening 42:25 45:24 47:11 56:22 57:9,10,23 59:21 93:14 prescreenings 45:19 presence 5:16 present 3:16 5:7,17 18:9 83:7 104:24 105:9,16 presentation 49:10 68:19 78:5 presented 15:2 104:9 106:5 Preservation 89:3 presume 80:17 presumption 103:16 pretty 28:6 72:13 previa 49:10 previous 12:18 previously 12:19 105:15</p>
--	---

<p>pre-hospital 20:16 26:6 29:10 29:16 30:8,10 32:17 74:24 100:19 103:14</p> <p>pre-hospitally 29:6</p> <p>pride 52:19</p> <p>primarily 103:9</p> <p>primary 33:9 34:24</p> <p>principle 47:20 48:19</p> <p>principles 47:21,23</p> <p>print 77:2</p> <p>printer 26:15</p> <p>prior 60:24</p> <p>priorities 67:4</p> <p>privileges 42:3</p> <p>pro 85:15</p> <p>proactively 99:13</p> <p>probably 23:3 34:2 38:2,3 44:14 62:24 64:9 88:7,22 90:17,21 99:18,21 106:2</p> <p>problem 20:22 22:11 48:23 52:21 53:11,11 54:4 58:25 59:3</p> <p>problems 49:12</p> <p>procedure 81:3</p> <p>proceed 23:20</p> <p>process 24:20 32:13 36:25 50:6 53:22 59:12 61:7 63:7 66:13 66:18,21 67:12 71:16 90:13 98:19,22 99:18,19 105:8,16 106:12</p> <p>producing 70:12</p> <p>product 52:16,20</p> <p>professionals 75:24 76:8</p> <p>program 30:14 33:5 34:18 36:9 39:8 42:19 45:18 46:18 47:10 50:14,17 51:4,7,25 52:5,12,25 53:13 55:9 59:23 60:9,21 65:14 66:2 71:13 85:5 90:20 96:14,19 102:15</p> <p>programs 51:4</p> <p>progress 37:4,22 38:9 68:6</p> <p>prohibit 81:11</p> <p>prohibiting 80:14 81:7,16</p> <p>project 25:23 36:7 37:9 38:10 41:24 70:3,19,20 88:8,8,20,20</p> <p>projects 34:17 35:10 70:22,25 71:10 87:14 88:5</p> <p>promise 66:12 69:16</p> <p>promised 7:6</p> <p>prompted 28:3</p> <p>pronounced 88:11</p>	<p>proper 23:12 88:18</p> <p>proposal 6:22 43:22 44:6 65:13</p> <p>proposals 54:11</p> <p>proposed 71:15</p> <p>protocol 17:25 18:4,5 61:13 98:4</p> <p>protocols 7:23 8:6,8,12,13,16 8:20,21 9:3,4 10:23 11:3 12:20,20,24 14:25 15:3,4,8,11 15:12,14,16,18,18,23 17:23,23 20:6 23:17,19 31:2</p> <p>proud 90:8 95:19</p> <p>provide 20:15,21 63:5 82:11 83:3 88:6 89:19</p> <p>provided 20:19 30:11 35:19 73:24,25 75:15 104:21 109:8</p> <p>provider 21:3 38:15 39:17 42:7 61:4 65:6 78:21 83:2 84:10</p> <p>providers 15:24 17:24 24:25 27:5 32:2 33:12 38:19 39:14 41:13 42:3 50:13,19 51:8 73:25 74:6,19,24 82:17 83:15 91:20 99:8</p> <p>provides 99:6,7</p> <p>providing 21:2,8 40:6,7,23 42:3 58:24 64:11 84:7</p> <p>provision 20:14</p> <p>prudence 101:22</p> <p>psychomotor 48:25 49:5,8</p> <p>public 5:23 69:7,10 72:19 75:13 89:17 97:9,10</p> <p>publicly 60:8</p> <p>pull 6:13</p> <p>pulse 98:13,19 100:10,22 104:5 104:11 105:2,14 106:15</p> <p>purpose 48:20 69:22 81:2</p> <p>purposes 33:22 86:3 103:10</p> <p>pursuant 81:4</p> <p>pursuing 72:17</p> <p>pushed 39:13</p> <p>pushes 64:4</p> <p>pushing 90:8 95:13</p> <p>put 15:3,6 42:5 44:4 52:20,25 53:14 54:11 57:13,18 58:9 72:21 73:16 75:10,13 78:5 91:16</p> <p>putting 48:22</p> <p>puzzled 44:2</p> <p>P.A.D 71:22</p> <p>P.C.R 28:19 29:2,3 33:7,10,20</p>
--	--

37:24 38:2,8	61:23 62:15 66:17 69:9 70:21
P.E.C 102:2	71:24 74:11 75:7,13 77:4
p.m 1:11,11 3:2 108:22	79:10,14,15 81:20,25 95:23
	100:24 101:11
Q	realm 71:25
qualifies 88:5	reason 36:12 49:24 61:3 68:25
quality 32:25 36:20,25 47:6	70:7 77:8,9,14 98:18 99:24
58:13 103:11	104:12 105:22,24
quarterly 73:11	reasonable 63:9
question 11:6 23:4 53:2 59:17	reasons 34:8 50:16 83:24 101:19
61:19 63:11 80:6,8,11,13,17	103:4 105:5
81:14 83:15,23 84:8,14 107:9	recall 37:6,16
questions 23:16 40:13 41:17	receive 40:10 41:5 63:2
76:12 79:21 80:21,22 85:23	received 6:25 40:4 67:18 68:2
90:23	receiving 30:12 35:19 37:8
quick 83:14	recertification 51:3,16,25
quickly 36:8 37:9 40:19 99:16	reciprocity 62:3
quite 7:22 8:3 27:18 29:8 33:9	recognition 6:4
44:14 52:6 62:13 68:25 70:21	recommend 99:3
70:23 84:2 85:17 101:19	recommendation 25:10 47:16 52:7
quorum 108:16,18	54:7 59:11 103:8
quote 100:4 106:10	recommendations 26:24,24
quote/unquote 45:2	recommended 15:22 55:6
Q.A 30:14 32:25 41:11,14,20	reconsideration 105:11
Q.I 35:25 36:11	record 27:19 28:23 29:3,8,9,11
	29:18,23 30:6 34:23 109:6
R	recordkeeping 35:10 72:3
radar 65:4,23	records 26:11 28:10 29:12 33:6
radiologist 30:3	35:18
raise 59:25 62:8 63:15	recourse 78:23
raises 83:21	recovered 88:17
raising 13:4 73:18	recreate 23:4
ramifications 22:6	redirect 93:15
ran 77:11	referring 84:16
ratchet 70:21	reflected 31:4
rate 74:25 99:4 101:21 102:6,8	reflects 7:2 82:13 103:23
103:8 104:5,11 105:2,14	reform 6:17,17 72:5
rationale 100:23	refreshed 28:5
reach 82:24	refresher 50:14,17
read 30:5,5 40:19 63:11 68:24	regard 28:5 29:14 38:14
70:5 73:2	regardless 95:20
reading 30:2	region 6:8 8:15,18,21 12:19
reads 82:7	39:12 86:21 88:2
ready 45:16 63:10	regional 7:4 8:6,13,14,20 9:4
real 58:25 62:20	32:18 33:6 34:17 38:20 47:4
realistic 65:21	61:13 86:13
reality 69:16	regions 16:4,11 23:18 33:19
realize 70:25	36:12,19 39:14 40:15,18,22
realized 78:9	41:4,18,25 42:4
really 22:21 23:15 35:11 42:20	registry 89:8,8 103:10 104:7

105:24	requested 21:13 82:9
regs 33:2	require 23:14 28:20 61:8
regular 39:13 59:23 99:3,7	required 20:24 28:13 97:8
regulation 20:17 97:8	requirement 43:19
regulations 71:14 72:4,9,10 73:13	requirements 32:2,4 61:14
regulatory 61:9,14 72:5	requires 41:12,15
reimburse 66:5 67:7	research 6:10 64:19 75:22
reimbursements 66:4	researched 62:17
reinventing 62:16	researcher 64:16
reissue 77:24	residing 37:15
related 70:11	resource 62:22
relationship 22:15 84:12 86:15	resources 63:5 93:15
relatively 52:4	respect 62:17
release 106:16	respond 99:13 103:5
released 34:22 99:16	responded 74:3 98:4,5,7
relegate 24:12	response 49:14 75:25 80:19 89:6 89:14,16 96:17 99:17 100:8
relying 81:5	responsibility 47:5
REMAC 12:20,23 21:13,14 41:15 82:24 85:14 86:19	responsible 95:17
REMACs 86:10	rest 29:11 89:16
remain 24:18	restraint 15:14
remarkably 98:25	restrict 42:3
remember 65:18	restrictions 41:25 42:8
remind 25:4 38:22,23 106:13	result 10:22 38:11 85:25
reminding 32:23	resulted 38:18
remiss 91:13	results 41:16
REMO 15:2,2,19 16:6 20:8,9	resurrected 22:22
removal 15:7,13,14	retain 100:10
remove 15:10	reverse 54:2
removed 72:16	review 35:8 98:22 105:12
REMS 12:19	reviewed 65:7 78:8
REMCOs 66:3	reviewing 40:14
rendered 27:23	revise 21:5
repeat 15:7 59:18	revisions 98:21 99:12,14 106:23
report 7:19 22:9 26:3,7,8,8,18 26:22 30:22 36:4,13 37:3,9 39:18 41:16 42:8,11 63:21	revisit 34:13 97:21 105:10
reported 38:16 43:16 87:22	revisiting 100:3
Reporter 109:10	revitalize 25:21
Reporters 109:7	re-aware 28:17
reporting 21:14,15 64:16	re-consent 82:17
reports 7:15 20:9,12 30:9 32:17 38:11,21 39:12 73:11,11 87:14	re-educate 52:15 53:17
repository 37:15 38:6	re-educated 52:21
representation 25:10	re-looking 105:8
represented 84:23,25 85:2	re-screen 44:16
represents 25:7	RHIO 32:17 33:8,10,15 34:16,23 35:10 40:12
request 6:21 21:10 80:25 81:4,9 81:12	Rich 2:17 45:15,17 47:19 55:18 57:19 60:8
	richest 99:22
	Rick 5:14,19
	riding 95:17

<p>right 7:8,10,15 9:8 25:6,14 30:18 31:14 35:24 42:10 45:11 46:16,24 47:13,25 48:13,24 54:13 55:4,7 59:18 61:11 63:20 72:24 73:5 76:12 83:12 85:22 89:23 91:17 93:13 96:6 97:15 98:2 106:24 107:9,9 108:20 rigorous 98:22 99:19 rise 74:24 risk 22:7 79:7 103:10 risks 29:22 roads 88:21 roadway 39:2 Robert 2:8 5:2 Rochester 33:5,6 35:5 101:9 Roland 3:12 roll 3:4 5:8 10:19 12:15 13:10 14:20 17:21 20:2 91:14,16,22 93:11 107:10 room 6:23 20:25 64:25 route 27:24 44:20 row 67:20 rubberstamping 50:2 rudimentary 39:3 rule 18:6 rules 83:25 84:4 run 24:11 106:7 rural 20:22 rush 105:24 Ryan 97:5 R.M.A 83:16</p> <hr/> <p style="text-align: center;">S</p> <hr/> <p>s 18:16 26:13 33:7,10 46:3 49:12,12,14,14,19,19 50:3 51:7,20,20 53:4,23,24 58:2 71:15 80:15,25 81:16,17 86:20 87:6,9 88:24 95:16 safety 37:7 38:12,15,15 39:17 39:18 64:23 76:14,25 77:20,21 77:21,23 78:18 79:11 Sager 48:15 sample 39:18 82:8 saw 28:4 saying 49:3 50:4 52:10 73:15 85:6 says 20:17 26:17 30:7 35:17 70:7 71:25 105:4 SCAN 37:18</p>	<p>scary 74:24,25 scene 27:24 74:20 88:11 schedule 68:10 scheduled 55:8 school 95:8,9,15,18 96:3 scientific 77:10 scope 60:24 61:5,8,12,17,18 65:4,23 score 100:16 scored 51:18,18 screening 44:12 55:8 81:2 search 87:18 searching 87:17 seat 42:12 second 7:12 10:21 15:8 36:6 37:17 60:4,12 67:17 68:2 80:17 87:25 91:17 93:13 104:13 107:5 secondarily 58:11 secondary 103:15,17 seconded 9:7 15:25 18:11 36:16 107:6 section 30:18 42:25 49:9 see 16:2 27:20 33:10 34:24 40:21 56:5,11 76:21 77:4 86:8 89:7 107:2 seeing 38:17 55:16 seen 34:25 45:21 57:3,3 75:20 76:21 81:15 segue 36:4 seizure 34:21 41:2 select 52:13 selected 96:5 SEMAC 1:6 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 20:1,18 21:1,15,18 22:1 22:6 23:1 24:1 25:1 26:1,17 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 41:1,12,17 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 64:1,2 65:1 66:1 67:1 68:1,17 69:1 70:1 71:1 72:1 73:1 74:1 75:1 76:1 77:1 78:1,12 79:1,13 80:1 81:1 82:1 83:1 84:1 85:1 86:1 87:1 88:1,2 89:1 90:1 91:1</p>
---	---

92:1 93:1 94:1 95:1 96:1 97:1	shown 105:14
98:1,17 99:1 100:1 101:1,13	SHRPC 69:8
102:1 103:1 104:1 105:1,7	side 65:13 99:5
106:1 107:1 108:1 109:1	sides 101:20
semi-annual 73:11	sign 104:5
SEMSCO 23:21 69:25 71:4	signed 65:8
SEMSCO's 63:3	significant 20:13 38:9 72:10
send 32:11 50:8 75:21 76:4	101:22 104:5
sending 24:18 46:3 73:14	significantly 62:10
sense 6:4	signify 13:3
sensitivity 100:24	similar 77:9
sent 98:4 100:8,14	simple 39:3 52:4 67:8 73:16
separate 23:5 58:14 60:21 67:14	simply 104:25
89:4	simulated 49:8,11
separately 31:6	single 102:15
September 67:17	sir 63:17,18
series 39:9 85:2 97:13	sit 67:19 69:12,14,14
serious 23:11 42:20	sitting 51:14 76:22
seriously 77:19 103:24 104:18	situation 38:21
served 102:10	situations 24:8
service 28:11,18 30:11 71:23,25	six 6:7 37:25 60:2 93:10 94:25
71:25 74:17 75:22 80:6,14	95:15 108:13
81:10,15,17 85:11,13,20	sketchy 29:4
services 26:10 73:15,18 75:14	skiing 106:8
77:16 81:16 88:24	skill 11:2 42:21,22 43:12 45:22
session 45:20 50:7 59:21	46:6,11 47:8 51:5 57:6 59:21
set 15:3	93:13,15
setting 103:20	skills 42:25 43:2,4 44:3 45:8
seven 60:2 65:17 93:10 94:25	45:12 46:10,12,17,20 47:13,17
102:17	47:18 48:25 49:5,9 50:8,21
seventy-two 74:5	51:3 56:23,24 57:14 58:3,4
severely 104:2	63:8
severity 100:16	skill-wise 47:2
share 22:16 32:5,6 75:25	slide 68:19
shared 33:4	slightly 51:9
sharing 36:6 39:24,25 41:21	slow 66:6
Sharon 2:10 4:16	small 64:14
Shaw 65:8	smallest 66:11
sheets 32:7	snowstorm 73:24
Sheriff 84:24	solution 43:18
sheriff's 84:24,25	solve 53:10,11 54:3
she'll 7:7	solved 59:3
shift 55:20	somebody 41:7 50:25 66:21 83:16
Shore-LIJ 95:9	somebody's 91:4
short 24:4	someone's 6:12
shortage 49:23,25	somewhat 65:5
shortly 36:21	soon 39:19 73:4
short-term 29:5	sophisticated 62:11
show 34:6 38:19 46:18 70:12	sorry 12:22 54:18 76:16 83:14
showed 57:5	95:3,6

<p>sort 29:13 43:4 54:14 64:2 67:9 sound 105:23 sounded 48:2,3 sounds 39:2,3 43:10 49:17 55:2 58:4 sources 38:7 southern 75:7 speak 7:7 22:16 27:14 28:2 36:5 81:25 89:24 97:17,19 103:3 speaking 48:3 special 53:14 88:10,14,16 89:2 96:12 specialist 88:24 specially 26:20 Specialties 90:6 specialty 95:20 specific 40:13,14,17 41:4 78:20 79:21 specifically 75:5 86:14 specificity 100:25 spelling 3:12 5:15 65:9 72:8 77:6 84:19 85:9 spend 58:9 62:16 65:25 spending 56:21 57:9 67:5 spent 54:10 56:22 64:9 103:12 103:12 spiders 45:22 Spink 31:2 spiriting 100:6 splint 46:8,14,21,22 48:5,20 splinting 46:7 splints 46:8 spoke 31:22 71:13 101:19,20 spoken 89:12 sponsor 46:3 sponsored 53:7 sponsors 50:4 52:17,20 53:2,14 53:23 66:3 sponsorship 52:24 53:8 spun 52:3 squads 51:11 STAC 25:10 97:22 101:9,14 staff 6:20 37:3 63:20 staffed 88:24 stage 33:12 stakeholders 69:24 stalled 68:15 stand 72:17 74:13 102:23 standard 61:15 62:10,10,22 standardization 23:19</p>	<p>standardize 36:25 standards 7:19,21 21:11,15,17 23:2,17,17 33:5 60:14,25 61:21 63:14,14 87:15 91:20 105:19 standing 15:10 72:23 102:24 stands 69:10 80:4 start 47:17 50:15 52:4 90:17 96:5 started 52:9 56:25 68:18 starting 90:18 starts 44:17 state 1:2,5 8:5,6 9:2 18:8 20:16 22:19 24:3 27:4 29:15 34:16,17 35:9 36:23 37:2 38:5 42:6 50:13 51:14,17 52:18 55:21 61:12 62:2,11,18 66:16 66:16,25 73:25 76:7 84:22 89:8 90:13 91:21 95:9 99:8 103:10 104:12,14 105:2,4 107:4 stated 109:4 statement 38:11 39:10 72:25 78:10,18 79:10 81:24 82:7 statements 71:19 states 20:19 61:24 99:11 104:8 statewide 8:12 9:3,6 23:16 37:15 39:12 61:13 73:23 state's 30:13 37:24 65:12 status 40:25 statutory 61:9 68:24 steadily 50:15 steady 40:23 step 40:8 57:22 60:15 sterilized 68:23 Steuben 84:25 stick 55:20 STOP-D.W.I 84:20 85:2 strap 57:4 strategy 42:6 Street 1:13 stretcher 38:18,25 stretchers 39:5,5 strict 83:18 strikes 6:14 stroke 6:2 strong 5:18 22:10 25:22 41:7 104:4 strongly 95:13,19 structure 21:19 25:17 69:23</p>
--	---

structures 69:19	system 32:18 33:21 37:19,20 58:8,8
student 45:21 53:7 55:3	systems 8:3,11 9:2 21:16 22:15 22:24 26:11,13 27:4,10 40:10 83:15
students 47:8 49:3,6 50:9 55:10 57:2 95:14,25	S.D.N.Y 37:19
studied 52:6	
studies 34:6	
study 99:24 101:2	
stuff 29:17 36:13 47:15 65:8,22	
stunned 70:11	
subcommittees 7:15	
submit 8:15,20 36:20	
submitted 72:4	
subsequent 101:18 105:14 106:23	
Subsequently 59:22	
subset 33:14 103:23 104:17	
substances 72:20	
sub-specialist 90:21	
sub-specialty 90:6	
successful 88:23	
sudden 39:6 74:15	
suggest 66:18 98:17	
suggested 8:9 98:11 101:7,10 105:6	
suggesting 28:22	
suggestion 103:5	
suggestions 21:6	
summarized 72:14	
summary 34:16 76:5	
supervising 82:9 89:5	
supervision 23:15	
support 40:4,5 55:17 58:8,23 96:9 103:6	
supported 78:7 82:11	
supporting 101:21	
suppose 54:13	
supposed 49:6,9,11	
sure 7:7 21:7 23:12 25:18 26:25 27:11 31:3,7 32:2,9,19 38:13 44:13 57:16,20 67:6 69:10 72:11 81:20 88:5 90:2 91:9 97:19	
surgeon 101:8	
surgery 87:5,7,9	
surprise 65:9 81:24	
surprised 65:5	
surprisingly 49:3	
surveillance 64:16,20	
survival 6:5	
symptoms 27:23	
Syracuse 5:16	
	T
	table 97:12 98:10
	tackling 61:7
	TAG 21:11,12,14,21 23:3,4,5 45:17
	tagged 6:3
	TAGs 70:25 71:9
	Takats 2:16 4:13,14 10:14,15 12:13,14 14:18,19 17:19,20 19:24,25 93:5,6 94:22,23 108:12
	take 3:4 9:9 13:3,10 16:12 18:15,17 22:7 33:24 37:18,19 37:21 42:12,22 43:19 44:22 50:6,18,25 51:9 52:10 57:7,8 57:13 58:9 60:15 79:17 82:25
	taken 5:18 6:3,7 22:22 29:22 35:6 51:17 109:3
	talk 5:12,14 25:8 27:5,6 73:6 82:23 83:25 89:10 95:7
	talked 5:25 61:20 76:14 106:10
	talking 50:16
	tax 101:24 102:14,16 103:6
	teach 44:23 45:7,8,10,13 46:17 47:14,17 49:17 50:7 57:11,16 58:2 63:6
	teachers 49:18
	teaching 46:6,8 52:11 56:25
	team 22:8 50:7 88:16 89:4
	technical 24:13
	technology 29:13
	tell 66:7 67:4 74:21 80:11 85:4
	telling 82:15
	ten 60:2 65:12,21 93:10 94:25
	tenacious 66:11
	terms 6:15 7:5 26:21 27:16,24 28:13 58:12 86:3 106:11
	terrain 38:24
	terribly 62:18
	territory 86:5
	test 44:5 53:18 57:15 59:8,9 77:11 90:23 93:14
	testing 50:21 88:18

tests 50:18	tight 52:22,23
testy 71:17	Tim 2:7 4:24 22:2,16 25:2,23
thank 5:9 6:23 7:14,20 10:20	time 1:11 8:17 18:9 21:12 24:24
14:23 16:5 17:22 20:5 35:24	26:19 28:21 30:16 35:19,22
36:9 42:9 43:25 54:4 60:8	38:2,4 45:2 55:7 56:21,22
62:2,4 63:18,20 82:3 86:18	57:9,17 58:9,9 62:16,20 63:9
92:20 93:12 95:4 96:25 97:2	66:4 74:18 76:14 77:20 79:21
thanks 25:2 35:13 36:3,3 42:10	80:19 88:10,17 89:3 103:4
89:21 96:5 97:15	104:24 105:6,9,12,16 109:3
theirs 69:25	timeframe 26:21
therapy 79:2	timeline 63:4
They'd 45:21	timeliness 27:18
thing 8:7,18 24:12 28:25 36:18	timely 7:5 27:3 107:4
59:5 62:6 65:3 66:22 71:2	times 30:7 34:25 42:20 43:11
73:8 75:19 78:14 80:3 82:5	Timothy 2:12
things 5:10 33:4 34:19 61:13	tipping 39:5
63:4,25 64:7,17 68:7 72:16	tip-overs 38:18
74:11 78:5 79:25 105:20	tissue 71:13,14,20
think 6:21 13:2,9 22:12,18,20	today 7:17 36:15 52:5 68:6
22:24,25 23:2,6,12,13,20,25	69:12,14
24:11 25:16 27:9 28:3,9 31:21	told 57:5 69:12 72:25,25 76:17
32:20 34:11,15 35:11 42:14	78:14 87:11,11
45:11 50:24 51:21 52:2,4	tomorrow 25:18 68:6 69:14,24
57:22,25 58:11 59:12 62:6,19	71:4
62:25 63:25 64:6 65:4,19,21	tool 70:4,19
67:8 68:10 69:10 71:20 72:13	topic 5:22 6:10 7:8 22:5 26:2
73:5,6 75:25 76:2,10 77:23	27:9 31:21 33:25 34:12 88:4
83:9,10,11,21 84:13 86:6	topics 7:22 39:22 41:23
95:24 101:3 102:10 105:21	topography 38:24
108:19	total 102:5
thinking 5:25 68:16,18	touch 6:16 22:24 23:2 83:6
thinks 23:21 65:20	touches 22:13 72:24
third 15:13 37:19 91:6	track 39:16
thirteen 93:11	tracking 66:22
thirty 34:20 52:9	traction 46:7,8,14,21,22 48:5,6
Thomas 48:5,14	48:20 53:16
thought 21:19 22:14 34:2 52:13	Traffic 37:7 79:22
62:16,24 68:19 90:10 95:10	trained 48:19 95:16
105:15	training 22:23 23:17 24:25
thoughts 6:19 22:17	50:17 51:2 59:23 61:14 62:21
thousand 20:23	67:6,7 72:2 91:20 102:15
threat 69:16	transcription 109:5
threatening 97:8,13	transfer 7:5 28:21,24 30:16
three 8:10 9:2 16:4,11 34:25	32:23
37:6 39:22 59:9,25 74:2,10	transferred 26:19 35:20
90:24 93:9 94:24 108:12,14	transfers 22:7
tie 35:9	transition 27:17 28:14
tied 38:12,13	transmission 29:16
tier 75:7	transmitted 27:2,8
ties 41:10,20	transport 61:25 71:15 88:15

transported 34:21,25 89:13	Uh-huh 16:7 25:15 48:10 67:9
transports 21:21 22:20 24:2	98:6,8
25:12	ultimate 36:24
trauma 5:19,22 25:12 40:25	ultimately 32:10 38:4 51:20
97:18,24 98:17 99:19 101:8	59:14
102:3,9 103:10,11,14 104:7,19	unable 65:25
106:22	unanimously 63:17
travel 66:5	unbelted 78:25,25
treated 15:20 30:9 34:22	understand 47:22
treating 29:5,19 74:16	understanding 47:21 56:3 95:21
treatment 18:3 27:25 97:6	96:2
trees 106:7	understatement 66:20
tremendous 22:8	underway 37:13
trend 38:17,22 39:4,6	under-informed 83:2
trends 64:20	unfamiliar 56:24
triage 5:12 97:18,24 98:17	unfortunately 29:9 62:14
99:20 102:25 103:15 104:11,14	unique 62:18 96:14
104:15 105:3 106:22	unit 88:14 89:2,3
troubled 45:14 102:4	universe 100:12
Troy 1:14 2:4 68:9	unnecessary 29:22
true 109:6	unsafe 79:11
try 53:24 57:17,19,22	unscathed 65:15
trying 36:24 49:17 56:6	untapped 34:10
tube 41:22	unusual 38:11
tune 52:15	unwilling 79:9
turn 7:6 52:15 79:3	update 20:9 31:11 63:8 71:12,12
turned 72:2	81:18 83:12 88:6 89:20 97:5
turning 26:12 43:23 47:7	101:17
turns 64:12 105:12	updated 8:15 37:12 63:9
tweak 57:19	updates 20:7,11 99:7 101:18
tweaked 106:6	102:12
twelve 60:2 93:10 94:25 95:2	updating 72:22
twenty 102:6	upgrade 22:13
twenty-eight 100:21	uploaded 38:6
twenty-five 52:9 55:24	uploading 38:8
twenty-four/seven 20:25	urge 102:25
twenty-six 74:5	use 8:2,25 10:23,25 15:15,19,22
twice 14:24	18:6 21:7 28:12 30:13 41:5,12
two 5:14 14:23 17:23 38:3 40:8	53:16 55:22 57:5,6,17 98:21
42:14 52:22 59:25 60:10 67:14	101:7,9 102:14,23
67:14 70:8 74:15 75:7 79:24	useful 105:15
87:23 88:23 91:3,12 93:9	useless 73:16
94:24 95:2 102:3 108:12,13	users 33:9
type 6:8 46:21,21	utilize 28:19 56:2 70:3
types 5:18 46:7 48:13 59:2	utter 70:24
typewritten 109:5	
typical 24:17	V
typo 18:13,15	value 38:20 65:20
U	values 100:19
	variables 99:4

<p>variety 48:9 103:4 various 34:17 42:2 43:3 59:2 vehicle 79:22 88:10,21,23 89:4 106:11 Vehicles 81:23 84:21 85:4 vein 67:11 vendor 37:4,17,24 vendors 28:11 37:14 55:22 venue 23:12 58:14 venues 61:17 version 8:15 37:25 38:4,8 77:17 versions 28:10 vetting 96:16 view 33:14 47:6 105:18 viewed 54:17,21 visibly 83:16 visits 20:23 vital 27:24 volunteer 75:24 76:8 volunteered 87:24 vote 9:9 13:3,10 16:12 18:17 59:19 91:15 107:10 voted 31:2,5,5,6 91:17 106:14 votes 91:14 voting 108:18 vouchers 66:4,11,14,19 vulnerable 34:3</p> <hr/> <p style="text-align: center;">W</p> <hr/> <p>wait 105:18 waiting 88:16 106:16 want 5:9 6:20 16:3 22:16 26:25 36:8 44:8 49:20 53:24 54:22 58:2 68:15 69:21 72:12 73:8 84:20 89:24 95:7 97:19 106:4 wanted 18:5 77:15,15 88:6,12 89:19 91:10 96:20 97:21 100:19 103:5 106:13 wanting 28:11 wants 29:9 want-to-be 43:13 warm 87:4 wasn't 43:9 61:2 101:11 watch 38:23 water 67:19,25 Waters 4:15 20:2 waveform 41:13,16,19 way 23:21,22 29:13,14 48:2 49:21,21 51:10,22 54:22 55:17 65:23 78:10 79:8,13 82:20</p>	<p>96:7 104:13 ways 42:24 50:23 103:25 wealth 56:8 weaning 53:12 weapon 70:20 website 37:11,11 75:10,18 Wedge 42:11,14,17 43:15,20 44:6 44:11,19,25 54:9,18,24 55:11 59:20 60:5,7,18,20 61:2 63:13 63:18 weed 53:22,22 week 5:11 63:23 75:9,11 87:23 97:23 106:5 weeks 95:15 welcome 35:14 68:9 went 48:4,25 53:6 72:18 80:12 weren't 72:14 wet 30:2 we'll 9:9 16:12 25:14,17 30:19 30:19,20,20 39:12,14 53:17,18 57:18,21 59:18,19 66:25 67:2 68:11 73:3 76:4 88:2 89:24 91:16 107:10 we're 6:16 8:17,22 20:20 21:7 23:10 26:23,23 28:8,8 36:18 37:8 38:10 40:8,21 41:4,6,6 46:10 47:7 49:17 50:2,3,9 51:23,24 53:11 54:13 55:6 56:21 60:16 61:6,6,7 62:20,20 68:15 71:10,25 72:16,24,24 73:5,5,14,17 74:9,14,15,20 75:3,18 76:13,15,19 77:19 79:15 82:21 84:5 90:8 95:18 97:4 105:2,23 106:16 we've 6:18 8:7 36:14 39:7 40:20 42:23 57:9 63:25 70:2 71:24 71:24 72:2 75:3,16 83:13 105:18 108:18 whatsoever 51:14 wheel 62:17 where'd 35:17 white 77:13 97:5 William 2:9 willing 79:17 84:7 win 54:20 winter 68:3 wireless 26:15 wish 74:12,13 78:12 96:21 wishes 60:13 withdrawn 87:23,25</p>
---	---

<p>won 54:16 wonder 71:17 word 56:7 69:3 wording 17:25 words 70:24 work 15:4,19 22:8,10,20 25:21 34:18 38:13 55:10 60:9 66:2 66:23 69:5 70:21 79:12 81:22 82:18,23 83:5 84:5 worked 6:22,22 25:22 36:10 52:16 53:25 71:18 workgroup 104:9 working 25:23 36:14,18 38:10 39:7 40:9,17 52:5 57:20 60:9 70:20 71:5 80:19 82:3,21 84:12,17 85:5 86:9 89:6 90:22 91:5,8 working/representing 80:16 works 48:20 56:4 worry 51:22 worst 51:8 worth 90:10 wouldn't 44:14 52:20 56:2 60:23 85:24 Wow 70:7 write 80:14 written 35:20 37:25 60:14 63:8 79:8 97:24 102:2 wrong 45:12 47:14 56:5,11 Wronski 28:4</p>	<p>105:2,4 young 2:17 64:3 72:12,13 104:4 younger 64:24</p> <hr/> <p style="text-align: center;">Z</p> <hr/> <p>Zeek 2:9 5:6,7 23:7,10 24:22 58:17,19,22 ZOLL 37:20</p> <hr/> <p style="text-align: center;">0</p> <hr/> <p>0606 38:12 0801 26:17 41:12</p> <hr/> <p style="text-align: center;">1</p> <hr/> <p>1 109:6 1st 88:21 1:35 1:11 3:2 108 109:6 1101 80:24 81:24,25 1184s 77:22 1194 81:5 12180 1:14 14th 96:14 15 75:9 18 74:8</p> <hr/> <p style="text-align: center;">2</p> <hr/> <p>2005 8:3,4,14,16 2006 100:6 2009 97:6 2010 7:25 8:19,24 31:11 2011 1:10 90:19 96:5 97:9 108:21 2012 90:18,21 21st 75:9 235 1:13 24th 108:21 26 73:24 28 24:6 29 1:10</p> <hr/> <p style="text-align: center;">3</p> <hr/> <p>3-29-2011 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</p>
---	--

49:1 50:1 51:1 52:1 53:1 54:1
55:1 56:1 57:1 58:1 59:1 60:1
61:1 62:1 63:1 64:1 65:1 66:1
67:1 68:1 69:1 70:1 71:1 72:1
73:1 74:1 75:1 76:1 77:1 78:1
79:1 80:1 81:1 82:1 83:1 84:1
85:1 86:1 87:1 88:1 89:1 90:1
91:1 92:1 93:1 94:1 95:1 96:1
97:1 98:1 99:1 100:1 101:1
102:1 103:1 104:1 105:1 106:1
107:1 108:1 109:1

3:57 1:11 108:22

30 21:21 24:5 87:10

33 73:14

8

80 73:13

9

911 24:17,20 74:4

9501 20:18