NEW YORK STATE
DEPARTMENT OF HEALTH

NEW YORK STATE
EMERGENCY MEDICAL SERVICES COUNCIL
(SEMSCO)

Medical Standards Committee Meeting

DATE: March 29, 2011

TIME: 8:36 a.m. to 11:38 a.m.

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

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1 SEMSCO - 3-29-2011
2 **ATTENDEES:**
3 Yedidyah Langsam, Ph.D.
Jeremy Cushman, M.D.
4 Pamela Murphy, M.D.
John Freese, M.D.
5 Michael Dailey, M.D.
Mark Henry, M.D.
6 Lee Burns
Robert Delagi
7 William E. Huffner, M.D.
Storm Treanor
8 Mark Zeek
Sharon Chiumento, B.S.N., E.M.T.-P.
9 Lewis Marshall, M.D., Chair
Jack Davidoff, M.D.
10 James Deavers
John DeTraglia, M.D.
11 Donald Duvall
Carl Goodman, D.O.
12 Timothy Haydock, M.D.
Andy Johnson
13 Joshua Kugler, M.D.
August Leinhart, M.D.
14 Jeffrey Myers, D.O.
Daniel Olsson, D.O.
15 Joseph Takats, III, M.D.
Gregory E. Young, M.D.
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1 SEMSCO - 3-29-2011
2 (The meeting commenced at 8:36 a.m.)
3 **DR. MARSHALL:** So for this morning what I'd like to
4 do is take the agenda a little bit out of order because we
5 have a lot of action items that we need to address.
6 The -- the biggest one of course is the American
7 Heart Association 2010 guidelines. These went out awhile
8 ago and everyone should have had an opportunity to review
9 them. So, what we'll do is we'll -- we'll look at them in
10 terms of the B.L.S. protocols, which went out -- the state
11 B.L.S. protocols first. And then we'll do -- we'll talk
12 about the A.L.S. protocols, and then curricula --
13 certification curricula for the state curriculum. And then
14 we'll go back to some of the other protocol issues.
15 So, as we go forward, Sharon, or -- or Jack, do you
16 want to talk about the -- the TAG. Each -- each of the
17 protocols were looked at by a group of people. So, do you
18 want to talk about the B.L.S. protocols?
19 **MS. CHIUMENTO:** At the beginning, there's really
20 not too much at the very beginning I believe. Most of the
21 changes were down a little bit further.
22 The very first one, the thing that we were
23 discussing was the aspirin. Rather than having a range, we
24 thought that it might be worthwhile to have everybody at the
25 same, at the three hundred twenty-five milligrams of

1 SEMSCO - 3-29-2011
2 aspirin, but felt that that was something that may want to
3 be discussed a little bit further here. Just to make it
4 consistent across the board, and -- and to make sure that
5 the patient has -- has received enough aspirin.
6 Nope, nobody has any comments on that. We can move
7 down further.
8 Let's see. Okay. Now, we now added the additional
9 doses of -- of nitro. In the past we only had just the
10 first dose at the B.L.S. level, and now we've now added that
11 they can administer up to two additional ones as long as the
12 blood pressure is maintained and all the other steps are
13 in -- are in place, and that there's at least five minutes
14 between the doses.
15 **DR. HUFFNER:** Is it because everyone's not awake
16 yet that we're not going to fight about any of these things
17 that we've fought about for so many times in the past?
18 **MS. CHIUMENTO:** I guess.
19 **DR. HUFFNER:** I actually don't care about them.
20 But --.
21 **DR. MARSHALL:** Well, I think it's because we've
22 fought so much about them in the past, and then we wound up
23 adopting the guidelines. Just --.
24 **DR. HUFFNER:** We don't want four eighty-one
25 milligram tablets of aspirin, or let's make that a hundred

1 SEMSCO - 3-29-2011
2 and ten versus a hundred and twenty?
3 **DR. MARSHALL:** I would prefer three twenty-four.
4 **DR. HUFFNER:** We don't need another three-hour
5 discussion on that.
6 **MS. CHIUMENTO:** Quick, get them all approved.
7 **DR. MARSHALL:** Oh, just one little thing.
8 **MS. CHIUMENTO:** Uh-huh.
9 **DR. MARSHALL:** The microphone's have lights on them
10 so if there are four people that are talking then nobody
11 else can talk into the microphone, so only four people can
12 talk at a time.
13 **MS. CHIUMENTO:** Oh, really?
14 **DR. MARSHALL:** Okay. So, if you want to talk and
15 there are four lit raise your hand or something.
16 (Off-the-record discussion)
17 **MS. CHIUMENTO:** I'm just trying to see where we
18 are, Andy.
19 Let's see, where are we?
20 **DR. MARSHALL:** You want to continue through the
21 changes?
22 **MS. CHIUMENTO:** Yeah. Why don't you wait -- why
23 don't we vote on all of them at the end?
24 Okay. The next thing was down at the ventilation
25 rate. We -- we -- we moved all the information about the

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1 SEMSCO - 3-29-2011
2 advanced airway in place from this section -- or we didn't
3 remove it all, but we -- we changed the -- the wording a
4 bit. So, to ventilate five to six seconds without an
5 advanced airway, and then every six to eight seconds if the
6 C-care is ongoing and advanced airway is in place. So, it
7 was just a change in the wording to make it a little bit
8 clearer here, and remind people that they're not
9 ventilating -- that they are ventilating at the correct rate
10 in the respiratory. This is just the respiratory arrest.
11 This is not the cardiac arrest. But we -- it changes when
12 you get to the cardiac arrest, and so that little bit is --
13 is down further.
14 Let's see.
15 **DR. MARSHALL:** If anybody has any comments on any
16 of these changes, please just raise your hand and we'll
17 acknowledge you.
18 **MS. CHIUMENTO:** Okay. The -- with the pediatrics
19 again we changed the wording a little bit, but with the
20 every three to five seconds without an advanced airway, and
21 every six to eight with an advanced airway in place.
22 However, one of the things is that since we did
23 this as a group conference call, Dr. Van der Jagt, we -- on
24 another issue we were talking about, informed me that --
25 that if their profusion returns -- oh, actually this --

1 SEMSCO - 3-29-2011
2 that's not in this part. This is -- this is just -- yeah,
3 this is just respiratory arrest. Never mind. This is just
4 respiratory arrest and so forth. It's the -- it's the
5 cardiac arrest one where there -- there needs to be a minor
6 change, because if -- if pulse is returned then you go back
7 to the normal ventilation again.
8 We have a spelling error there, I see. Pulseless
9 is misspelled. That needs to be changed.
10 Okay. The A.E.D., putting it on as soon as
11 available without interrupting compressions, now this there
12 was considerable confusion, because it depended on where you
13 were reading within the -- the guidelines in -- in the -- in
14 the circulation.
15 They talked about as soon as an A.E.D. is available
16 starting immediately with compression -- starting with
17 compressions, and -- and then immediately using the A.E.D.
18 as soon as it is available. However, then there was
19 additional discussion that talked about if it's in -- in the
20 EMA setting, that it was up to the medical directors that --
21 that -- to do -- if they decided they still wanted to do the
22 two minutes in an unwitnessed arrest where the patient has
23 been down for five minutes or -- or more.
24 So, this is something we thought needed to be
25 discussed a little bit more in depth here as to which way we

1 SEMSCO - 3-29-2011
2 wanted to go. Whether we wanted to leave it just across the
3 board. You just do -- use the A.E.D. as soon as -- as it's
4 available, or whether we want to make sure it's at least two
5 minutes on the unwitnessed as we had it in the past.
6 As we say in circulations, it's -- it's either/or,
7 it can -- it can be done either way depending on what E.M.S.
8 prefers to do.
9 **MR. JOHNSON:** If I could just make a comment here.
10 We were finding as the TAG was going through all these
11 changes, we've been finding in the Bureau that there's some
12 inconsistencies and some very vague areas between numerous
13 A.H.A. documents. So, what we've done at the Bureau is we
14 decided to wait until the actual student manuals come out to
15 see exactly what instructors are going to be teaching for
16 some of the changes, especially for the state exam. So,
17 this was the one area that we really needed to discuss here,
18 because it was very vague and it wasn't concrete throughout
19 all the documents.
20 **MS. CHIUMENTO:** Anybody have any strong feeling one
21 way or the other. Leave in the two minutes, take it out?
22 **FROM THE FLOOR:** If -- if I remember correctly
23 there wasn't good evidence one way or the other, so I would
24 just say leave it at the two minutes that we have it now.
25 **DR. MARSHALL:** Any other comments?

1 SEMSCO - 3-29-2011
2 **DR. DAILEY:** I think the only thing that's
3 important to recognize is that causing some circulation to
4 occur prior to defibrillation definitely seems to improve
5 outcomes, so I would go right with that. I think the two
6 minutes is at least definitive. I think in practice it's
7 going to be an as available, it's going to be placed and
8 done, and the idea that we continue compressions as
9 frequently as possible, that can be the most important thing
10 for our patients.
11 **DR. MARSHALL:** So, everybody is in agreement, two
12 minutes unwitnessed? Okay.
13 **FROM THE FLOOR:** You want the two minutes --
14 (off-mic).
15 **DR. YOUNG:** I -- the literature also points out
16 it's totally safe to do compressions while you are
17 administering a shock. There's no risk to the E.M.T.s who
18 are doing it, just providing C.P.R.. There's been a couple
19 articles on that. Just to throw that into the mix. The
20 literature supports it.
21 **MS. CHIUMENTO:** Yeah. But it's still not one --
22 one of their recommendations. And we're down --.
23 **MR. JOHNSON:** Is there any additional comments, or
24 are we going to leave it at two minutes?
25 **DR. MARSHALL:** I think -- I think we'll -- anyone

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1 SEMSCO - 3-29-2011
2 else have any more comments about the two minutes?
3 No? Okay. We'll leave it at two minutes.
4 More?
5 **MS. CHIUMENTO:** Okay. All the -- all the wording
6 has now been added about under the age of eight, now that
7 they're allowed to be defibrillated with adult -- adult
8 patches if pediatric patches are not available. So, that
9 wording is now there if you want to just take a quick read
10 of it and see if it's clear to you, but basically that is
11 now acceptable to -- to go all the way down, even -- even
12 down to -- to the young infant.
13 **MR. JOHNSON:** This is actually the way it was in
14 our old protocol --
15 **MS. CHIUMENTO:** Uh-huh.
16 **MR. JOHNSON:** -- we just changed the wording a
17 little bit, because New York did differ from A.H.A. In 2005
18 A.H.A. said down to the age of one --
19 **MS. CHIUMENTO:** Uh-huh.
20 **MR. JOHNSON:** -- and nothing below the age of one,
21 but New York was below the age of one. It was down to
22 birth.
23 **MS. CHIUMENTO:** Right. So, we -- we already had
24 our discussion ahead of the A.H.A. Okay.
25 **DR. OLSSON:** Is this assuming you're using a newer

1 SEMSCO - 3-29-2011
2 biphasic defibrillator versus an older monophasic
3 defibrillator?
4 **MS. CHIUMENTO:** It doesn't really assume one way or
5 the other, and -- and they don't -- they don't make a
6 recommendation one way or the other. I mean they prefer
7 biphasic -- that -- what -- what it says is they have like a
8 hierarchy; they say first best thing to do is a manual
9 defibrillator, particularly on infants. If you don't have a
10 manual defibrillator, then if you use an A.E.D. -- A.E.D.
11 with a pediatric attenuator. If that doesn't -- you don't
12 have that available, then you go ahead and use the adult,
13 and they've shown that you can have energy levels up to
14 something like eight or nine times what you would predict
15 weight-wise, and -- and the heart seems to -- to accept that
16 in the very young. Just their hearts are much healthier and
17 they seem to accept that additional energy.
18 **DR. MARSHALL:** Yes?
19 **DR. YOUNG:** Sharon, a quick question. The
20 statement "the patient 'appears' to no longer be in cardiac
21 arrest," what -- what is -- can you define that a little
22 bit?
23 What they mean -- what they mean by the word
24 "appears."
25 **MS. CHIUMENTO:** I -- I -- I believe that's if, you

1 SEMSCO - 3-29-2011
2 know, they're starting to rouse, they're starting to move
3 around, starting to come to.
4 **MR. JOHNSON:** Yeah. The A.H.A. is really gone
5 towards the appearance of being in full arrest or not full
6 arrest. Either they're dead or they're not dead is
7 basically what they're saying. They're getting away from
8 the pulse checks and spending too much time assessing the
9 patient. That was one of the bigger changes in 2010
10 updates.
11 **MS. CHIUMENTO:** If all of you are not aware,
12 they've gone now to this -- to circulation being the first
13 thing. So, it's compressions and then airway and breathing.
14 So, it's a very marked change in what we've done in the
15 past.
16 And they've actually done some very interesting
17 research that show that you're only delaying your
18 respirations, your ventilations, by about eighteen seconds
19 by starting with compressions first. So, it's not a huge
20 change. But it does mean that we're not doing the look,
21 listen, feel anymore. We're just -- it's just do they
22 appear to be breathing. If they don't -- if they're not
23 looking -- do not look they're breathing, you go right ahead
24 and you get started. You don't -- you don't wait around
25 to -- to try to listen for the breath sounds, and you don't

1 SEMSCO - 3-29-2011
2 try to get pulses. You can try for a pulse, but no more
3 than like ten seconds. If you -- if you haven't found
4 anything, you assume that there's none and go on.
5 Okay. And then the other thing here was -- let's
6 see. There's one section I think we skipped over. When the
7 advanced airway is in place, did we see that in this part?
8 Okay. Yes. This -- this is where we -- you need
9 to add another line after -- after this. Return to the
10 normal ventilation rate if the pulses are restored. And
11 particularly in pediatrics, not so much in the adult, but in
12 pediatrics, the feeling is that if they need those
13 additional ventilations, and so instead of doing the every
14 six to eight seconds if they return to pulses, they should
15 go back to the every -- what is it? Every five -- five
16 seconds I think -- three to five, depending on the age of
17 the child. So, we should probably add that one additional
18 sentence.
19 **DR. MARSHALL:** Any comments on that?
20 That's fine. Okay. We'll add that.
21 **MS. CHIUMENTO:** The newborn, this is actually where
22 many -- a lot of the more unusual changes occurred. I think
23 the more surprising changes occurred in the newborn
24 population and the first one is that suctioning is no longer
25 a part of the care immediately. You know, we always just

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1 SEMSCO - 3-29-2011
2 kind of assumed as the head came out we were suctioning the
3 airway, and now what they discovered is that that actually
4 can cause additional issues for the infant, it can cause
5 bradycardias, can cause other issues, and so they no
6 longer -- they now are saying you suction the airway only if
7 the airway is obstructed, or you are going to need to
8 bag-valve the child, and this way you'll get a clear airway
9 before you start bagging. But other than that, they're not
10 recommending suctioning as a routine thing.
11 The other thing that they're not -- no longer
12 recommending as a routine treatment is the blow-by oxygen
13 that we were doing. If the child didn't respond immediately
14 we were doing blow-by oxygen. They found that actually
15 hyperoxia can cause as many problems as hypoxia, and -- and
16 so what they're recommending now is that if -- if the
17 patient does not -- is not breathing spontaneously after
18 stimulation that you should at that point give them a
19 bag-valve, with room air first, and then if room air is not
20 sufficient after thirty seconds, then move to add oxygen at
21 that point.
22 So, that -- there's -- that's kind of a surprise I
23 think for a lot of us. I don't think we knew that that was
24 anywhere -- that we were going in that direction. But --
25 and that's going to be a big teaching point for a lot B.L.S.

1 SEMSCO - 3-29-2011
2 providers, because they've been taught all these years you
3 suction and you provide oxygen and -- and then you move on
4 from there. And now we're -- we're going in a totally
5 different direction, so it's going to mean a lot of
6 additional education out there.
7 **DR. MARSHALL:** Yes?
8 **DR. OLSSON:** Should the -- should there be a
9 reference, and maybe, Art, you can -- is Art Cooper here?
10 **MS. CHIUMENTO:** No, Art is not here,
11 **DR. OLSSON:** He's not here.
12 **MS. CHIUMENTO:** He won't be here until this
13 afternoon.
14 **DR. OLSSON:** Just with regards to what the expected
15 oxygen saturation is going to be in a neonate? You know
16 there's always that temptation to, you know, bag these kids
17 up to a hundred percent, and --
18 MS. CHIUMENTO: No.
19 **DR. OLSSON:** -- most of the time, you know --
20 **MS. CHIUMENTO:** Actually they recommend --
21 **DR. OLSSON:** High eighties, low nineties or --
22 **MS. CHIUMENTO:** -- ninety-four is what they --
23 they -- they say to aim for.
24 **DR. OLSSON:** -- you know, pretty typical for these
25 kids.

1 SEMSCO - 3-29-2011
2 **MS. CHIUMENTO:** Ninety-four percent.
3 **DR. OLSSON:** I just recommend that that reference
4 be in there.
5 **MS. CHIUMENTO:** Uh-huh. That's a good idea.
6 **MR. JOHNSON:** The B.L.S. level does not have
7 S.P.O.-two capability.
8 **MS. CHIUMENTO:** Or at least not mandatory. I think
9 they have it, but they don't --.
10 **MR. JOHNSON:** It's not in the curriculum, so --.
11 **DR. MYERS:** I -- I think they also comment
12 specifically about color is not a good indicator --
13 **MS. CHIUMENTO:** Right.
14 **DR. MYERS:** -- for resuscitative purposes.
15 **MR. CHIUMENTO:** Right. That's true.
16 **DR. MYERS:** So, include that in there, and the
17 premature infant, so less than thirty-four weeks, they're
18 recommending thirty-four percent oxygen. So, that --
19 that -- that would be an exception to that rule as well.
20 So --.
21 **MS. CHIUMENTO:** But again these are B.L.S.
22 protocols, and that gets a little too complicated for them I
23 think. That's -- that's the problem. We have to kind of
24 keep it simple for them. Hopefully, there'll be A.L.S. if
25 it was a premature infant, hopefully.

1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Any other comments? Okay.
3 **MS. CHIUMENTO:** I don't think there's any change in
4 any of that. We're still doing the same rates for
5 ventilation. We're still doing the same three to one
6 compression-ventilation ratio. I don't think there was
7 anything else in the childbirth.
8 I think that's it. I think those are the primary
9 changes.
10 **DR. MARSHALL:** Okay. Any -- any comments on any of
11 the recommended changes for the -- this is just for the
12 B.L.S. protocol -- the statewide B.L.S. protocol.
13 Anybody? No takers? No.
14 Okay. Sharon, thank you. Jack, thank you.
15 **MS. CHIUMENTO:** All right.
16 **DR. MARSHALL:** Dr. Kauffman, yes, thank you.
17 All right. So, we need a vote.
18 So, all those in favor of approving the statewide
19 B.L.S. protocols with the changes from the American Heart
20 Association as presented say aye.
21 **FROM THE FLOOR:** Aye.
22 **DR. MARSHALL:** Opposed?
23 Abstain?
24 (The motion carried.)
25 **DR. MARSHALL:** Motion carries.

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1 SEMSCO - 3-29-2011
2 Thank you.
3 **FROM THE FLOOR:** Question?
4 **DR. MARSHALL:** Yes.
5 **FROM THE FLOOR:** Andy, when do you expect to roll
6 these out for the classes?
7 **MR. JOHNSON:** Our initial plan was going to be for
8 June, but we're looking probably more towards August now,
9 because we had to wait for the A.H.A. materials to come out.
10 **FROM THE FLOOR:** So, August then?
11 **MR. JOHNSON:** Yeah. Just stay tuned. I'll
12 continuously update you via e-mail on things, but right now
13 it's looking like August probably.
14 **FROM THE FLOOR:** Thank you.
15 **DR. MARSHALL:** Okay. Moving right along. The next
16 item is the regional A.L.S. protocols. 2005 -- or -- yes,
17 2005 when the last set of American Heart Association
18 guidelines came out we spent a lot of time discussing
19 individual recommendations from the American Heart
20 Association and whether or not to include them in
21 prehospital A.L.S. protocols at -- at the regional level.
22 We had long discussions about individual changes
23 and after at least a few meetings that I recall, we finally
24 adopted the American Heart Association guidelines in block
25 to be included in all regional prehospital protocols.

1 SEMSCO - 3-29-2011
2 The regions were then requested to send a final
3 copy to the Department. I think there was -- at that time
4 it was thirty copies in paper, but we've moved forward and
5 electronics has made life a little easier. So, we could
6 possibly do the same thing, only send an electronic copy to
7 the Department, rather than thirty paper copies.
8 There are a lot of changes, and I think each region
9 may need to go through them and include them in their own
10 protocols. And so my recommendation would be that we do
11 exactly what we did in 2005. As we adopt the American Heart
12 Association guidelines, as they pertain to advanced life
13 support in the prehospital setting, each region will then go
14 back and include these changes into their protocols and
15 submit one electronic final copy to the State.
16 It would still have to go through the thirty day
17 comment period and all the other requirements of protocol
18 changes.
19 MS. CHIUMENTO: No.
20 DR. MARSHALL: No?
21 Just submit it. And then we would move on from
22 there.
23 Anybody have any other discussion, or would you
24 like to go through each change? Yes.
25 **DR. HUFFNER:** What about a statewide A.L.S.

1 SEMSCO - 3-29-2011
2 protocol? That might be a novel idea.
3 Dr. Dailey, any thoughts on that?
4 **MR. JOHNSON:** Well, the REMO protocols are coming
5 up for a vote in awhile if you just want to make those
6 statewide.
7 **DR. HUFFNER:** I -- I wouldn't have a problem with
8 that.
9 **DR. DAILEY:** No thoughts on that, Dr. Huffner.
10 **DR. MARSHALL:** Just -- I would just remind you that
11 we should make sure we say A.C.L.S., advanced cardiac life
12 support, not just advanced life support for the changes.
13 So, is there any other discussion, and other than
14 statewide advanced life support guidelines?
15 Yes.
16 **FROM THE FLOOR:** This past December, the six
17 regions around central New York all met and we've had two
18 other computer meetings and we've taken the A.H.A.
19 guidelines and put them into prehospital format that all six
20 of the Central New York regions have at least agreed in
21 concept to follow. We're working on the rest of the
22 protocols. But we'll be happy to share those if anyone has
23 an interest.
24 **DR. MARSHALL:** I think that would be great. Thank
25 you very much. Maybe we could just send them out to all the

1 SEMSCO - 3-29-2011
2 regions so they can have them to look at.
3 Any other comments?
4 Seeing none -- what? Okay, yes.
5 **MR. DELAGI:** Just speaking from an administrative
6 perspective, I'd like to support the idea of approving these
7 in block, but it always brings up the invariable question as
8 to when can we expect the practical skills exam and the
9 written test, to be reflective of the new changes. If we
10 implement these locally almost immediately, how long before
11 we see changes on state exams. That always gives angst to
12 the students.
13 **MR. JOHNSON:** As of right now with the time line of
14 A.H.A., we're probably looking at October for A.L.S. exams
15 to be updated. Again, it's very dependent on the A.H.A.
16 materials coming out. They've had several delays, so that's
17 caused delays on our end as well.
18 **MR. DELAGI:** Thank you.
19 **DR. MARSHALL:** Any other comments, suggestions,
20 concerns?
21 None?
22 Okay. All those in favor of adopting the American
23 Heart Association 2010 guidelines as they pertain to
24 A.E.C.L.S. treatment in a prehospital setting, say aye.
25 **FROM THE FLOOR:** Aye.

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1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Any opposed?
3 Abstain?
4 (The motion carried.)
5 **DR. MARSHALL:** Thank you very much.
6 All right. Moving on to the next topic. In
7 addition to B.L.S. and A.C.L.S. protocols, in terms of the
8 statewide curriculum, we also have to adopt the guidelines
9 as they pertain to the statewide curriculum for P.A.D.,
10 B.L.S. and -- and A.L.S.
11 We can -- does anybody have any specific comments
12 about any of those? We can do them in block as, you know,
13 one vote or we can discuss each one separately.
14 In block?
15 Andrew, any comments?
16 **MR. JOHNSON:** This would be approving it for C.F.R.
17 through paramedic as well as the PAD curriculums as well, to
18 change them, bring them up to date.
19 **DR. MARSHALL:** Comments, concerns?
20 Nothing?
21 Wow, I'm shocked, speechless.
22 Okay. All those in favor of adopting the American
23 Heart Association guidelines in terms of a state curriculum
24 for -- what did you say? P.A.D., B.L.S., A.L.S. and C.F.R.,
25 say aye.

1 SEMSCO - 3-29-2011
2 **FROM THE FLOOR:** Aye.
3 **DR. MARSHALL:** Any opposed?
4 Abstain?
5 (The motion carried.)
6 **DR. MARSHALL:** The motion carries. Thank you.
7 Well, we're done. No, I'm kidding.
8 It would be nice.
9 Okay. Moving right along. Fentanyl changes.
10 Andrew, what are those? You want -- Lee.
11 **MS. BURNS:** Actually, I'm kind of concerned you're
12 all taking fentanyl, and you could.
13 We've been diligently working with our partners at
14 the Bureau of Narcotics Enforcement, and we are just kind of
15 cleaning up the last and final hopefully draft of the -- of
16 the policy statement, and I just want to run through some of
17 the changes. I -- I credit Mike Dailey with sacrificing
18 himself before the pharmacists, and interestingly this --
19 this version that I'm hiding from you all because I do that,
20 but this version has been approved by John Morley and the
21 Commissioner is reviewing it. So, that's hugely encouraging
22 I think.
23 But basically the big difference in this policy
24 from the existing policy with regard to fentanyl, is that
25 fentanyl would be permitted to be used on standing orders

1 SEMSCO - 3-29-2011
2 for specific conditions. So, I just -- just the requirement
3 procedures are the same. The real issue is that there's two
4 big differences: One is the ability for the medical
5 director of the service to agree to -- or to work with a
6 service to -- and the protocol to use fentanyl on standing
7 orders, and the second is to expand the substock.
8 Currently by our -- our requirement, the Health
9 Department's, any substock cannot exceed two hundred
10 micrograms, and what we're -- what this policy will allow
11 the service medical director to do is -- is basically show
12 the Health Department that there's a necessity for their
13 service to increase the substock for their -- their
14 ambulances.
15 So, if you're in a rural area with long transports,
16 you know, the doc sends us a letter and says, you know, two
17 hundred micrograms doesn't cut it. But if you're in an
18 urban area with many hospital options, two hundred
19 micrograms may be what -- you know, what works for you.
20 With the idea honestly to -- for the physician, the medical
21 director to really use their judgment and keep as little
22 fentanyl as operationally necessary in the substocks.
23 I -- I honestly believe that if you go wild and
24 say, "we need a thousand micrograms in each of our
25 substocks," you really have -- I hope you are really good at

1 SEMSCO - 3-29-2011
2 writing -- at -- at creative writing, because the
3 pharmacists and Dr. Morley sweat at the very thought.
4 So -- what basically fentanyl may be administered
5 on standing orders for adult patients in -- as delineated in
6 the approved regional A.L.S. protocols, and other
7 administrations will require direct medical control. So,
8 right now they're not willing -- "they" is pretty much the
9 Commissioner and Dr. Morley, want pediatric patients not to
10 receive fentanyl on standing orders, but under the
11 consultation of a -- of a physician.
12 So, other than that, it's the same kind of pain in
13 your butt that the old one was. So, they're -- what we're
14 working with though in a -- and we've turned to Mike and
15 Jeremy to a great extent, is to develop a more meaningful
16 quarterly reporting instrument. And I think we're going to
17 get better data as more of the services come online with an
18 electronic patient record. So, we're just trying to
19 establish what meaningful information would be useful in --
20 in a quarterly report.
21 Because, quite frankly, our quarterly report is a
22 test for our services's ability to read pretty much, and
23 if -- and if you are a fairly intuitive human being, you
24 will know that if you, you know, start with this much, you
25 gave this much, you should have this much at the end, it's

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1 SEMSCO - 3-29-2011
2 not a real brain strain.
3 So, we're -- we're working on really providing the
4 quarterly reporting instrument to be more useful to you
5 at -- at the regional level, and at the service medical
6 director level.
7 With that said, and we'll talk about this a little
8 bit at SEMAC as well, B.N.E. and Gary in my office are doing
9 an audit of the required submissions and -- and we have
10 found that compliance with semi-annual and quarterly
11 reporting is -- is, oh, let's see a good word, dismal. And
12 what we have said to services, and we've been pretty
13 dogmatic about copying the medical directors, is that, "if
14 you do not tell us what is going on, we will tell you, you
15 cannot have controlled substances" and Article 33 allows us
16 to do that.
17 So, it's -- it's -- it's pretty draconian, but it
18 is a wake-up call, particularly for the services that think,
19 "oh, controlled substances, what a really good idea." So,
20 we're pretty serious about this.
21 Did I miss anything?
22 Questions?
23 **DR. DAILEY:** No, Lee, I would -- I would actually
24 just like to really thank the bureau of E.M.S. and the
25 Bureau of Narcotics Enforcement for working together with us

1 SEMSCO - 3-29-2011
2 on this. I think these are really important changes for
3 patient care. I think they'll make a big difference for our
4 patients.
5 And I appreciate the stepwise fashion in moving
6 next to standing orders for adults and withholding standing
7 orders for children at this point. I can understand the
8 conservative nature of both the Commissioner and -- and Dr.
9 Morley. I certainly appreciate that. And I look forward to
10 bringing back good data on -- on safety within New York
11 State with some of the improved reporting.
12 The one question I had is among the things that we
13 discussed was the utility of quarterly reporting for
14 fentanyl, and whether or not we'd be better off just with a
15 much more in-depth, standardized report every six months on
16 the use of all controlled substances, so we could better
17 audit services and assure that all these drugs are being
18 used safely?
19 **MS. BURNS:** And I -- I have absolutely no issue
20 with that. That would be great, because really when we
21 start looking at the quarterly reports, the quarterly
22 reports are marginally more useful than the semi-annual one,
23 the semi-annual one is entirely bureaucratic I must say.
24 But my -- my real issue in -- that's something I would like
25 to continue working towards, but if we wait to do that, it

1 SEMSCO - 3-29-2011
2 will hold this up, which would therefore hold your protocols
3 up, and I don't want to do that.
4 So -- yeah, actually, I -- I'm not sure -- I think
5 we may have negotiated that out. What we had -- in one of
6 the earlier conversations with B.N.E., we had -- they really
7 don't want to see anything more than six hundred micrograms
8 in a substock, and -- but I -- I'm not sure it made it into
9 the final version.
10 I'll -- I hate to ask them.
11 You shake your head like you would never want to do
12 that much?
13 **DR. CUSHMAN:** No, I -- I think that's very
14 reasonable. You know my concern for two hundred micrograms
15 was even in some urban environments our patients are big
16 enough that if they're getting a milligram per kilo, or a
17 microgram per kilo, that that's so -- yeah, and six
18 hundred -- I -- I thank you.
19 **MR. JOHNSON:** There was some discussion, and we're
20 going to check with the final version, because this just
21 came out yesterday, that if a medical director for a
22 particular agency wanted an additional amount to have on
23 hand, because of a rural setting, they just had to petition
24 the Department with good cause, and we would look at that.
25 **DR. DAILEY:** I'd just like to go on record one more

1 SEMSCO - 3-29-2011
2 time in saying that while I do encourage the liberalization
3 of the use of pain management, I also remain extremely
4 conservative on the approach I'd like the Department to take
5 to people that are not compliant with the guidelines for
6 either the administration or the handling of those drugs.
7 And I would encourage the Department to very loudly
8 remove controlled substances from people that are not
9 compliant with the -- with the paperwork requirements.
10 While, you know, quarterly reporting becomes not
11 quite draconian, quarterly reporting is a nuisance, but it's
12 a requirement.
13 Whether it's a reasonable requirement or not is
14 something we should discuss in this forum and then in
15 meetings with the Bureau of Narcotics Enforcement and then
16 change it. But if a service is indeed using fentanyl and
17 the requirement from the Bureau is quarterly reporting, they
18 should be making those quarterly reports, and if not, they
19 should no longer have fentanyl.
20 **MS. BURNS:** Yeah. I mean we -- to change the -- we
21 did quarterly reporting with fentanyl and ketamine also
22 mostly, quite honestly, because of the concern of that -- of
23 the nature of the drug and people who are -- who have a
24 great experience in regulating the medical community in use
25 of those kinds of drugs, really were -- were very -- they

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1 SEMSCO - 3-29-2011
2 don't understand E.M.S., and they -- and they're getting
3 there, but they -- they really thought that the -- a real
4 conservative approach in terms of regulatory oversight made
5 sense. If we could come up with -- and it's something we've
6 been -- you know, a couple of the pharmacists are working on
7 it with us, to come up with a meaningful report that would
8 tell us, but mostly you, what your services are doing.
9 The -- actually, the regulatory requirement is for
10 a semi-annual report. It is the -- it's the Department
11 policy for the quarterly report. You know the ketamine
12 thing was mostly to -- you know, poke at you I guess. No.
13 **DR. DAILEY:** And I appreciate it, thank you.
14 **MS. BURNS:** Just kidding.
15 But -- but again, if we come up with something
16 that -- that is meaningful in terms of overall -- oversight
17 and to a great extent frankly surveillance, that would be
18 fine to switch it to a semi-annual, as long as, as medical
19 directors, you're involved in it.
20 And honestly present company excluded, your
21 colleagues tend not to be so involved.
22 **DR. DAVIDOFF:** I just want to comment. I agree
23 with everything that's been done and Dr. Dailey, everyone
24 that's involved, I think adding a larger substock of
25 fentanyl is very much in favor of good patient care.

1 SEMSCO - 3-29-2011
2 I would also like to agree that if there are
3 services that are not providing the appropriate
4 documentation, that the D.O.H. does come down hard on them.
5 This is very important that we continue to have these
6 medications available, but they are not diverted, and that
7 they are safely preserved and utilized for the appropriate
8 use, so I would back the D.O.H. coming down hard on services
9 that are not appropriately doing the documentation.
10 However, I'd also like to throw out that there's
11 another side of E.M.S. and that's the specialty care
12 transports, long-distance transports, paramedical transports
13 where larger quantities of these drugs are very important
14 for quality patient care, and there's nothing worse than
15 trying to struggle in the middle of a transport to figure
16 out what have we got left in our drug box to take care of
17 this patient when they've been doing very well on something
18 say like fentanyl, but now we're out of fentanyl because we
19 can't carry enough.
20 So, I'd like to remind the D.O.H., and maybe if you
21 could remind B.N.E., that there are some services that will
22 need larger quantities to provide appropriate care.
23 **MR. JOHNSON:** That was actually the -- one of
24 several discussions with B.N.E., when they did not want us
25 to carry above a certain level, we did discuss the fact that

1 SEMSCO - 3-29-2011
2 rural transports and -- and long-distance transfers with
3 medications.
4 **MS. BURNS:** The other piece to this, and -- and
5 jump in Dr. DeTraglia, and -- and Dan Brodell (phonetic
6 spelling), wherever you are and particularly in the midstate
7 region the hospitals, there -- there's a -- I would say an
8 E.M.S.-ignorant section of regulation that says that the
9 hospitals cannot provide more controlled substances -- I
10 think it's very -- what happens is an ambulance service
11 that's doing a great-distance transfer can't get a certain
12 amount of medication from the hospital.
13 **DR. DETRAGLIA:** The hospitals can't administer or
14 supply medications for transport unless it's greater than
15 three hours. And the hospitals in our area -- the state
16 said, "well, just keep doing what you're doing," and -- or
17 what you have been doing, and the hospital's pharmacy people
18 dug in and said, "no, we're not going to do this."
19 So, we've decided we're going to do it from stock,
20 and that means we'll have to probably increase the stock,
21 since most of our transports are less than three hours, but
22 we do have a fair number of transports to higher level of
23 care.
24 **MS. BURNS:** Again, in -- in conversations with
25 B.N.E. people and this -- you know, they knew about this

1 SEMSCO - 3-29-2011
2 regulation. I didn't know. But what -- what -- you know
3 if -- what -- what they're asking is that as the
4 physician/medical director of a service that -- that does
5 this, you know, that that's written in the plan. That you
6 know they -- they recognize the fact that this is a need.
7 So, that's it not, you know, the East Elbow Rescue
8 Squad who, you know, transports to a couple of hospitals
9 within forty-five minutes, it's not in their plan, they're
10 not doing interfacility or long-distance transports as a
11 general rule, but it is in the plan of services that do,
12 whether it's air medical services or ground critical care,
13 whatever.
14 **MR. ZEEK:** Yeah. Lee, we're one of the services
15 that has that problem. We've taken a number of patients to
16 Pittsburgh or Boston or Philadelphia, and they're long runs,
17 and we have, within our plan, a provision to take extra
18 meds.
19 **DR. DETRAGLIA:** Pittsburgh is fine, but Syracuse
20 doesn't work, it's too close. Three hours or more you can
21 get all the meds you need from the transporting hospital.
22 More than three hour -- I'm sorry -- less than three hours,
23 nobody wants to talk to you.
24 **MR. ZEEK:** Actually, in -- in Part 80.75, you're --
25 in a transport over three hours, you're only allowed one

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1 SEMSCO - 3-29-2011
2 extra dose.
3 **DR. DAVIDOFF:** Utilizing your medicine could help
4 you out immensely.
5 **MR. ZEEK:** I'm sorry.
6 **DR. DAVIDOFF:** Utilizing your medicine could help
7 you out immensely. We'll take those long transports away
8 from you.
9 **DR. DETRAGLIA:** They can't -- they can't get it
10 either. We did look at that.
11 **DR. MARSHALL:** Any other comments or questions on
12 the fentanyl?
13 I don't think there's anything we have to --
14 there's no action for us at this time.
15 Okay. We have a couple protocols. We have three
16 protocol changes that are coming forward. The first one
17 we'll do is REMS. You guys --.
18 **DR. GOODMAN:** If I may, can we strike the word
19 "REMS" from our agenda, since we are the REMAC, and the REMS
20 is a defunct organization that does not need to be brought
21 up here unless it's about the Department giving our records
22 back.
23 **DR. MARSHALL:** No problem. So noted. We'll take
24 care of that.
25 **DR. GOODMAN:** I also do want to point out that we

1 SEMSCO - 3-29-2011
2 did incorporate the 2010 guideline changes in our protocols.
3 This is a major change for -- the format is a major change
4 for us in where we had transitioned from the algorithmic
5 format that we had previously to the format that is used by
6 the Albany Region, several other regions around the state.
7 Hence the large packet of protocols.
8 The interfacility transfer protocols were also
9 updated, which had been a long time coming, and so I just
10 wanted to apologize for the volume up front to those who had
11 to review it.
12 **DR. MARSHALL:** Okay. Who reviewed those?
13 Dailey -- Dr. Dailey? No.
14 **DR. GOODMAN:** That means they're accepted, right,
15 so somebody reviewed them?
16 **DR. MARSHALL:** I'm sorry.
17 **DR. GOODMAN:** That means they're accepted, right,
18 because nobody reviewed it?
19 **DR. MARSHALL:** Yes. Correct. Absolutely correct.
20 **DR. GOODMAN:** Thank you.
21 **MS. CHIUMENTO:** I have a few comments. As usual.
22 Most of the comments are -- are related to things
23 that are allowed at C.C. level that are not in the
24 curriculum, and while I'm not against doing that, it does
25 mean that you're going to have to do that extra education.

1 SEMSCO - 3-29-2011
2 So, I actually will provide you a list here of each page and
3 which -- which things are not in the -- in the C.C.
4 curriculum.
5 **DR. GOODMAN:** Thank you.
6 **MS. CHIUMENTO:** The only one that I am a little bit
7 more concerned about is the CPAP at the I level, which is on
8 page ten and page fourteen. That is not -- it's not only
9 not in the C.C. curriculum, it's not in the I curriculum,
10 and I'm not sure whether -- and I don't believe anybody in
11 the -- else in the state has CPAP at the I level, so that
12 might be something you may want to look at.
13 **DR. GOODMAN:** If I could --.
14 **MR. JOHNSON:** I'm sorry. That has not been
15 approved at the intermediate level. This body and SEMAC did
16 approve it for C.C. level, with the use of the paramedic
17 curriculum at the C.C. level. So, that would require a vote
18 to approve that at the intermediate level.
19 **DR. GOODMAN:** And -- and that's what we would be
20 seeking. In -- in terms of the use of CPAP, the -- the
21 complications, the intermediate level has the
22 neodecompression skill within their skill set to be able to
23 handle that complication. This would require use of the
24 paramedic curriculum, or equivalent training, for those
25 services that wanted to proceed with that, as well as

1 SEMSCO - 3-29-2011
2 involvement from their medical director.
3 **DR. MARSHALL:** Okay. Any -- any questions?
4 So, this is for using CPAP at the I level, using
5 the paramedic training curriculum.
6 **DR. GOODMAN:** Correct.
7 **DR. MARSHALL:** To educate them and the medical
8 director has to be involved, or what -- what's the medical
9 director -- you mentioned that the last --?
10 **DR. GOODMAN:** Well, the medical director should
11 always be involved in --
12 **DR. MARSHALL:** Well, yeah.
13 **DR. GOODMAN:** -- these type of issues. But no, to
14 ensure that the -- the correct training is undertaken, just
15 like we did when we rolled out CPAP at the paramedic and
16 C.C. levels in our region.
17 **MR. JOHNSON:** And the way it is now they have to
18 use the paramedic curriculum. If they want to differ from
19 that, that has to go through an approval process.
20 **DR. MARSHALL:** Okay. Any questions?
21 Yes.
22 **DR. OLSSON:** Is this to be considered as a new
23 skill for a new level for a new set of training?
24 As painfully as it is for me to say this, does this
25 constitute a pilot study, a -- I -- I know. Trust me, I

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1 SEMSCO - 3-29-2011
2 feel the pain, but we're introducing a new skill, and I
3 think CPAP is great. I don't know if the intermediates have
4 the background, the knowledge, the training as a whole to do
5 it. I just don't know. And so, I throw it out there. If
6 that can be done, great, but I'm just wondering if we're
7 venturing into deeper waters that we haven't been into.
8 **MR. JOHNSON:** Just as a side note, there is a
9 region that is going to be doing a demonstration project for
10 CPAP at the B.L.S. level. They were going to try and have
11 something ready for this meeting, but they weren't ready
12 yet. So, maybe by the next meeting they're going to have
13 demonstration project for E.M.T.s to use CPAP.
14 To answer your question, yes, this is bringing a
15 new skill to a lower level. So, technically it does require
16 a demonstration project.
17 **DR. OLSSON:** And as we've seen with hypothermia, we
18 can't have one region doing a protocol or a practice when
19 one other region is doing a demonstration project. So -- I
20 don't know.
21 **DR. MARSHALL:** Any comments?
22 **MR. JOHNSON:** Just out of curiosity, how many
23 intermediate-only agencies do you have?
24 **DR. OLSSON:** In our region?
25 **MR. JOHNSON:** Approximately.

1 SEMSCO - 3-29-2011
2 **DR. OLSSON:** I'm going to guess probably about
3 thirty or so.
4 **MR. JOHNSON:** Thirty that are just intermediate
5 level?
6 **DR. OLSSON:** Somewhere around there. We have -- we
7 have about two hundred agencies within our eight-county
8 region, so we're talking -- that's probably in there when we
9 count the A.L.S. for F.R. as well as the transporting
10 agencies. Or the paramedic agencies who may have -- who are
11 volunteer may have an intermediate who responds rather than
12 a paramedic. That in -- that increases the numbers.
13 I -- I do also want to point out that there --
14 there are probably many people in this room that use CPAP at
15 night with very little training, and very few -- very low
16 complication rate, which is kind of where things were going
17 when we thought of bringing this forward.
18 **DR. MARSHALL:** Yeah. I -- I think as -- as you
19 mentioned it -- it might be painful, however, I think under
20 the -- the -- the way the rules and regulations are
21 currently that this would have to be a demonstration
22 project. I don't think we could approve CPAP at the I level
23 without -- without that.
24 Not -- not that -- I don't disagree with you that,
25 you know, it's not a difficult technology to use, but the

1 SEMSCO - 3-29-2011
2 way our system is set up I think we'd have to do that.
3 **DR. OLSSON:** Perhaps -- perhaps we can pull that
4 from this set of protocols, and I will discuss with Andy
5 afterwards the region that is looking at doing it from a
6 B.L.S. standpoint, and perhaps we can pool our resources.
7 Because one of the issues with a lot of the demonstration
8 projects is -- as has been discussed here in the past is
9 there are very few numbers to really, with good certainty,
10 say whether something is beneficial or not. We can usually
11 say that no harm is being done, but in terms of showing
12 benefit outside of a small town to the south of us, we
13 really don't have the numbers to say that.
14 **DR. MARSHALL:** I don't necessarily think that
15 you -- you want to show that it's beneficial for the
16 patient, as much as you just want to show that the skill can
17 be done at that level. I think the benefit of the
18 technology has already been shown from a clinical
19 standpoint, so I think that it's just moving the skill to --
20 to a different level of provider.
21 **DR. OLSSON:** So, I -- I will pull that out of --
22 out of our protocols, and then we'll proceed with partnering
23 for the demonstration.
24 **DR. DAILEY:** Should part of our decision on this
25 involve the potential harm to the patient and whether or not

1 SEMSCO - 3-29-2011
2 it's reasonable?
3 You know, brief education on CPAP demonstration
4 that, indeed, this mask can be applied to patients, that
5 these participants can then be tested out to see which
6 patients are appropriate for CPAP. I don't -- I don't see
7 that this would really be something that we should withhold
8 from the intermediates if Jeff believes that he's got a
9 training program that can work well with them.
10 And the fact, frankly, that our demonstration
11 project process becomes difficult to work within, and while
12 I appreciate the idea that Jeff would merge in with the
13 B.L.S. program, a B.L.S. program and an intermediate program
14 are two very different things. The intermediate providers
15 have got a different skill set, because they've got an
16 additional set of training on top of what they're already
17 doing.
18 I would say go ahead with it.
19 **DR. HENRY:** I think a lot of it's what we ask the
20 outcome from the demonstration.
21 For me it would be can the intermediates identify
22 who needs it, and then the question is how long does it take
23 to do the training? That's what's of use to everybody.
24 Say, "well, it took an -- took an hour, it took
25 three hours,' whatever, and then it could -- it could get

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1 SEMSCO - 3-29-2011
2 added to the curriculum. Sort of like the Albany glucose.
3 You know, that wasn't an outcome thing. It was, can you --
4 can you do it? And -- and how much time did it add?
5 **MR. JOHNSON:** And just so you know, I've already
6 spoken to the D.O.H. I.R.B. This would not require I.R.B.
7 approval at the intermediate or E.M.T. level. So, we've
8 already gone through those hurdles.
9 I think it would basically be two demonstration
10 projects. One for intermediate, one for E.M.T., but the
11 data could be merged, and I think it can be done
12 successfully and fairly quickly. Especially if he's got
13 thirty-plus agencies at the intermediate level in Western
14 New York, I think you might see the numbers. It would be
15 better than some areas.
16 **DR. OLSSON:** All right. Then I will withdraw --
17 withdraw my withdrawal. I'll leave it in there.
18 **MR. JOHNSON:** Unfortunately we can't leave it in
19 there, because it's not within the scope of practice at the
20 intermediate level.
21 **DR. OLSSON:** Okay.
22 **DR. MARSHALL:** The withdrawal of the withdrawal is
23 withdrawn. Okay.
24 **DR. DETRAGLIA:** Excuse me.
25 **DR. MARSHALL:** Yes.

1 SEMSCO - 3-29-2011
2 **DR. DETRAGLIA:** What am I missing? This is not
3 brain surgery. People do this -- thousands of people,
4 millions of people, do this every night at home. Why can't
5 we train an E.M.T. in ten minutes to put a mask on someone?
6 And why do we need a demonstration project? None of this
7 makes sense.
8 **MR. JOHNSON:** Well, it makes clear sense if you
9 look at the curriculum. That is not within the scope of
10 practice to use CPAP.
11 **DR. DETRAGLIA:** Well, let's make it the scope of
12 practice.
13 **MR. JOHNSON:** Then you're going to have to look at
14 the entire curriculum. We have a new curriculum coming out
15 soon, and even at the master level CPAP is not in B.L.S. for
16 intermediate. So, you can't make a decision off the cuff
17 here on changing curriculum.
18 **DR. DETRAGLIA:** It's not off the cuff. It's pretty
19 standard, routine care at home for patients.
20 **MR. JOHNSON:** Who are not in crisis, and are not in
21 an emergency situation. You're talking about moving a
22 level, a skill, from a higher level to a lower level. The
23 regulation is very clear on that. If you don't like that,
24 change the regulations.
25 **DR. DETRAGLIA:** Okay. Let's do it.

1 SEMSCO - 3-29-2011
2 **DR. DAVIDOFF:** Yeah. We are able to accept new
3 material from the American Heart Association even though we
4 haven't done any demonstration project within New York State
5 regarding that material.
6 **MR. JOHNSON:** To the best of my knowledge, there
7 was nothing outside the scope of practice with paramedical
8 critical care that are in the new A.C.L.S. guidelines for
9 2010.
10 If somebody has reviewed that, and thinks that
11 there are, then that needs to be brought up, but the TAG
12 that reviewed everything found nothing outside the scope of
13 practice.
14 **DR. HENRY:** Well, not to be contrary, but if people
15 are going to use L.M.A.s instead of intubate, that's
16 different for some. People don't use that. It's just a
17 different airway device. You could think of CPAP as a
18 different oxygen delivery device. You know, it's -- I mean
19 we're -- we're drawing straws here.
20 I mean it used to be that education dictated
21 practice, period, because if it wasn't -- the curriculum
22 dictated the protocols. Then we tried to go, and say, look,
23 we should do protocols by patient needs, and then we should
24 educate people to treat people, and I think that's kind of
25 what's happening here, and -- and what we have is sort of

1 SEMSCO - 3-29-2011
2 the lag in terms of what goes first?
3 And we've devised this way, right or wrong, in the
4 past with demonstration projects when we moved a skill to a
5 different level to just demonstrate it could be done safely
6 and effectively and -- and give us the feedback, and then we
7 could use it, if we wanted to, as a group.
8 So, I mean it doesn't have to be awkward. I mean
9 Jeff can say, "we'd like to do a demonstration project," and
10 we could say, "what are the outcomes we'd like?" "We'd like
11 to know do your people know who needs it," for example, and
12 say, "tell us how long it took to train; ten minutes, an
13 hour?"
14 He can come back in a month with the results of
15 something like that if he wants to.
16 But it's just putting it in that format. So,
17 whether it's awkward how we've done this, and that's sort of
18 how I recall the history. It used to be twenty years ago
19 if -- the education dictated all of E.M.S. The -- the --
20 the curricula, that was it. That changed every ten years or
21 so, fifteen years.
22 **DR. MARSHALL:** Yes.
23 **DR. GOODMAN:** I've heard this discussion regarding
24 demonstration projects for now -- a year and a half now, or
25 pilots, whatever you want to call it. I think we have to

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1 SEMSCO - 3-29-2011
2 look beyond our borders and find whether we actually need a
3 demonstration project. You know, literature, as
4 demonstrating safety, efficacy, in this level of skill, can
5 we do it elsewhere? If you can do it in Minnesota or
6 Wisconsin, why would we need a pilot --
7 **FROM THE FLOOR:** Well, it's different in New York
8 State.
9 **DR. GOODMAN:** -- in New York State?
10 So, perhaps when considering this, we need to look
11 outside of our borders and decide whether a demonstration
12 project is justified. We're trying to measure what somebody
13 else has already done and they've done quite successfully,
14 and we're set atop of that. Why do we need to do the CPAP
15 here?
16 **MS. BURNS:** Perhaps you wouldn't have to
17 necessarily repeat the -- the project itself, but the
18 regulation is very clear that the -- the Commissioner has
19 the last say, and -- and considering the fact that at this
20 point - and I -- I shudder at the thought of kind of going
21 forward - but at this point in our evolution, the scope of
22 practice in New York State is defined by a series of
23 different things, and the curriculum is a -- is part of
24 that. And if this particular skill -- and it's not just the
25 skill, I mean putting on a CPAP mask is just little more

1 SEMSCO - 3-29-2011
2 than a pain in the neck, but -- but the assessment piece of
3 it is what concerns me a little bit.
4 You know, personally as a paramedic, a CPAP is a
5 prehospital gift, and I see -- I see this as all good. But
6 what I would say is if you're -- if you're, you know, going
7 to present data from outside of New York State, that would
8 be fine as long as this body accepts that, and it's
9 something that the Commissioner will entertain, because the
10 regulation gives the Commissioner the last word.
11 **DR. MARSHALL:** Just one quick announcement. The
12 Q.A. Committee will be meeting at ten, not nine-thirty, so
13 if you're going to the Q.A. Committee, you still have a few
14 minutes.
15 Dr. Kugler and then Dr. Huffman.
16 **DR. KUGLER:** Thank you, Dr. Marshall.
17 So, I -- I -- I think everyone's echoing each other
18 in here, in that we're -- we're talking about this is real,
19 this is good, and we should do it. My -- I'm going to try
20 to take a little step to the side. I want to echo Dr. Henry
21 just a second and say that we're not really changing
22 medicine here, we're changing a technology. And every time
23 we change a technology, which by the way is going to happen
24 every day while we're here, are we going to need to go back
25 and re-devise the curriculum, and go through a demonstration

1 SEMSCO - 3-29-2011
2 project?
3 I think we need to figure out a way that when
4 technology shifts for the better, that we need to be able to
5 adopt it more readily than we're doing today.
6 **MS. BURNS:** That's a very interesting thing,
7 because the -- the national movement is to define a scope of
8 practice, as opposed to what we've done sort of -- we've
9 done this backwards. You know, we've trained people to do
10 all this stuff, and then there's new technologies, and if --
11 as we -- we need -- actually the scope of practice in
12 concept is very good, but in reality for us, it -- it
13 requires a statutory and regulatory change, which we've
14 actually begun talking about. So, I think if as we head --
15 as we look at the new national education standards and
16 rolling them out, we're moving more towards a scope of
17 practice as opposed to each little prescribed technique or
18 procedure.
19 **DR. MARSHALL:** Dr. Huffner.
20 **DR. HUFFNER:** I agree with Lee. Couldn't we
21 perhaps simply redefine advanced airway management to now
22 include CPAP, and this will all be moot.
23 **DR. MARSHALL:** That would be my thought also. Is
24 that --?
25 **DR. HUFFNER:** I'll make that motion that advanced

1 SEMSCO - 3-29-2011
2 airway management for all levels include the option of the
3 use of CPAP in the prehospital setting.
4 And again it's all about local training and what
5 individual service medical directors need to do, and avoid,
6 I think, a demonstration project.
7 **DR. DAILEY:** I'll second that motion.
8 **DR. MARSHALL:** Discussion.
9 **MS. CHIUMENTO:** That will still not take care of
10 the B.L.S. That would just be for the I.L.S.; correct, yes.
11 **MR. JOHNSON:** No, that -- to go back to
12 regulation --
13 **MS. CHIUMENTO:** It's -- B.L.S. would not do
14 advanced airways.
15 **MR. JOHNSON:** -- to go back to the regulation
16 again, you're still moving a skill down from an upper level
17 to a lower level.
18 **DR. HUFFNER:** I -- I would disagree. We're
19 defining what advanced airway management is. So, it's --
20 it's not a new skill. It's just further -- better defining
21 what advanced airway management is.
22 **MS. BURNS:** But it's not in any other current
23 curricula.
24 **MR. JOHNSON:** You have to remember, the
25 intermediate has little to no more lung assessment or

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medical assessment capabilities than an E.M.T.

DR. HUFFNER: But -- but they also can put in an endotracheal tube with appropriate education.

MR. JOHNSON: That's already in their curriculum, yes.

DR. HUFFNER: And -- and now, we're redefining what advanced airway management is, and it includes now not only endotracheal tubes, but also CPAP, and that would be something that would be up to the individual service's medical director to make sure that they're appropriately trained to, just like they are trained to intubate.

DR. MARSHALL: Any other comments?

FROM THE FLOOR: Who had moved that?

DR. HUFFNER: I moved it.

DR. HENRY: Who has -- who has intermediates here?

So, what -- what are people's thoughts who work with intermediates?

DR. DAILEY: I have four intermediate agencies. All of them actually have paramedic backup. So, in terms of pertinence of this protocol, not particularly in my region. They would certainly assist with the application and administration of the device, but wouldn't be doing it independently for the most part.

DR. MARSHALL: Yes, Jack.

DR. DAVIDOFF: I've got several intermediate agencies as well, also with paramedic backup, but we're -- we're the region that's going to bring forth hopefully at the next meeting the thoughts of doing a project for E.M.T.s. It's currently done in Pennsylvania and several other states, and -- and certainly it's not a complex procedure, it does not require a lot of advanced training, and I think a lot of our patients are probably suffering because they don't have availability of CPAP to them early on. So, I'm in favor really of all levels being able to provide CPAP to their patients when required.

DR. MARSHALL: Okay. All right. Dr. Kugler, did you have anything else?

DR. KUGLER: We have a very large intermediate delivery service in Nassau County, probably the largest.

DR. HENRY: Do you think they'd be able to do this?

DR. KUGLER: Absolutely.

DR. MYERS: Just one other comment if I -- if I --

DR. MARSHALL: Yes.

DR. MYERS: -- particularly for Upstate New York and the North Country, that's -- that's with prolonged evacuation times and not necessarily a predominance in intermediates, but certainly a large quantity of our agencies have an intermediate, it's a big issue for us.

When you're talking forty-five minutes, an hour, to get to the hospital.

DR. MARSHALL: Okay. Any other comments?

Okay. It seems like there is pretty much -- yes.

MS. BURNS: Again, while I do not dispute the -- the logic to any of this, Andy's putting the reg up, and the reg is -- is -- whether you -- it's antiquated or not, and no one would dispute that, the reg is very, very clear.

And so, what I would ask you to do is give us the option to bring this forward within the Department. I have no issue talking with John Morley and our lawyers, and -- and in the meanwhile what I would say is if you have information, data, curricula, from other states or you have access to that, get it to Andy, and we'll take a look at that. But at the -- really at present, it's a new skill not currently practiced by intermediates and E.M.T.s, and the logic to the demonstration project is -- is to prove its appropriateness in moving the skill.

I don't think you'll have an issue with doing that, but -- but the -- the Commissioner does have to weigh in on this, and or his designee who is Dr. Morley.

DR. HUFFNER: I -- I would have to disagree with you again, Lee, because we are not moving a new skill. Advanced airway management is already in the curriculum for

an intermediate, it's -- it's optional, and what we are doing is further defining what that includes. Nothing more, nothing less. And I think that's the emphasis that we have to stress here. That it is further define -- better defining what advanced airway management includes.

MS. BURNS: So, you're specifically talking about intermediates.

Jeff, are you?

DR. MYERS: Yes.

MS. BURNS: Okay.

DR. MYERS: Yes.

DR. HUFFNER: I would like to be able to expand it to B.L.S., but at this time I don't think that would be consistent with the regulation, because advanced airway management is not part of a B.L.S. curriculum, but it is part of the intermediate curriculum.

And, yes, it's a little wriggle around it, but the bottom line is we have done many, many of -- of these -- I don't even want to call it -- tests or demonstration projects, and our ability to really recoup -- recoup sound outcomes has been a little bit less than stellar, and I won't go back to my favorite example, of course, which is B.L.S. administration of --.

FROM THE FLOOR: Hold yourself back.

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1 SEMSCO - 3-29-2011
2 **DR. HUFFNER:** Okay. I'll hold myself back.
3 **DR. CUSHMAN:** I -- I realize this is semantics, but
4 the semantic is important. And that this reg says "may,"
5 not "must." That "the State E.M.S. Council may authorize
6 after review," not that it must.
7 **MS. BURNS:** Subject to approval of the
8 Commissioner.
9 **DR. CUSHMAN:** Yes. But --.
10 **FROM THE FLOOR:** The demonstration project is
11 subject to approval.
12 **DR. DAILEY:** Everything we do is subject to the
13 approval of the Commissioner.
14 **DR. CUSHMAN:** Sure. But it -- it is may, and so
15 we, the SEMAC, may choose to report, we may not.
16 **MR. JOHNSON:** It gives you the authority to do so.
17 **DR. CUSHMAN:** Call the question, but not that we
18 must.
19 **DR. HUFFNER:** I made a motion a hundred years ago.
20 **DR. MARSHALL:** You made a motion to call the
21 question.
22 **DR. HUFFNER:** Yeah.
23 **DR. MARSHALL:** All those in favor of calling the
24 question raise your hand.
25 Opposed.

1 SEMSCO - 3-29-2011
2 (The motion carried.)
3 **DR. MARSHALL:** The question's been called. The
4 motion on the floor is to consider that CPAP is an
5 advanced -- and correct me if I'm wrong; CPAP is an advanced
6 airway device and should be included in the regional
7 definition of advanced airway devices, and may be used at
8 appropriate levels, which at the current time includes
9 intermediates, C.C.s and paramedics.
10 Any -- with appropriate training. With advanced
11 training -- no appropriate training.
12 **FROM THE FLOOR:** Appropriate training's fine.
13 **FROM THE FLOOR:** Will the curriculum be updated?
14 **DR. MARSHALL:** Yes. The curriculum will have to be
15 updated.
16 Any further discussion?
17 **FROM THE FLOOR:** The question --.
18 **DR. MARSHALL:** The question has already been
19 called. You're right. Thank you.
20 All those in favor raise your hand.
21 Opposed?
22 One.
23 Abstain?
24 (The motion carried.)
25 **DR. MARSHALL:** Motion carries. We recommend that

1 SEMSCO - 3-29-2011
2 CPAP is an advanced airway device.
3 Okay. With that motion, now back to -- I'm just
4 going to call it REMAC --
5 **DR. GOODMAN:** Thank you.
6 **DR. MARSHALL:** -- as opposed to the other title.
7 The REMAC protocols, any other comments on the REMAC
8 protocols?
9 Sharon.
10 **MS. CHIUMENTO:** Okay. On page twenty-four there's
11 a reference to giving diltiazem and other calcium channel
12 blockers, but there's no reference to not being using -- not
13 using them for preexcited rhythms such as atrial
14 fibrillation or flutter with W.P.W., and so I just recommend
15 that you add a little comment after that, not to be used
16 in -- if the patient has a history of one of those problems.
17 That's a class three recommendation by A.H.A.
18 Additionally, even amiodarone drip and I don't know
19 that I'd seen the name amiodarone drip in any other
20 protocols, and I just wondered usually you would just use a
21 three hundred and then a one fifty bolus, but I've not seen
22 an amiodarone drip in the prehospital setting. Didn't know
23 whether that was --.
24 **DR. MYERS:** Can you please say again, which page
25 you're on?

1 SEMSCO - 3-29-2011
2 **MS. CHIUMENTO:** Page twenty-four.
3 It's a one milligram per minute I.V. you've got
4 written.
5 **DR. MYERS:** Amiodarone.
6 **MS. CHIUMENTO:** It's down under the irregular
7 polymorphic or unresponsive to adenosine.
8 **DR. MYERS:** I think I might have a different page
9 number than -- page count than yours.
10 **MS. CHIUMENTO:** Oh. Okay, the --.
11 **DR. MYERS:** What's the protocol again, please? I'm
12 sorry.
13 **MS. CHIUMENTO:** The protocol name is tachycardia
14 with a pulse. Let me see which section, that's --.
15 **MR. JOHNSON:** You got that page --?
16 **DR. MYERS:** Yes. Yeah, I am on the right page now.
17 **MS. CHIUMENTO:** You've got the --.
18 **DR. MYERS:** Yeah. I think that -- that it was more
19 following the -- the A.H.A. guidelines, I know that it
20 hasn't been -- we don't usually see that in the prehospital
21 setting.
22 **MS. CHIUMENTO:** Right.
23 **DR. MYERS:** I'll -- I'll defer to your
24 recommendations.
25 **MS. CHIUMENTO:** Again, normally you use just a

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1 SEMSCO - 3-29-2011
2 three hundred and then a one fifty, and then that's it.
3 Call it quits at that, but --.
4 **DR. MYERS:** Well, this -- this is -- this is with a
5 pulse, though.
6 **MS. CHIUMENTO:** I know. But I mean saying that
7 in -- in the past, though, if you look at the other regions,
8 it was -- it's always been just -- you know, and maybe if --
9 perhaps if you wanted to do that as a physician option, move
10 it down to a physician option to do a drip.
11 **DR. MARSHALL:** Is that a --
12 **DR. MYERS:** I --
13 **DR. MARSHALL:** -- is that a --
14 **DR. MYERS:** -- I --.
15 **DR. MARSHALL:** -- dose that's a -- in the --
16 acceptable in the guidelines, amiodarone one fifty as --
17 **MS. CHIUMENTO:** In the guidelines --
18 **DR. MARSHALL:** -- opposed to three hundred?
19 **MS. CHIUMENTO:** -- it only does the three hundred
20 and the one fifty.
21 **DR. MARSHALL:** Three hundred --
22 **MS. CHIUMENTO:** It does not move --
23 **DR. MARSHALL:** -- down to one fifty.
24 **MS. CHIUMENTO:** -- past that.
25 **DR. DAILEY:** I'm -- I'm really sorry, but since --

1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Yeah.
3 **DR. DAILEY:** -- I haven't seen what the protocol
4 is, and I currently can't see what the protocol is, if this
5 is going to be a session of bargaining across the room with
6 none of the rest of us participating, perhaps we can
7 deteriorate this meeting into another function. But right
8 now this just is not particularly valuable to anybody in
9 this room.
10 Can we come up with some change really quickly that
11 will make this more inclusive of the rest of the body?
12 **DR. MARSHALL:** Any other recommendations?
13 I mean in -- in the past we've always had these
14 discussions that involved dosages of medications, and we've
15 gone back and forth, and they haven't been very helpful.
16 **DR. DAILEY:** But we've also been able to see it,
17 Dr. Marshall.
18 **DR. MARSHALL:** True. Can we show that?
19 **DR. DAILEY:** We don't have copies of these
20 protocols. We can't currently see the protocol.
21 **MS. CHIUMENTO:** Andy, do you have it there? I
22 have -- I have it here if you --.
23 (Off-the-record discussion)
24 **MS. CHIUMENTO:** There you go. There it is.
25 **DR. MYERS:** There you go. Tachycardia with a

1 SEMSCO - 3-29-2011
2 pulse.
3 **MS. CHIUMENTO:** So, for -- with a pulse usually we
4 just do the one fifty, and then I've seen -- I've seen a few
5 places where they've gone for a second bolus of one fifty,
6 but I've not seen a drip. And that was my -- I mean --.
7 **DR. MYERS:** Is the concern with the paramedic being
8 able to set up a drip, or what -- what is the concern?
9 **MS. CHIUMENTO:** I just want to know, with -- I
10 mean, this is -- well, this was intended to be this way,
11 or -- since it's different from anything else we've seen so
12 far, I just wanted to make sure that it was something that
13 was acceptable, so I -- I don't have a big --.
14 **FROM THE FLOOR:** (Off-mic) dosage for -- dose of
15 (off-mic) on diltiazem fifteen to twenty milligrams per
16 kilogram? Is -- is twenty milligrams or point (off-mic)
17 milligrams per (off-mic).
18 **DR. MARSHALL:** Okay. I would -- I would like to
19 recommend that you just review the dosages on the
20 medications and make sure that they're appropriate rather
21 than -- and that they meet the current A.C.L.S. 2010
22 guidelines rather than --.
23 **FROM THE FLOOR:** (Off-mic)?
24 **DR. MARSHALL:** Yeah. Like twenty, twenty-five.
25 Okay? Rather than continue going --.

1 SEMSCO - 3-29-2011
2 **DR. DAILEY:** As long as we've got that protocol up,
3 verapamil, anybody still using it?
4 FROM THE FLOOR: No.
5 **DR. DAILEY:** I don't.
6 **DR. MARSHALL:** REMAC, are you still using
7 verapamil?
8 **DR. DAILEY:** REMAC, I mean if they want to --
9 verapamil?
10 **DR. MYERS:** Well, now that we have therapeutic
11 hypothermia and we have coolers, we're back to using
12 diltiazem for the most part, because we can keep the
13 medication cool now, which was one of the issues.
14 **DR. MARSHALL:** You have services that are using
15 verapamil?
16 **DR. MYERS:** We did, yeah.
17 **DR. MARSHALL:** Okay.
18 **DR. MYERS:** Currently I'm not sure. I'd have to
19 poll the two hundred agencies in our area.
20 **DR. CUSHMAN:** I'm sorry, Jeff --
21 **DR. MARSHALL:** Any other --?
22 **DR. CUSHMAN:** -- just -- just going back to some of
23 the things that we've talked about in this group in the
24 past, is that if -- if we have one effective medication, why
25 are we adding more, therefore increasing the risk of

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1 SEMSCO - 3-29-2011
2 medication errors and so forth. So, if -- I would encourage
3 us, if we have one calcium channel blocker that we have one
4 calcium channel blocker. If we have, you know, one
5 benzodiazapine, stick with one benzodiazapine. The -- the
6 addition of many medications starts increasing --
7 **DR. MARSHALL:** Right. Yeah.
8 **DR. CUSHMAN:** -- our risk of errors and patient
9 harm.
10 **DR. MARSHALL:** Yeah. I -- I would just ask that
11 the regions go back and just make sure that their protocols
12 are in agreement with the guidelines.
13 If they want to chose one versus two, I mean
14 medications, I think the regions can do that. I mean we
15 have midazolam, lorazepam, so we have multiple meds for
16 different things. So, if they want to have two for one
17 particular issue, I think that that should be up to the
18 region.
19 Certainly they have to consider patient safety and
20 medication safety when they make their and do their
21 deliberations, but I think until we have a - dare I say - a
22 statewide guideline - I am going to say it - A.L.S.
23 guideline, protocol recommendation, that -- that the regions
24 can -- can make those decisions.
25 **DR. DAILEY:** Dr. Marshall.

1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Yes.
3 **DR. DAILEY:** Dr. Myers did point out one thing that
4 was extremely important, which was the shortage of diltiazem
5 that we suffer. One of the things that we discussed at this
6 body, and we all echoed, and I think we were as loud
7 speaking of one voice as we have ever been, is to make sure
8 that there weren't any large doses of diltiazem that were
9 being substituted for the lifolize (phonetic spelling) or
10 whatever the term is, version of diltiazem that was no
11 longer available.
12 I have seen report from across the state that there
13 are agencies that were carrying hundred milligram or three
14 hundred milligram doses, and then breaking that down to
15 individual patient applications, which is something that was
16 prohibited by this body. And I just ask the Bureau to make
17 sure to disseminate the information that it come from that,
18 to make sure that multidose vials or multidose bags were not
19 being used of any of these medications.
20 **DR. MARSHALL:** Yeah, thank you.
21 **DR. MYERS:** I agree with the patient safety
22 concerns Dr. Cushman had brought -- brought forward.
23 However, the reason that we have multiple different
24 medications within the protocols is because of the rolling
25 shortages that do occur, and rather than having to go

1 SEMSCO - 3-29-2011
2 through the administrative process of coming back to our
3 REMAC body at the schedule to approve quote/unquote a
4 substitute medication, we felt it would be more important to
5 put in that you do need to carry one benzodiazepine but the
6 other two are acceptable if you need to substitute.
7 **DR. MARSHALL:** Yeah. I think a lot of the regions
8 are -- are doing the same thing because of the absence or
9 missing drugs.
10 Any other recommendations for REMAC protocols as
11 presented?
12 **MS. CHIUMENTO:** I believe the remaining ones are
13 just some little wording additions that I would suggest and
14 I -- and I'll give all -- all those to you.
15 **DR. MARSHALL:** Okay. Any other comments on REMAC's
16 protocols, including the CPAP since that was approved as an
17 advanced airway?
18 Seeing none, all those in favor say aye.
19 **FROM THE FLOOR:** Aye.
20 **DR. MARSHALL:** Opposed?
21 Abstain?
22 (The motion carried.)
23 **DR. MARSHALL:** Motion carries.
24 Yes.
25 **MS. CHIUMENTO:** Additional thing, and that is --

1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Okay.
3 **MS. CHIUMENTO:** -- page sixty-eight and the
4 neonatal.
5 **DR. MARSHALL:** Sixty-eight on your sixty-eight?
6 **MS. CHIUMENTO:** Yeah. Sixty-eight on -- on the
7 copy I got, it was page sixty-eight, but basically it's the
8 neonatal resuscitation. You still have naloxone in there.
9 Naloxone has been taken out, that is not recommended at all
10 for -- for E.T. You had it E.T., and it's not recommended
11 by intubation, ever, in a newborn. And epi is only if no
12 other method is available. So, that's --
13 **DR. MARSHALL:** All right.
14 **MS. CHIUMENTO:** -- you know, one -- one thing I'd
15 ask you to remove is the E.T. epi -- E.T. naloxone.
16 **DR. MARSHALL:** Under which one? Under neonatal
17 resuscitation?
18 **MS. CHIUMENTO:** That's right. Uh-huh.
19 **DR. MARSHALL:** Which is page sixty-three. Okay.
20 **DR. MYERS:** It -- it is under medical control
21 option for the rare case where it may be acceptable. For
22 example, if the administering -- if the paramedic caring
23 were to administer -- if the paramedic caring for the
24 patient -- for some reason you need to give analgesia prior
25 to delivery, then that's the one indication for naloxone

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1 SEMSCO - 3-29-2011
2 in -- in the -- I mean, I -- it's under med control option
3 at this point in time. I'm happy to strike that if the body
4 so -- so would prefer that.
5 **MS. CHIUMENTO:** I believe though what the issue is
6 that if you get into -- by E.T. method, it's recognized by
7 the body as a withdrawal even though it's only been in the
8 short-term, so that's the one thing -- I believe it was a
9 class three in the last 2005. In the current one it
10 doesn't -- it just says administration of naloxone is not
11 recommended for resuscitation efforts in the delivery room
12 for newborns with respiratory depression, just ventilate is
13 what they recommend.
14 **DR. MARSHALL:** So that will be removed? i.
15 Do you agree?
16 Okay. All right. That's already been approved,
17 voted on.
18 I'd like to take a five-minute break. Stretch your
19 legs and then come back and we have New York City and REMO.
20 Thanks.
21 (A recess was taken at 9:58 a.m.)
22 (The meeting resumed at 10:17 a.m.)
23 **DR. MARSHALL:** Okay. I'd like to get started so we
24 can finish up.
25 Anybody need to sign the sign-in sheet so we can

1 SEMSCO - 3-29-2011
2 know that you are here. We'll pass it around again.
3 During the break there was a recommendation that we
4 change REMAC back to something else - he's not listening -
5 REMAC is too generic.
6 Okay. Dr. Freese, you want to talk about New York
7 City protocol changes?
8 **DR. FREESE:** The -- I believe the changes came to
9 the Committee after the thirty-day review period. From what
10 I saw there were three questions, three minor questions as
11 it was phrased, about the protocols and I remember one of
12 those questions which was "why did we pick the age of
13 thirty-three for" --.
14 **DR. OLSSON:** That sounds like one of mine.
15 **DR. FREESE:** Okay. "For the administration of
16 epinephrine," and that was a very conservative baby step
17 because of the concern for adverse cardiac events --
18 **DR. OLSSON:** Okay.
19 **DR. FREESE:** -- given the A.J.'s latest position
20 that thirty-three is the new age of concern. That's where
21 they came from.
22 **DR. OLSSON:** So, I did review them. I didn't find
23 anything substantive. There was a couple minor things, and
24 one was the -- the age of thirty-three. I hadn't -- that
25 was in your protocols prior and I had either forgotten,

1 SEMSCO - 3-29-2011
2 didn't remember, or otherwise was confused.
3 There was a couple other -- in the C.O.P.D. five o
4 seven five o eight, you changed the wording from "may" to
5 "should" regarding mixing albuterol and ipratropium. My
6 only worry would be that there's going to be a provider that
7 says, "well, if I should it doesn't mean I have to," so
8 they're not going to. And again that's taking it to an
9 extreme, which I don't know if it's worth making it "you
10 will mix them," or "they will be mixed," or something. If
11 you want to leave it "should," that's fine.
12 But C.F.R.s, the burn protocol, three twenty-eight,
13 less than ten percent you treat it wet to dry, more than ten
14 percent it's only dry. C.F.R.s in our area, as well as
15 event residents, have trouble deciding whether it's eight,
16 nine, ten, twelve percent, and I'm wondering if that's not
17 going to create an issue, and if it's going to be simpler to
18 just treat burns one way. But again depending on what your
19 experience is, that's up to you.
20 And then the last one has to do with nitroglycerin.
21 In the myocardial ischemia you're changing it from three
22 doses to four, and in acute pulmonary edema you've
23 eliminated the maximum doses of nitroglycerin altogether.
24 Again, I wonder if that's not going to create some
25 confusion. Do we give -- is this a case when we give four?

1 SEMSCO - 3-29-2011
2 Is it a case where we give as much as we want? I don't know
3 if it wouldn't be easier just to make it four for everybody,
4 or unlimited for everybody. So, those were the only
5 observations I had.
6 **DR. FREESE:** I think the "may" versus "should"
7 versus "will," we initially had made it change to "should,"
8 again baby steps. There was a lot of discussion initially
9 about are we dictating that the medical directors must make
10 their crews mix, or can they leave it optional. In the
11 spirit of keeping the meeting short, I think that was a
12 we'll leave it as "should" just to avoid any further
13 discussion on the issue.
14 The issue of the burns was just to be consistent
15 with our B.L.S. protocol.
16 And the nitroglycerin, the thought there was that
17 if given that the current standard for managing prehospital
18 acute pulmonary edema is nitrates, nitrates, nitrates, and
19 CPAP if you have it, as opposed to the presumed acute
20 coronary syndrome where it's nitrates, nitrates, a little
21 more nitrates, and at that point we probably need to add
22 something else, the -- the reason for the difference in the
23 protocols was so that the A.P.E. patient could be managed
24 without requiring telemetry contact, and for those patients
25 who were having acute coronary syndromes at that point where

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1 SEMSCO - 3-29-2011
2 we had taped four nitros if you haven't yet arrived at the
3 hospital, maybe we should be making a phone call to either
4 add on some morphine, or stimulate you to move quickly to
5 the hospital.
6 **MS. CHIUMENTO:** In reference to the burn issue, I
7 just went back to the C.F.R. curriculum, the C.F.R.
8 curriculum only says dry dressings, period, doesn't -- it
9 doesn't give a percentage.
10 **DR. OLSSON:** The C.F.R. does not do rule of nines.
11 **DR. HUFFNER:** Would it -- would it be helpful if
12 the Medical Standards Committee said to New York City that
13 you shall -- you shall, and then you avoid the political
14 ramifications of that decision?
15 **DR. FREESE:** Fantastic.
16 **DR. HUFFNER:** I would suggest that we require that
17 it says not "should," not "may," not "might," not "perhaps,"
18 but "shall" in the interest of patient safety.
19 **DR. MARSHALL:** "Shall mix."
20 **DR. HUFFNER:** "Shall mix."
21 **DR. MARSHALL:** "Shall mix." We will -- New York
22 City will accept that.
23 And for the burns, C.F.R. protocols, we'll just
24 stick with the dry dressing?
25 **DR. FREESE:** I -- I think for the burn, we can

1 SEMSCO - 3-29-2011
2 stick with the dry dressing. We're at a point right now
3 where for the fire department, who has the majority of the
4 C.F.R.s in the city, because of the New York City burn plan,
5 because of the timing where we're just about to kind of hit
6 a new cycle of training, it was an opportunity to really try
7 to push them toward rule of nines, not to be contradictory
8 to the State, but simply to add on to what the State already
9 does. But if the Committee feels we should leave it dry
10 dressings, that -- that's fine.
11 **DR. MARSHALL:** Any other comments? Is that good?
12 **MS. CHIUMENTO:** I think the only other thing was
13 the one that you actually commented on yourself, the
14 ipratropium at the B.L.S. level.
15 **DR. MARSHALL:** Okay. Yeah.
16 **DR. GOODMAN:** A comment on the dry versus wet --
17 patient hypothermic, hypothermia is a result of a large burn
18 and they're underlying disease state. Whether they
19 mistakenly confuse somebody who has nine percent or eleven
20 percent, I don't see clinically that that's going to make a
21 difference. You know, when you have somebody who has got a
22 burn, the first thing that anybody does at home is they run
23 it under cold water, put an ice pack on it. You know, I --
24 I -- I think to use cold is perfectly fine, and will provide
25 some benefit to the patient without any harm. You know, an

1 SEMSCO - 3-29-2011
2 argument of whether it's nine percent or ten percent I think
3 is really irrelevant here, it's a small burn. Use something
4 that's going to make the patient feel better.
5 **DR. MARSHALL:** Thank you.
6 **MS. CHIUMENTO:** As I said, just the only thing was
7 the ipratropium at the B.L.S. level since currently we only
8 have them put the albuterol.
9 **FROM THE FLOOR:** Dr. Freese, do you know anything
10 about ipratropium at the B.L.S. --?
11 **DR. FREESE:** No, we -- this was actually I think
12 inserted with the thought that given the previous work done
13 in this state on nebulized albuterol, given the safety
14 profile particularly for Atrovent as compared to albuterol,
15 that adding it to the B.L.S. level was simply for those
16 admittedly small percentage of patients for whom it may make
17 a difference, a safe option to again expand the B.L.S. scope
18 of practice in the -- in the interest of patient care.
19 If the Committee likes we can pull that back, make
20 that a demonstration project. I think measuring the
21 implications of Atrovent would be really tough. I'm not
22 sure what we would be looking to measure given that we're
23 not doing peek flows, but we can certainly consider that if
24 the Committee would like.
25 **DR. MARSHALL:** Okay. I would recommend pulling

1 SEMSCO - 3-29-2011
2 that back for the time being, and if you want to do a
3 demonstration project that would be fine.
4 Any other comments?
5 So, for New York City I have changing "may" or
6 "should" to "shall mix," C.F.R. will be dry dressing only
7 for burns for C.F.R., and we'll pull ipratropium from the
8 B.L.S. level.
9 Anything else?
10 No?
11 Okay. All those in favor of approving New York
12 City protocols as amended raise your hand.
13 Opposed?
14 Abstain?
15 (The motion carried.)
16 **DR. MARSHALL:** Thanks.
17 REMO, where's Dr. Dailey?
18 You want to -- you want to do it?
19 **DR. DAILEY:** Sure.
20 (Off-the-record discussion)
21 **DR. MARSHALL:** Reviewers, any comments?
22 **DR. DAVIDOFF:** I just had a few. First of all,
23 overall they -- they were really tremendous protocols. I
24 was kind of sorry that we had just submitted ours because I
25 think I might have just copied yours. It really was a good

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1 SEMSCO - 3-29-2011
2 job.
3 However, a couple concerns. On the therapeutic
4 hypothermia you talk about using repeated dosing with
5 Etomidate, and I wonder with the reports of adrenal
6 suppression whether or not that's really a good idea or not.
7 **DR. DAILEY:** Jack, that's a great question. And
8 actually the number of reviews we got around the state of
9 the protocols was pretty huge. That was one that came up a
10 couple times, both in the therapeutic hypothermia question
11 as well as in the M.F.I. and in the sedation protocols, and
12 based on all of that, that was one of the discussion items I
13 wanted to bring back to Dr. Leinhart and Dr. Broderick. So,
14 I think it's a good idea for us to remove that.
15 **DR. DAVIDOFF:** Substitute a different agent --
16 **DR. DAILEY:** Exactly.
17 **DR. DAVIDOFF:** -- for repeated sedation.
18 **DR. DAILEY:** Exactly.
19 **DR. DAVIDOFF:** Yeah. I think you jumped the gun a
20 little bit on the fentanyl as a standing order. Obviously,
21 we're heading in that direction, but we're not there yet. I
22 think it was written that fentanyl would be given as a
23 standing order.
24 **DR. DAILEY:** Actually based on Lee's discussion, I
25 think we're there.

1 SEMSCO - 3-29-2011
2 What we do need to do is modify these protocols.
3 These protocols were written under the expectation we'd be
4 able to do that for pediatrics as well.
5 **DR. DAVIDOFF:** Okay.
6 **DR. DAILEY:** We'll make that adjustment to put it
7 below the stop line for pediatric patients, which we will
8 define not as under the age of eight, but meeting the A.H.A.
9 criteria for pediatric patients.
10 **DR. DAVIDOFF:** Okay. And -- and -- and the only
11 other comment I had is you made a comment about no MAST
12 trousers in peds. I couldn't find it, are you using MAST in
13 adults still?
14 **DR. DAILEY:** There are some agencies, particularly
15 in the rural environment that still have MAST pads.
16 **DR. DAVIDOFF:** Really.
17 **DR. DAILEY:** And we only hope that when they
18 inflate them, the latex doesn't -- or the -- the -- the
19 rubber doesn't start breaking right in front of them.
20 Which -- which it meant.
21 **DR. DAVIDOFF:** And there's probably no replacements
22 available.
23 All right. Otherwise, like I said I thought they
24 were really good. They were laid out well, and we liked
25 them. Thank you.

1 SEMSCO - 3-29-2011
2 **DR. DAILEY:** Thanks, Jack.
3 **DR. MARSHALL:** Oh, one -- what was being removed?
4 You mentioned that you were going to remove something? The
5 Etomidate?
6 **DR. DAILEY:** Repeat doses of the Etomidate and move
7 fentanyl below the stop plan for pain management in
8 pediatrics, at the request of the Bureau -- or in compliance
9 with the Bureau.
10 **DR. MARSHALL:** Okay, thanks.
11 Yes, Dr. Huffner?
12 **DR. HUFFNER:** Just -- just for the record, Mike, do
13 these protocols incorporate all the changes -- new A.H.A.
14 A.C.L.S. changes?
15 **DR. DAILEY:** Yes-ish.
16 **DR. HUFFNER:** That's not what I wanted to hear, you
17 know that.
18 **DR. DAILEY:** One of the ones that is below the stop
19 line, would be adenosine for Y complex tachycardia which
20 reviewing the A.H.A. materials there is absolutely no
21 evidence to suggest that's a good idea. That one just sort
22 of appeared. Therefore we leave it below the stop line, so
23 a physician could be part of the decisionmaking in that
24 intervention.
25 **DR. HUFFNER:** But other than that one, it's all

1 SEMSCO - 3-29-2011
2 incorporated?
3 **DR. DAILEY:** To the best of my understanding,
4 although I'm sure Sharon will correct me.
5 **DR. HUFFNER:** Thank you.
6 **MS. CHIUMENTO:** Okay.
7 **DR. MARSHALL:** But each region will send a final
8 copy to the Department. Okay.
9 **MS. CHIUMENTO:** Okay.
10 **DR. DAILEY:** Now --
11 **DR. MARSHALL:** Okay.
12 **DR. DAILEY:** -- I -- I will send a final copy of
13 the collaborative protocols, because it's a single document
14 that will be followed by the three regions, and is open to
15 any other region who would be interested in participating,
16 although I would prefer if they let me know before we do the
17 cover art.
18 **DR. MARSHALL:** Any other comments?
19 **MS. CHIUMENTO:** Yes, I have a few things.
20 **DR. MARSHALL:** Yeah. Uh-huh.
21 **MS. CHIUMENTO:** On the antiarrhythmics after return
22 to spontaneous circulation, those are no longer included in
23 the A.H.A. guidelines, and as a matter of fact it says that
24 there is no evidence to support or refute continued or
25 prophylactic administration of -- of antiarrhythmics.

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1 SEMSCO - 3-29-2011
2 What we've done in the past with that, is just made
3 it a physician option, with the -- with the regions who have
4 wanted that in the past. So, I just suggest that you move
5 it down as a physician option.
6 **DR. DAILEY:** That's certainly very reasonable. I
7 can do that.
8 However, after a shockable rhythm we already have
9 the administration of an antiarrhythmic, so it really
10 doesn't change -- change our call.
11 **MS. CHIUMENTO:** Right, no, it's during the -- it's
12 when they still have the rhythm. It's that post -- when
13 they return to spontaneous circulation it's -- it's -- it's
14 no longer recommended to give an additional antiarrhythmic
15 dose at that time, like we use -- we used to do the
16 lidocaine drips and things like that and that's no longer
17 recommended.
18 So, if you -- what we've done in the past protocols
19 when this has come forward, we just add them and put it down
20 as a physician option, so if a region wants to do it they
21 can do it, but with the physician's guidance.
22 **DR. DAILEY:** Absolutely.
23 **MS. CHIUMENTO:** Okay. Let's see. The other thing
24 is you may want to consider now that the B.L.S.
25 administration of nitros has moved up to three -- a

1 SEMSCO - 3-29-2011
2 potential of three doses. You might want to consider adding
3 that to your protocol. I think right now you still have the
4 one dose. The same thing with the -- as similar to with the
5 R.O.S.C., amiodarone postconversion of Y complex
6 tachycardia, again they didn't have it in -- in there as a
7 recommendation -- an ongoing recommendation, so again I
8 would suggest making it a physician option there as well.
9 So, once you've converted your -- your Y complex tachycardia
10 by cardioversion.
11 **DR. DAILEY:** Since that's actually not a
12 recommendation, but is not something negative either, I'd
13 like a consensus from the body.
14 Those of you in the room, if you convert a patient
15 from Y complex pulseless rhythm, do you give them a drip of
16 an antiarrhythmic?
17 I do. Anybody that doesn't?
18 (Off-the-record discussion)
19 **DR. DAILEY:** Yeah. My cardiologist would be less
20 than pleased if I didn't. So, if it's all right with this
21 body, I'd like to go along with leaving that in exactly
22 where it is, as well as in the therapeutic hypothermia so it
23 is consistent, so the providers don't have any confusion.
24 **DR. CUSHMAN:** I have one thing. I believe in your
25 protocol you still had the use of Haldol for chemical

1 SEMSCO - 3-29-2011
2 restraint, and I would consider you to consider removing
3 that agent for a number of different reasons. Many of us
4 have gone to either I.M. or I.N. Versed for restraint of the
5 agitated patient. Haldol is probably not a very good drug
6 for the individual with excited delirium, in particular
7 given it's anticholinergic qualities. And you know, benzos
8 are certainly the -- the treatment of choice for that. So,
9 I'd encourage you to consider taking Haldol out of that,
10 given the side effect profile, when we have a great med in
11 your formulary already for agitated delirium or other folks
12 that need some chemical restraint.
13 **DR. DAILEY:** The comment from Dr. Leinhart is that
14 simplifies the -- the formulary, the comment from me is
15 absolutely. Would we be able at this point then after our
16 protocol has been loaded on, Dr. Marshall, to make the
17 motion that through the next year that drug be removed from
18 the state formulary, and therefore not be used anywhere in
19 the state prehospitally, with the emphasis being on benzos?
20 **DR. MARSHALL:** Yeah. Is any other region using
21 Haldol prehospitally?
22 **DR. OLSSON:** We -- we actually went from Versed to
23 Haldol, and we've had no problems with it, and we don't use
24 it a lot, fortunately, but we've used it and had no issues
25 with it.

1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Okay. Yes.
3 **FROM THE FLOOR:** North Country many of our agencies
4 do not yet have controlled substances, so Haldol is our only
5 means, and again like Dr. Olsson said, we don't use it very
6 often, but we've had no issues with it when we have used it.
7 **DR. MARSHALL:** If anybody is using it. Okay.
8 Yeah. If you bring whatever data you have on the
9 use of Haldol and complications in the prehospital setting
10 then I think it would be interesting to look at before we
11 make a decision to remove it from the -- the state formulary
12 if that's the will of the group.
13 **DR. DAILEY:** We are certainly willing to remove it
14 and will remove it from the collaborative protocol. So, for
15 safety, based on the terms that Dr. Cushman has just
16 mentioned.
17 **DR. MARSHALL:** Okay. So, you're going to remove
18 it. Okay.
19 **MS. CHIUMENTO:** A couple of other recommendations.
20 On the stable irregular rhythms, again as I mentioned
21 before, if you could add a little comment about no -- the
22 patient shouldn't get diltiazem if there's a history of
23 preexcitation syndrome, such as W.P.W., and similarly in the
24 atropine and the bradycardia you may want to put a note at
25 the bottom about being ineffective in patients with cardiac

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1 SEMSCO - 3-29-2011
2 transplants, or in patients with type two second degree or
3 third degree heart blocks.
4 In the neonatal also if -- to be consistent now
5 with our new B.L.S. protocols, you can remove suction,
6 and -- and that's in both the -- the normal childbirth and
7 in the meconium. It's only if it's obstructive or needs --
8 there is a need to ventilate with the bag-valve.
9 You may want to add to your C.P.R. guidelines of
10 the three to one ratio and the hundred and twenty
11 compressions since it's no place in -- in -- in either the
12 pediatric or the neonatal section there. So, you may just
13 want to add those.
14 And also in the pediatric C.P.R. ratios there's no
15 mention of the fifteen to two for a two-person C.P.R. And
16 the cycles are -- are ten cycles for two minutes, not five
17 cycles.
18 I will give you a list of these, Mike.
19 I can't remember what was on page thirty-eight, but
20 I -- they've recommended that you add Hs and Ts there
21 because you had them on page thirty-seven, but not on page
22 thirty-eight. I think if one was the stable and one was
23 unstable or something along those lines.
24 Page thirty-nine, which is -- I think was a
25 pediatric bradycardia, you may want to put in criteria for

1 SEMSCO - 3-29-2011
2 when you -- when to use atropine related to bradycardia
3 being due to increased vagal tone or primary A.V. conduction
4 block. And it's -- it's not routinely given.
5 And also you've got infant bradycardia is less than
6 eighty. That may be confusing since C.P.R. is only done if
7 the heart rate is less than sixty. So, I think it might be
8 confusing to your providers, so I suggest just making it
9 less than sixty as that's when C.P.R. starts.
10 Similarly hypotension is less than seventy after
11 age one according to PALS (phonetic spelling). And so,
12 again just some minor things.
13 And then the Narcan as we mentioned before, Narcan
14 only recommended if respiratory depression, not just
15 symptomatic -- symptomatic may include respiratory
16 depression, but I think in one place you do spell it out, in
17 another place you don't. So, that's just a suggestion to
18 add that.
19 Diastat for B.L.S., I'm not sure whether B.L.S. is
20 allowed to assist with the administration of diastat.
21 It's not -- I mean they're allowed to assist with
22 nitro --
23 **DR. DAILEY:** It's a medication --
24 **MS. CHIUMENTO:** -- and albuterol and --.
25 **DR. DAILEY:** -- assist and --.

1 SEMSCO - 3-29-2011
2 **MS. CHIUMENTO:** Medication assist, but right now
3 currently it's only nitro and albuterol that they're allowed
4 to assist with, and then epi pens. I -- I don't believe
5 diastat is one that they're allowed to administer or assist
6 with.
7 **DR. DAILEY:** Frankly, Sharon, I -- assisting a
8 parent with diastat would usually be holding the legs while
9 the parents administer it in the bottom. Frankly, I think
10 that's a safety issue, not something that we need to -- to
11 broach here other than just saying it's okay if they choose
12 to assist a parent. This -- I -- I don't think that even
13 becomes a teaching point.
14 **MS. CHIUMENTO:** As long as they don't think that
15 they are giving it. That's the only thing.
16 Okay. On page thirty -- fifty I think was -- was
17 related to respiratory in -- in patients. It says -- it
18 says clear airway with an E.T. tube in it, but the way it's
19 on there, it looks as though you would do it for all
20 patients and not just for patients with obstruction. So,
21 like for instance, if I was just reading the protocol it
22 would look to me like for croup or for milder forms of
23 stridor I would -- that's what it was, a stridor, that you
24 would automatically include that. And so, I -- just like a
25 little bit of wording in there, some recommendations down at

1 SEMSCO - 3-29-2011
2 the bottom perhaps.
3 And then, the rest of them I believe -- we have an
4 I.V. bolus for an eye injury. Why -- why would you be doing
5 an I.V. bolus for eye injuries? It's -- it's I.V. -- it's
6 I.V. slash head trauma -- no, it says eye -- eye injury and
7 you've got I.V. bolus. So, I'm not quite sure what --
8 why -- and I think that may have just been a typo.
9 **DR. DAILEY:** If the notes -- if the notes are
10 comprehensive you send them along.
11 **MS. CHIUMENTO:** I will. I would be glad to send
12 these to you.
13 **DR. DAILEY:** I would appreciate those.
14 **MS. CHIUMENTO:** Okay.
15 **DR. DAILEY:** Because they will probably tie in with
16 some of these others that we've gotten to make this a really
17 good comprehensive document, which is where we'd like them
18 to be.
19 **MS. CHIUMENTO:** And the -- the MAST -- you know,
20 Jack mentioned the MAST. The only thing is that you also
21 have it in there for treatment of shock, not just for pelvic
22 fractures and bilateral femur fractures and things like
23 that. And it's not in New York State's protocol for
24 treatment of shock, only for those other injuries.
25 And then the last thing that I've got, A.T.V.s are

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1 SEMSCO - 3-29-2011
2 not in the E.M.T. curriculum. I can't remember what that
3 was about. And a question whether or not there would need
4 to be a demo for that. I don't remember what A.T.V. stood
5 for, so --
6 **DR. DAILEY:** I didn't -- I didn't hear that,
7 Sharon. I'm sorry.
8 **MS. CHIUMENTO:** A.T.V. It's on page seventy-one.
9 **DR. DAILEY:** Automatic transport ventilator.
10 **MS. CHIUMENTO:** Oh, thank you. I don't believe
11 that's in the E.M.T. curriculum.
12 **DR. DAILEY:** That's an individual agency training.
13 It's the process of holding a mask while the A.T.V. cycles
14 instead of squeezing a bag. It's been demonstrated in
15 multiple studies to be much safer for the patient.
16 **MS. CHIUMENTO:** Okay.
17 **DR. DAILEY:** So, I don't -- I don't see that that's
18 even a change from the standards.
19 The other thing, by the way, I was just discussing
20 with Dr. Leinhart, we'll be removing MAST from the protocols
21 altogether, there will be no references in there.
22 **MS. CHIUMENTO:** That's -- the rest of the things
23 are just minor things, I'll just pass on to you.
24 **DR. MARSHALL:** Thanks.
25 **DR. DAILEY:** May I just meet a couple of these

1 SEMSCO - 3-29-2011
2 head-on really quickly before we move on?
3 **DR. MARSHALL:** Yes.
4 **DR. DAILEY:** Did anybody else review the protocols?
5 **DR. MARSHALL:** Yes. There were -- Jack and Dr.
6 Takats.
7 **DR. BAILEY:** Okay. One -- one other -- or two
8 other things. First, there was a typographical area in
9 the -- the pain control protocols, that has been corrected.
10 And the dosing will be twenty-five or fifty mics. It is not
11 a per kilo dose, which was what the -- one of the typos that
12 had gotten out there was. That was actually caught by one
13 of my -- my editors as well.
14 The other thing that I just wanted to catch here
15 which hadn't been mentioned is our movement from dextrose
16 being given as D-fifty and D-twenty-five to D-ten throughout
17 to assure that we have less potential for drug error or drug
18 complications -- drug confusion. The other thing we did
19 with that is we would like to do D-ten for intermediates as
20 well. So, we have a single concentration of dextrose
21 throughout the region.
22 What we found when we studied this during the drug
23 shortage last year was actually that there was -- originally
24 we demonstrated -- we were looking to demonstrate whether or
25 not there was equipotency between D-fifty and D-ten, and we

1 SEMSCO - 3-29-2011
2 did that as a quality improvement study because we were
3 forced into the drug substitution.
4 We actually found that, indeed, our D-ten
5 administration patients were coming back with ten grams or
6 fifteen grams of dextrose, rather than a full twenty-five
7 gram bolus, and anecdotally they were telling us later that
8 they felt much better than they had on previous hypoglycemic
9 reversals where they had gotten a much larger dose of
10 dextrose.
11 We haven't studied that at more length because it
12 was -- of the complexities of developing this study once the
13 dextrose formulation was available to us again, but are
14 making the substitution of D-ten through -- for D-fifty
15 across the board. In discussions about moving it down to
16 the intermediate level as well, we saw absolutely nothing
17 that became complex in the idea of hang the D-ten rather
18 than the D-five. Patients get less total volume, and it was
19 not going to be something complex for them to -- to take on.
20 **FROM THE FLOOR:** Go for it.
21 **DR. MARSHALL:** I don't know, I think you might need
22 a demonstration project on that.
23 **FROM THE FLOOR:** Sounds like he already has one.
24 **FROM THE FLOOR:** What was the end point of the Q.I.
25 study?

1 SEMSCO - 3-29-2011
2 **DR. DAILEY:** It was normalcy. Patients waking up.
3 **DR. HENRY:** Wives tales, you know. I mean the
4 article I remember on this was the quote, coma cocktail, in
5 JAMA that Goldfrank and one of the other toxicologists
6 wrote, and the range of blood sugars after getting D-fifty
7 is all over the place, depending on who you are. So, I
8 don't know that there's one right dose. That's just been
9 the dose people have been giving forever. And I thought
10 the -- you know, the D-ten is something like you think about
11 for kids, but -- so the total dose you're giving is ten?
12 **FROM THE FLOOR:** Hang a two fifty bag. You hang a
13 two fifty bag, which is the same twenty-five grams of
14 dextrose, when they get better turn it off.
15 **DR. HENRY:** Yeah.
16 **DR. DAILEY:** For this -- for the Q.I. study itself
17 what we did is we gave boluses fifty milliliters at a time.
18 That involved some stop cocks, and pushing, and then waiting
19 and pushing and waiting, which frankly was a system that was
20 developed by some of our paramedics, and unfortunately got
21 some of our other paramedics quite cranky. However, it did
22 yield valuable data, in that we found out that indeed these
23 patients normalized at ten to fifteen grams of dextrose
24 rather than a full twenty-five.
25 **FROM THE FLOOR:** A glass of orange juice.

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1 SEMSCO - 3-29-2011
2 **DR. DAILEY:** Best if they can't swallow on command
3 not to give them the orange juice, it -- the gurgely sounds,
4 not good.
5 **FROM THE FLOOR:** No, I mean, because the doses you
6 give are all over the place, that's just -- you know.
7 **FROM THE FLOOR:** Mike, did anybody seize?
8 **FROM THE FLOOR:** Were there patients who were
9 actively seizing?
10 **DR. DAILEY:** In that -- in that group of patients
11 there were no patients who were actively seizing.
12 (Off-the-record discussion)
13 **DR. DAILEY:** That -- that actually was brought up
14 by one of our paramedics, and we discussed it for a little
15 while. Then one of the things that -- that we've seen, and
16 I had some commentary with the acting director of the Bureau
17 as well as some directors of Bureaus in other states, one of
18 the complications that's seen with -- with some frequency
19 with D-fifty administration is extravasation, leading to
20 compartment syndrome and leading to fasciotomy, and the
21 patient that that's most likely to happen with, is one who
22 is fighting you while you're starting an I.V. So, it's a
23 double-edged sword. Yes, potentially you could get
24 twenty-five grams of dextrose into the patient faster, but
25 that's also the patient you're most likely to have an

1 SEMSCO - 3-29-2011
2 extravasated I.V. You could actually get a twenty-five gram
3 bag of D-ten into a patient relatively quickly, because it
4 flows actually much more easily than the D-fifty.
5 (Off-the-record discussion)
6 **DR. MARSHALL:** In your -- in your protocol -- in
7 the protocol for adult diabetic, at the paramedic level,
8 you're going to D-ten. At the intermediate level it's
9 D-five-W five hundred.
10 **DR. DAILEY:** And the reason was that this body
11 needed to approve the change to D-ten, and we had not
12 pursued that here before.
13 **DR. MARSHALL:** Okay.
14 **DR. DAILEY:** So, the goal would be D-ten across the
15 board, one drug.
16 **DR. MARSHALL:** Even at the intermediate level --
17 **DR. DAILEY:** Uh-huh.
18 **DR. MARSHALL:** -- as opposed to the I.V.?
19 **DR. DAILEY:** The -- the fear that I would have
20 actually is a little bit different. If we have the D-five
21 on board the ambulance we now have something else that has
22 the ability to get bolus into a patient. If you look at the
23 way we have structured our formulary right now, we have no
24 saline in the two hundred and fifty bags. We are going to
25 have the mylar-encased dopamine as our only vasoactive

1 SEMSCO - 3-29-2011
2 medication that's premixed. So, we hope that there won't be
3 drug errors between a clear bag and a silver bag, and there
4 won't be any other small clear bags.
5 A five hundred bag could be mistaken for a liter
6 bag in a time of crisis, and a patient could be bolused with
7 five hundred mls of D-five when they didn't need it, in a
8 trauma situation in the back of an intermediate ambulance.
9 So, this all revolves back around drug safety.
10 **DR. MARSHALL:** Is that in the curriculum?
11 FROM THE FLOOR: No.
12 **DR. MARSHALL:** Is there anything that mentions
13 anything about it?
14 FROM THE FLOOR: No.
15 **DR. MARSHALL:** Okay. Any -- any other comments or
16 concerns about that?
17 No. Okay. Any other comments about the protocols?
18 What I have is -- and please add, remove repeat doses of
19 Etomidate, move fentanyl under pediatrics to medical control
20 options, removing Haldol, removing MASTs. There were some
21 other typos and other suggestions that Sharon had that I
22 didn't -- that didn't sound like they were major changes
23 that you were going to look at, she's going to send them to
24 you. And changing D-fifty to D-ten across the board. Those
25 were the majors ones that I got.

1 SEMSCO - 3-29-2011
2 Okay. Any -- any comments on those?
3 Concerns?
4 Okay. Seeing none, all those in favor of the REMO
5 protocols as presented and amended and accepted, raise your
6 hand.
7 Opposed?
8 Abstain?
9 (The motion carried.)
10 **DR. MARSHALL:** Thank you.
11 Thank you, Dr. Dailey.
12 Okay. I think that's -- that's all the action
13 items. There was some old business, which are updates from
14 hypothermia from New York City REMO.
15 Dr. Freese, Dr. Dailey, you guys want to give a
16 quick update on the hypothermia?
17 Dr. Dailey, go ahead.
18 **DR. DAILEY:** It's working fine. Thanks.
19 **DR. MARSHALL:** Okay. Good. Thank you.
20 Dr. Freese, is it working just as well in New York
21 City?
22 **DR. FREESE:** In three sentences: It's working
23 well. The return of spontaneous circulation rates for the
24 thirty-seven hundred patients we've cooled to date are
25 increased versus the prior control period. And the third

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1 SEMSCO - 3-29-2011
2 sentence is that pulmonary edema continues to occur at a
3 rate of seven percent with actually higher immediate
4 survival rates than any other population.
5 **DR. MARSHALL:** Thank you. Very nice.
6 Dr. Dailey, anything on the Narcan -- Narcan
7 demonstration project?
8 **DR. DAILEY:** The Narcan demonstration project is on
9 hold. The waiting Bureau of -- excuse me, the agents to --
10 who will be partnering with us in this, they're going to
11 assist us with the development of materials for
12 dissemination out to the services, and likely an arm as well
13 for education of emergency physicians as well. So, they've
14 asked us to -- to hold on this while we wait for some of
15 their resources to get in order.
16 **DR. MARSHALL:** Thank you.
17 I'm going to --.
18 **DR. GOODMAN:** (Off-mic).
19 **DR. MARSHALL:** Yes? Uh-huh.
20 **DR. GOODMAN:** (Off-mic).
21 **DR. MARSHALL:** Turn your mic on.
22 Turn your mic on.
23 **DR. GOODMAN:** (Off-mic).
24 **DR. MARSHALL:** Can we get him a new mic?
25 **FROM THE FLOOR:** This mic is working.

1 SEMSCO - 3-29-2011
2 **DR. GOODMAN:** Yeah. Let's move on over here.
3 Suffolk continues to be interested in participating
4 with the REMO region, and we should be ready in June.
5 **DR. MARSHALL:** Thanks. Take that mic away from
6 him, please.
7 Okay. We had some discussion in the past about
8 online medical control and who provides direct online
9 medical control. I think I'll -- I'll hold off on that
10 until we can do some more work on the language for Policy
11 9501, which is the one we were going to revise. So, we'll
12 bring that back to the next meeting.
13 There was a request to talk about the interfacility
14 TAG. There is an interfacility TAG that since interfacility
15 transports have been included in Article 30 that the TAG
16 become an actual committee both here and in Systems. So, if
17 anybody has any thoughts on that, I think that interfacility
18 transport is -- is a big portion of what we do in
19 prehospital care, and it probably should be a committee
20 rather than a TAG at this point. Any comments? Comments,
21 suggestions --
22 **MR. ZEEK:** Dr. Marshall?
23 **DR. MARSHALL:** -- volunteers?
24 **MR. ZEEK:** Dr. Marshall?
25 **DR. MARSHALL:** Yes.

1 SEMSCO - 3-29-2011
2 **MR. ZEEK:** This came about as a result of an e-mail
3 from Dr. Funk that came to me and Tim Czapranski and Dr.
4 Henry in early February, where she requested that the State
5 Council set up a separate committee for interfacility
6 transport.
7 In discussing this with -- with Tim, and somewhat
8 with Lee, and I know Dr. Funk has talked to Lee about this,
9 that if it's not possible to set up a committee, which I --
10 I hope maybe we can do, is to at least reactivate the TAG as
11 an interfacility transport TAG that would report to this
12 Committee and to Systems. That was Tim Czapranski's thought
13 about this.
14 I bring it up here because of that, and I hope that
15 we can provoke some conversation about it, because it's an
16 issue that there's a lot of it going on and there's not much
17 ownership about standardization of training, despite the
18 fact that many, if not most, regions have some interfacility
19 protocols. So, that would be the point of setting up this
20 committee as a standing committee.
21 **DR. MARSHALL:** Okay. I -- I -- I think it's a good
22 idea. I think that for the SEMSCO I think it would call for
23 a bylaws change or something, SEMAC for a bylaws change to
24 make it an -- an actual committee, but --.
25 **MR. ZEEK:** There's -- there's really nothing in the

1 SEMSCO - 3-29-2011
2 bylaws about what types of committees, from my review of it.
3 **DR. MARSHALL:** Yeah. Okay.
4 **MR. ZEEK:** So, we could do that.
5 **DR. MARSHALL:** Let's do that.
6 **MR. ZEEK:** We could set up -- we already did for
7 the Safety TAG, so --.
8 **DR. MARSHALL:** True.
9 **MR. ZEEK:** Yeah.
10 **DR. MARSHALL:** Well, I would certainly support that
11 recommendation. Either at SEMAC or at the Subcommittee of
12 Medical Standards and reporting to Systems also. If
13 that's -- anybody else have any thoughts on that?
14 Does that sound reasonable?
15 **DR. DAILEY:** Dr. Marshall, I'd actually suggest
16 that that be -- rather than come here, I would suggest that
17 that committee report directly to the SEMAC, and it be a --
18 be a portion of that body. I'd also suggest that the
19 constituents of that committee include members of the STAC
20 as well, and that they have representation there because
21 there's a significant amount of patients that are moved
22 interfacility as a result of trauma, and they have an awful
23 lot to -- to bring to bear to this, as well as a lot of very
24 effective data. So, they would be a very valuable member of
25 this committee. So, I would suggest that this be a

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1 SEMSCO - 3-29-2011
2 subcommittee of the SEMAC, with clear representation from
3 the STAC as well. I think it's extremely important.
4 **DR. MARSHALL:** Okay. Do you have any thoughts?
5 Okay. So, recommend that the Interfacility
6 Transport TAG become a committee reporting to SEMAC, a
7 subcommittee of SEMAC. Okay.
8 And what about protocols? Interfacility protocols
9 would come here first?
10 **DR. DAILEY:** Why?
11 **DR. MARSHALL:** Well, normal process for protocols.
12 **DR. DAILEY:** But -- but since this is a group
13 actually here, that's reviewing protocols under Article 30,
14 and the interfacility transports are actually being done
15 both under, I guess, a little bit of Article 30, but more
16 the responsibility of Article 28 facilities, the way the
17 Code is written, these -- the protocols for interfacility
18 transport could come directly from the interfacility group
19 to SEMAC. They wouldn't have to come here, and having this
20 group discuss them after they've already been vetted through
21 that group probably wouldn't be reasonable.
22 **DR. MARSHALL:** Okay, well --.
23 **DR. HUFFNER:** Except that how will the scope of
24 practices and -- and that type of information -- how will we
25 ensure that that's integrated into that process if it's

1 SEMSCO - 3-29-2011
2 separate outside of us?
3 **DR. DAILEY:** Through your participation, Dr.
4 Huffner.
5 **DR. MARSHALL:** Well, I -- I don't think we want to
6 duplicate the process of approving protocols. So, I -- I
7 think that -- my -- my thought would be that protocols would
8 come through Medical Standards like --
9 **DR. DAILEY:** Right.
10 **DR. MARSHALL:** -- they do for the regional
11 protocols, and then -- yeah.
12 **DR. DAILEY:** I -- I think the thrust of this
13 committee, we can do a committee, would be to set standards
14 that would then be -- evolve into protocols.
15 **DR. MARSHALL:** Right.
16 **DR. DAILEY:** Just because there really is not
17 really standardization in terms of what you should have in
18 your protocols and what you shouldn't have for interfacility
19 transports.
20 **DR. MARSHALL:** Okay. We'll bring that to SEMAC and
21 we'll -- we'll let SEMAC decide how they want to proceed.
22 **DR. DAILEY:** Great. Okay.
23 **DR. MARSHALL:** Can you put that up?
24 I want to go back -- the last thing we do have the
25 online medical control. The language that we developed,

1 SEMSCO - 3-29-2011
2 which we had conference call, we had input from the rural
3 hospital group, from the pediatrics, and the issue of who
4 provides direct online medical control to the field
5 personnel, and in 9501 it said the physician, however, in
6 the regulation that said under the direction of a physician.
7 So, can you highlight the language?
8 Yes. So, under the direction of a physician,
9 the -- the -- this -- 9501 essentially states pretty much
10 the same, the idea of who can actually provide online
11 medical control. And so, under the direction of a physician
12 means a physician, a physician assistant, nurse practitioner
13 or a registered professional nurse that meets or exceeds
14 those requirements under Title 10, Section 40519 for
15 emergency services, and there was an additional -- we also
16 talked about having a requirement for having online
17 training, medical director -- online medical director
18 training for those people who would be providing online
19 medical control.
20 Some of the arguments were that in some rural
21 hospitals where you do not have a physician on duty, the
22 P.A. or the nurse practitioner who may be on duty is one who
23 is receiving the phone call from the prehospital providers,
24 and they're the ones that may be giving prehospital
25 direction, and they are the ones who are going to be

1 SEMSCO - 3-29-2011
2 receiving the patient. So, that was -- and if you look at
3 New York State data, there's about twenty-five percent of
4 the rural hospitals in New York State do not have a
5 physician twenty-four hours a day. So, it's a
6 significant -- significant number. It's not insignificant.
7 So, that's how this came up several years ago.
8 **MR. JOHNSON:** One of the things the Committee
9 looked at was trying to be consistent with other D.O.H.
10 regulations and laws, and we looked at 40519 and tried to
11 stay consistent with that as far as the training went, and
12 the size of the hospital E.R. population, and so forth.
13 **DR. MARSHALL:** Yes?
14 **DR. GOODMAN:** I think most of us work pretty hard
15 to become physicians. Just "under the direction of a
16 physician shall mean a physician, physician assistant, nurse
17 practitioner or registered professional nurse." I would
18 object to using the term "physician" first, and I recommend
19 changing that to "licensed independent practitioner," so as
20 not to have confusion with --.
21 **DR. MARSHALL:** Any particular reason?
22 **DR. GOODMAN:** See, the reason is it seems -- I'm
23 reading this that you're defining a "physician" as a
24 physician, a physician assistant, a nurse practitioner, a
25 registered professional nurse.

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1 SEMSCO - 3-29-2011
2 **DR. MARSHALL:** Okay.
3 **DR. GOODMAN:** When I think the intent here is that
4 "under the direction of a licensed independent
5 practitioner."
6 **DR. MARSHALL:** Yeah. Yeah, licensed independent
7 practitioner, I mean you can certainly put that, it doesn't
8 matter. It would also include nurse practitioners in New
9 York State.
10 **DR. GOODMAN:** Yes, I understand.
11 **DR. MARSHALL:** So, you could just --
12 **DR. GOODMAN:** I understand that.
13 **DR. MARSHALL:** -- put independent practitioners and
14 physician assistants or registered professional nurse.
15 **DR. GOODMAN:** It -- it just -- it reads awkward.
16 **DR. MARSHALL:** The language I think here came out
17 of 40519. So, we -- we didn't make it up.
18 All right. So, we can change it or we can leave
19 it, it's -- I -- I have no preference.
20 **DR. GOODMAN:** It just seems awkward, that under the
21 direction of a physician shall mean a physician and somebody
22 else other than a physician.
23 **DR. MARSHALL:** Well, anybody else have any thoughts
24 on that one way or the other?
25 **DR. YOUNG:** The -- so reading that literally, the

1 SEMSCO - 3-29-2011
2 physician could be a resident physician, and that could be
3 why that -- that's included and the resident would be
4 working under the license of a licensed physician.
5 If you're talking an RN, so what I'm getting at is
6 if this goes through, then the RN could wind up giving
7 orders on your additional doses of fentanyl or whatever
8 occurring on E.M.S., an E.D. RN under these -- under this
9 proposal then --
10 **DR. GOODMAN:** Right. For medical direction.
11 **DR. YOUNG:** -- to your E.M.S. squad.
12 **DR. MARSHALL:** I -- I don't think in the original
13 thought we had included RN, but this was the language --
14 **DR. YOUNG:** Well, it does and that's what we need
15 to clear up.
16 **DR. MARSHALL:** -- of 405.
17 **DR. YOUNG:** Because there's the whole narcotic
18 piece.
19 **DR. MARSHALL:** Well, we can -- we can take that
20 out. We should take RN out, I think.
21 **DR. KUGLER:** I have a comment, Dr. Marshall.
22 I -- I wouldn't take it out actually.
23 DR. MARSHALL: No?
24 **DR. KUGLER:** I think it's redundant, but purposely
25 redundant so it avoids ambiguity. I think, "so what? A

1 SEMSCO - 3-29-2011
2 physician's in there. It specifically says a physician, a
3 P.A., a nurse practitioner or a licensed nurse," and I think
4 if you take it out then someone's going to say, "well, what
5 does that mean? Can a resident physician" -- it's going to
6 be confusing. I say leave it in, it's redundant, and you
7 know, we'll take it on the chin.
8 **DR. MARSHALL:** Okay. Leave physician in? Leave
9 physician in?
10 **DR. KUGLER:** No, I think it was fine to leave
11 physician in. My recommendation was change the first
12 physician to "L.I.P. shall mean physician." That word,
13 correct. Change it to licensed independent practitioner.
14 **DR. MARSHALL:** No, not there.
15 **DR. HUFFNER:** But -- but doesn't that include
16 chiropractors, veterinarians and podiatrists?
17 **DR. KUGLER:** Well, you've defined -- you've
18 subsequently defined it, what you mean by L.I.P.
19 **DR. MARSHALL:** Yeah. I would leave -- I would
20 leave physician in. I -- I would just leave it the way it
21 is in 405, because we're so easily confused.
22 But I -- I would recommend -- I would recommend
23 taking out registered professional nurse. Although there
24 are times when the nurse may relay orders from the doctor
25 who is doing something else, but they shouldn't be giving

1 SEMSCO - 3-29-2011
2 direct medical control online.
3 **DR. MYERS:** But that's -- that's in a situation
4 where you're relaying, you're actually not getting --
5 **DR. MARSHALL:** Right.
6 **DR. MYERS:** -- orders from the registered nurse.
7 **DR. MARSHALL:** Right. But this --
8 **DR. MYERS:** So, I -- I would --.
9 **DR. MARSHALL:** -- in this you're getting it from
10 the registered nurse.
11 **DR. MYERS:** Correct. And I would -- I would
12 recommend that that's changed to allow you to do -- give the
13 orders through a registered nurse, but not from a registered
14 nurse.
15 (Off-the-record discussion)
16 **DR. MARSHALL:** I -- I would -- yeah, I would take
17 out --.
18 (Off-the-record discussion)
19 **DR. MARSHALL:** Under the direction, yeah, it does
20 kind of say that. Yeah. All right.
21 **DR. LEINHART:** I think we have to clarify, you
22 know, what kind of a facility are we talking about. Is
23 there a physician in this department?
24 We haven't said that. I mean we've said there are
25 places that have no physicians, so can an RN give direct

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1 SEMSCO - 3-29-2011
2 medical control with no physician on site. That's what this
3 would lead to.
4 **FROM THE FLOOR:** That's correct.
5 **DR. LEINHART:** I think we could clarify. Is there
6 a physician on site. Yes/no, and if not, can a P.A. do it,
7 can an N.P. do it?
8 **DR. MARSHALL:** In the hospitals in New York State
9 that do not have twenty-four hour physician coverage, they
10 do have either a physician assistant or a nurse
11 practitioner.
12 **DR. LEINHART:** Right.
13 **DR. MARSHALL:** As far as I am aware of those
14 hospitals, there's not one hospital that I'm aware of, and I
15 looked at -- there's like two hundred and twenty acute care
16 hospitals in the state, and the rural hospitals, there's not
17 one -- and you can correct me -- that has a nurse and no
18 P.A. or nurse practitioner in the facility. So, there's
19 really no opportunity that a nurse, unless the -- you know,
20 the P.A. was eating lunch or something.
21 **MR. JOHNSON:** I think what we'd fine is that it
22 would become a convenience issue. So, most of those -- at
23 least all the facilities in our region have a nurse
24 practitioner or a P.A., but now it becomes a convenience
25 issue for their registered nurse. So, the P.A. may not be

1 SEMSCO - 3-29-2011
2 readily available, may be in the back, in the I.C.U.,
3 somewhere else, because there's only one provider in the
4 entire facility. And so, now the registered nurse will go
5 ahead and give medical control because she has that
6 capability, even though -- even though she has also the
7 capability -- or he or she, also has the capability of -- of
8 getting that provider. So, yeah, I would be very cautious
9 about putting the registered nurse in this, seeing they
10 truly -- they can't give orders in the hospital so why would
11 they do it prehospital.
12 **DR. DAILEY:** The -- one of the problems we face
13 here is -- is the three different settings that we're
14 talking about. You know, we're talking about a nurse
15 relaying an order, we're talking about a nurse practitioner
16 or a P.A. giving a primary order at a small hospital where
17 they're going to be receiving the patient, and then we have
18 the unlicensed resident physician giving an order under the
19 direction of their attending.
20 You know by grouping all three together here, you
21 are making it look like we have one scenario when really
22 there are three different ones, and I think we -- we do have
23 to be careful about how we clarify under what circumstances
24 an RN can give that order, because that actually may leave
25 the RN in an interesting position where they may order the

1 SEMSCO - 3-29-2011
2 administration of controlled substances at our behest,
3 however, may not independently prescribe or administer
4 controlled substances within the facility, and that would --
5 would be a very odd dichotomy.
6 **DR. MARSHALL:** Yes?
7 **DR. DETRAGLIA:** I have a question. Does the -- is
8 it necessary that the receiving hospital take medical
9 control? Can this be bounced to another facility, and let a
10 physician do it, and then the receiving hospital still
11 receives the patient?
12 And the second question is this really a scope of
13 practice question for RNs. They can't order narcotics.
14 They -- they should not be able to do this.
15 **DR. MARSHALL:** The -- the second question is you're
16 right, and the nurse would only be doing it under the
17 direction of a physician who was there, or the P.A. or nurse
18 practitioner who is a licensed independent practitioner.
19 And for your first question, yes, they did look at
20 that.
21 (Off-the-record discussion)
22 **DR. HUFFNER:** I would agree with Dr. Dailey. This
23 is confusing the way it's -- there's different scenarios and
24 there's two different paragraphs there. If you read them
25 independently, you get a different point of view. We should

1 SEMSCO - 3-29-2011
2 try to clarify this.
3 **DR. MYERS:** And -- and -- and I'm always sensitive
4 about the fact when one of the facilities I work at -- we're
5 in the process of getting medical control, so I'm -- I'm
6 currently receiving patients that another physician gave
7 orders in the field on, which some of which I agree, some of
8 which I would prefer he had not. So, that's the only issue
9 with that -- with not having the medical control at the P.A.
10 or N.P. level. They're going to receive that patient, the
11 first thing I'd like them to know what was given prehospital
12 and why.
13 **DR. MARSHALL:** Yeah. The issue of another facility
14 providing direction was discussed, and it was recommended
15 actually that some of the rural -- rural facilities or rural
16 services have a regional -- one of the regional hospitals
17 provide medical control, and the issue -- some of the issues
18 were liability of the hospital who is providing direct
19 medical control who is not the medical director of the
20 service or the receiving institution, as you mentioned,
21 and -- and not knowing what's going to be provided.
22 Also there was some questions about interregional
23 protocols. And you know, if you're -- the hospital you're
24 going to get medical direction from is in a different
25 region, they're going to be operating under different

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1 SEMSCO - 3-29-2011
2 protocols.
3 So, there was a lot of those issues were discussed
4 at the -- when discussing that. So, we need more work on
5 the language, so we'll keep working on it and -- and bring
6 it back again. Job security.
7 All right. Any other comments; any other comments
8 or questions or suggestions on that?
9 What I'm hearing is there's questions about the
10 registered nurse, and being very specific about under what
11 circumstances an RN may or may not relay a physician's order
12 to a prehospital provider.
13 **DR. LEINHART:** If -- if you're going to try to
14 rewrite this, my suggestions would be identify the on-site
15 provider. You know, there's -- there's three types that can
16 be the on-site E.D. provider, a physician, P.A., nurse
17 practitioner. Whoever that is, they can -- they may be able
18 to initiate online orders, and nurses may relay verbal
19 orders from any one of those providers on those sites.
20 (Off-the-record discussion)
21 **DR. GOODMAN:** But I think you -- you can exclude
22 any language about who is relaying the orders. If you're
23 going to include language with regards to who is relaying
24 orders and include the RN, then you need to include a
25 paramedic as well, because there may be systems where the

1 SEMSCO - 3-29-2011
2 paramedic is relaying orders from the physician.
3 **DR. MARSHALL:** Well, that's a tough one, because
4 technically a paramedic should not be operating within a
5 hospital emergency room as a paramedic. So, that's a tough
6 one, but there may be some P.S.A.P.S. were there's a
7 paramedic sitting there that's doing the medical control. I
8 don't know.
9 Dr. Langsam?
10 **DR. LANGSAM:** Shouldn't it say somewhere that this
11 is specifically only when a physician is not available?
12 Because otherwise I could see hospitals where for cost
13 saving reasons, they are going to start not using the
14 physicians there and putting someone who is of lower
15 standard of care in front of the microphone or in front of
16 the radio. Shouldn't you say only -- that all of these
17 exceptions are only when a physician is not available?
18 **DR. MARSHALL:** That's certainly a possibility. And
19 those facilities under the regulation which have under
20 fifteen thousand visits a year may not have a physician on
21 duty. Those that are above must have a physician on duty.
22 Whether that physician is available or not, I would imagine
23 they'd be available, you know, in some capacity. No?
24 Napping?
25 **FROM THE FLOOR:** When this came up in our

1 SEMSCO - 3-29-2011
2 region --.
3 **DR. MARSHALL:** Taking care of an -- oh, always,
4 yeah. So they could relay a message or relay an order from
5 the doctor who's doing the code, and at the same time --.
6 **FROM THE FLOOR:** When this came up in our region,
7 there was a concern that in some of the hospitals that do
8 not have resident coverage that your primary physician may
9 be working with a mid-level. The primary physician is
10 involved in doing something and can't come away from the
11 bedside to the phone, and it's very time consuming and it
12 adds the additional risk of error to relay through somebody
13 that in those situations I think it's appropriate that you
14 have your mid-level provide the online medical control.
15 That's the discussion that we had in our region when we went
16 forward with allowing the P.A.'s to provide med control.
17 **DR. DAILEY:** I think while I appreciate the concern
18 of physician jobs being replaced by mid-level providers to
19 ease this process, I think the reality of hospital staffing
20 is that the process of giving online medical control doesn't
21 even enter into the thought process behind it. I think it's
22 a concern that we all need to watch for, but I don't think
23 it's real.
24 No, Dr. Henry, what I mean is if you've got -- if
25 you're determining whether to staff based on regulations and

1 SEMSCO - 3-29-2011
2 you're an emergency department of twenty thousand visits and
3 you know in one of your shifts you require two physician
4 coverage, you're not going to make your decision as to
5 whether it's two physician or one physician, one mid-level
6 practitioner based on your medical control calls. You know,
7 your medical control calls won't even enter into that
8 thought process.
9 **DR. MARSHALL:** You're right. And the issue came up
10 with services and especially in rural areas that were not
11 able to get medical control from a physician. So who are
12 they getting it from? Well, they're getting it from the
13 P.A. or the nurse practitioner who is working in the E.R.
14 that sees five thousand visits a year or they're getting it
15 from the registered nurse who is relaying the order from the
16 P.A. or the nurse practitioner who is working in that area.
17 And there's other scenarios that exist also.
18 So just in trying to address the conflict between the state
19 regulation and SEMAC policy, that's how it came for this
20 discussion. So it's mostly in the rural areas. I don't
21 think the urban areas have much problem and whether, you
22 know, you have one or two docs only in the E.R., if you have
23 more than fifteen thousand visits, they don't care about
24 pre-hospital control. They're going to staff to their
25 finances. So -- but -- okay.

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1 SEMSCO - 3-29-2011
2 Any other comments? It's the language. We have to
3 fix the language somehow. Yeah, okay. So we'll come back
4 with some -- if anybody has some suggestions, just send it,
5 you know, to Andy and we'll put it together and bring it
6 back as another document, and we'll send it out before the
7 next meeting, okay, so everybody will have the chance to
8 look at it. Any other business? New business?
9 **DR. HUFFNER:** I have one item. There was an
10 offline conversation between myself and Dr. Young concerning
11 a point that Andy made earlier in the meeting about regions
12 who wish to incorporate the A.H.A. changes in their
13 protocols. That if the region adopts the A.H.A. as the
14 standard and they take the steps necessary to change the
15 protocols so that they're consistent with that, that the
16 process for regional protocol approval does not need to be
17 followed. And that's correct Andy, Dr. Young?
18 **MR. JOHNSON:** That was correct. That was the
19 decisions made by SEMAC in 2005.
20 **DR. HUFFNER:** Okay. Good. Thank you.
21 **DR. MARSHALL:** Any other new business, old
22 business? Move to -- yeah?
23 **DR. HENRY:** I just have a question. You know, I
24 don't know if others have this issue but we have some
25 difficulty getting patient records when people move to

1 SEMSCO - 3-29-2011
2 electronic records. So you look around, you got a patient.
3 The E.M.S. has left. People have questions. The
4 consultants come down. The neurologist wants to know what
5 time were they last normal. There's no record there. It
6 gets sent in later, maybe. And I don't know -- we went
7 through a lot of work to have the regs such that the
8 pre-hospital care worker was part of the medical record. It
9 was supposed to be filed with the medical record. I'm
10 afraid we're moving into a -- as vendors come up with
11 different systems, they haven't thought through how they're
12 going to give a copy at the point where you need it. And I
13 don't know if others experience that issue, but from a
14 medical point of view, I think we should make it a
15 requirement that there is a record left with the patient.
16 **DR. LEINHART:** There actually is some history on
17 that, Mark. I think if we look back, we'll find that Mr.
18 Wronski actually addresses in a memo form, I think, wherein
19 the departing agency must leave some facsimile of a medical
20 record. They can complete the more formal documentation at
21 some later date, but they must leave with the E.D. staff
22 specifics about that patient prior to their departure. And
23 delayed submission of that is not acceptable.
24 **DR. CUSHMAN:** Mark, I think you do bring up a
25 really important point in that, you know, for years

1 SEMSCO - 3-29-2011
2 irrespective of whether or not a paper P.C.R. was left at
3 the bedside, those paper P.C.R.'s typically disappeared into
4 some void space. And something that our region has been
5 doing over the last few years and is really starting to come
6 to fruition is integrating our E.M.S. system with our RHIO.
7 So we have a very robust Rochester Regional Health
8 Information Organization, and we have -- we have built in
9 all of the constructs to allow the pre-hospital care report
10 from any vendor to be repurposed into a specific RHIO
11 document. So all the NEMSIS data gets output from the
12 E.M.S. charts and other vendors up to the RHIO where it's
13 then repurposed into a relatively clinician-friendly
14 document. And that clinician-friendly document then gets
15 populated for that individual patient's medical record. So
16 the individual that we picked up off the floor six times
17 last week but never transported can actually be seen by the
18 primary care provider or the D-ten wake-ups or what have
19 you. And that is also allowing those hospitals that have
20 electronic medical records to simply input that information
21 as well.
22 So I think, yes, you know, one of the -- one of the
23 main issues that we had going to electronic P.C.R.'s in our
24 region was assuring that agencies were completing P.C.R.'s
25 in a timely fashion, and we tracked that at the regional

1 SEMSCO - 3-29-2011
2 level. We go after agencies from a quality assurance
3 perspective to make sure that their chart closure times are
4 within a certain period of time. But the next step is
5 making sure that irrespective of when they're -- when
6 they're closed, because before what was happening is that
7 they would get faxed to the E.D. and then end up in a
8 secretary's office somewhere that was never used. So
9 identifying passive ways to assure that this system works to
10 integrate that patient care data into both the hospital and
11 the patient's medical record is something that we should
12 certainly be taking back to any of our agencies. And if any
13 of you want what we've been doing in Rochester, let me know.
14 **DR. YOUNG:** Jeremy, a question. Can that be
15 downloaded? Because the RHIO in the western New York area,
16 that's not permitted. You can actually download it to your
17 records because you get into consent issues and everything
18 else.
19 **DR. CUSHMAN:** So yes, particularly -- so if you
20 brought patient A to hospital X, because the disposition was
21 hospital X, hospital X can download that report. If it is
22 to a physician's -- you know, the primary care physician of
23 record can be able to do that. What we're working on right
24 now is the opposite so that we can actually go pull data out
25 of the RHIO for what's called a continuity of care document,

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1 SEMSCO - 3-29-2011
2 which is six data elements that I've identified, including
3 the electronic MOLST so that in -- across the board it ends
4 up being N.P.D.S. determines it's delta and echo, that you
5 don't have to necessarily get permission. And then any uses
6 outside of delta and echo determinants then require an audit
7 within the system because obviously everything is tracked.
8 That's the harder perspective. But this is tremendous
9 information for our providers to be able to get the
10 electronic MOLST and actually know that Dr. Dailey here does
11 not want C.P.R.
12 **DR. MYERS:** So are you saying that you can get
13 access to that -- that P.C.R. as they're inputting it so you
14 can get real-time access to the P.C.R. or only when they
15 submit it?
16 **DR. CUSHMAN:** As soon -- as soon as that P.C.R. is
17 closed, locked.
18 **DR. MYERS:** They have to close it out?
19 **DR. CUSHMAN:** That system works.
20 **DR. KUGLER:** So was Dr. Henry's question or point
21 answered? I think I agree with you. I think we have a big
22 void. We do not get that information. That's a really
23 important part of the handoff of care. I don't believe the
24 provider should be leaving the department with valuable
25 information without handing it off appropriately, and I

1 SEMSCO - 3-29-2011
2 think it's the only document we have until we get fully
3 integrated with the H.R.'s. Not everyone's RHIO is as
4 robust as Rochester. So while we have one, I don't think
5 that's going to be effective. And then there's a gap
6 between the time it's uploaded and you still have to effect
7 care. That gap could cost -- change the treatment
8 algorithm.
9 So I think we need to have some sort of mandate.
10 They cannot leave the department until there is an effective
11 handoff. And if that effective handoff is a document, the
12 P.C.R., per se, then that's what we should mandate from this
13 body.
14 **DR. DAILEY:** There are actually three different
15 elements to this that all tie together ultimately into a
16 functional E.M.S. system and potentially the SEMAC
17 through -- it's the 405-Bs, isn't it, Mark, where we get the
18 control over emergency department operations, the SEMAC?
19 And potentially that's where we should be really effecting
20 the change. But the three elements are -- first of all, the
21 emergency department's requirement for recordkeeping that
22 includes the P.C.R.'s, and that ultimately pertains to
23 day-to-day patient care in the emergency department. The
24 second is feedback to our E.M.S. providers which is
25 authorized under HIPAA and is what builds a good E.M.S. --

1 SEMSCO - 3-29-2011
2 good and robust E.M.S. system from a quality perspective.
3 And the third part is actually most important for the fiscal
4 prudence of the system, which is getting billing face sheets
5 back from these hospitals who have more of an opportunity to
6 collect this information for our providers who are billing
7 in this extremely lean financial times to assure that these
8 agencies remain viable.
9 So those three things, I don't see as being easily
10 separated. I see they all involve an information services
11 exchange between hospitals and E.M.S. agencies. I think
12 that the 405-Bs give the SEMAC the ability to push on the
13 hospitals to assure that this can occur. And I think that
14 as Jeremy points out there's some very good models for these
15 exchanges of information within currently existing
16 information technology structures that could be integrated
17 into the other facilities. You know, some of the examples
18 of how these fail, you know, we can discuss ad infinitum.
19 There certainly are more examples of how they fail than how
20 they work, but we should really accept that there are best
21 practices out there for it and encourage it from the SEMAC
22 and potentially, through the 405-Bs, do more than encourage
23 emergency departments and facilities in participating in
24 this information exchange with E.M.S. providers.
25 **DR. MARSHALL:** There is a policy Andy found that

1 SEMSCO - 3-29-2011
2 does require E.M.S. to leave a pre-hospital care report at
3 the hospital, but it doesn't have a specific timeframe. So
4 what is your -- I mean, you know, that's something you can
5 develop policy around in terms of what is an appropriate
6 handoff and what -- how should that handoff occur. You
7 know, what -- should there be some physical piece of paper.
8 **DR. HENRY:** I don't know in your place, but we get
9 over forty percent of the people who come by ambulance end
10 up being admitted. So they're a sicker group of people.
11 We've had people who have been P.I.A.'s, but you know, the
12 syndromes where the region for the call, by the time they
13 get there, they may have resolved. You don't even know --
14 you don't have a document from an observer what -- what
15 existed. So I -- I think we need, as you say, something, a
16 document, a medical document. And in this emergency care
17 situation, pre-hospital care. I don't care if they have to
18 fill out a piece of paper, but if they can't -- if their
19 electronic system is not up and running so they can't
20 produce a document there, then let them fill out a P.C.R.
21 But it's been an issue with us and it must be with others,
22 too.
23 **DR. CUSHMAN:** Well, and I think it's much deeper
24 than just a piece of paper or electronic chart. I mean, I
25 think we have a serious cultural issue between our emergency

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1 SEMSCO - 3-29-2011
2 departments and our E.M.S. providers in that E.M.S.
3 providers very often do want to give a report, but it is not
4 heard, or physicians or nurses do not want to hear that
5 report. And so even though -- so I think regardless of if
6 there's paper or not -- and I don't have the solution, but I
7 think we have to figure out some ways to really enhance that
8 culture of -- of teamwork and transitions in care and so
9 forth so that when I'm bringing that patient so you I'm
10 saying, yes, the symptoms resolved at this time. Because
11 the paper is -- is sometimes irrelevant, quite frankly, and
12 oftentimes doesn't even reflect the information that I
13 wanted as a clinician for whatever reason. So I don't -- I
14 don't know if that -- you know, maybe that's something even
15 for -- for the safety group to consider. A lot of this
16 stuff is patient safety related and might be a good focus
17 for that group to identify some best practices for patient
18 care handoffs and --.
19 **DR. MARSHALL:** It is a big patient safety issue.
20 And looking at handoffs -- I mean, everybody's looking at it
21 now, joint commission. I participated in a group up at
22 Harvard looking at handoffs and communication between
23 doctors and nurses, and so it's part of the continuum. We
24 have to have an appropriate handoff and what that entails
25 and how it is. In my shop, sometimes the nurse is the one

1 SEMSCO - 3-29-2011
2 who takes report and the doctor never hears anything. You
3 know, and then you lose -- the P.C.R. is gone. So a lot of
4 valuable information. Comment over here?
5 **DR. MURPHY:** What we did was the people that have
6 electronic records, we put a specific printer for them in
7 the Department, and so they go and hook up to that one
8 printer. So it's a designated printer so they can give us a
9 report and a piece of paper right then and there. And how
10 we encourage them to do it right then and there is we give
11 them medical control contact hours for their C.M.E. and we
12 give them a certain percentage point for every one they
13 interact with us with the doctor with the medical control
14 physician, and we give them credit back. So it encourages
15 them to come over, give us a report, and we have a true
16 handoff.
17 **DR. YOUNG:** I think part of the issue to consider
18 is that electronic P.C.R.'s do take a little bit more time,
19 especially when folks are using them, newer folks. And we
20 already have a problem with ambulances backing up and being
21 stacked up in hospitals and having delayed STAC calls in
22 many systems. At least up in the west, we do anyway. So
23 they'll actually not complete it till -- they'll do it on
24 their way back to their next call. So that becomes one
25 issue.

1 SEMSCO - 3-29-2011
2 And in the old days when I started practicing --
3 and I think we've gotten away from it -- we used to have
4 this thing called verbal sign-out where I'd actually get to
5 talk to the E.M.T. and I'd learn a whole lot more in one
6 minute discussion than I would five or ten minutes going
7 through papers. So maybe we can kind of encourage that
8 approach. I know it's ancient, but once in a while our
9 ancient approaches do work.
10 **DR. MARSHALL:** But I think that that's a good --
11 something nice that we can work on going forward, another
12 project. Yes?
13 **DR. OLSSON:** There's another spot farther on down
14 in 0801 where it does say that records have to be
15 transferred when the patient is transferred or a record has
16 to be given. But in central New York, we have a contingent
17 of providers who feel that if we don't come after them and
18 prove that they haven't left anything, then they're not
19 going to. And we have no way of enforcing -- I don't have
20 the manpower to track down -- we've provided them with a
21 downloadable form that just gives the name, the age, chief
22 complaint, and what they did. It'll take thirty seconds.
23 But because nobody's coming after them and slapping them on
24 the wrist, it's, "Well, I'll get back and I'll fill out the
25 P.C.R. when I get to it." And that's the problem that we

1 SEMSCO - 3-29-2011
2 have.
3 **DR. MARSHALL:** So there's our policy. Patient
4 records have to be provided to the receiving hospital at the
5 time the patient care is transferred or a predetermined
6 written plan must be in place.
7 **DR. HENRY:** So can we affirm -- can we bring this
8 up at SEMAC then? Can we affirm this policy and get it out
9 to people? Okay.
10 **DR. DAILEY:** Mark, let's just make sure we amend
11 those other two items to it as well so we make sure that
12 it's a give and take.
13 **DR. HENRY:** Yeah, I think it's great, and I hear
14 what Jeremy said. There should probably be a culture of
15 teaching. I mean, I admit I purposely -- growing up with
16 paramedics at Jacobi in my training, emergency medicine
17 residencies just started and so did paramedic training. I
18 make a point when they come in -- I tell everyone to be
19 quiet, just listen to the story if someone can tell it. But
20 even with that, there are so many things going on as you
21 know that when they leave, you still want to go back. What
22 was that again? What was that again? So -- so I -- I'm
23 glad we found that policy and we can fix this. I mean, I
24 understand the problem with electronic records. Estimates
25 that emergency physicians and nurses spend twenty-two hours,

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1 SEMSCO - 3-29-2011
2 so I can understand the frustration
3 **DR. MARSHALL:** Okay. Any other -- anything else?
4 I will entertain a motion to adjourn. Thanks. Thank you.
5 (The meeting concluded at 11:38 a.m.)
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1 SEMSCO - 3-29-2011
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ability 24:4 25:22 53:21 91:22 120:12
able 36:22 44:2 48:4 51:11,17 53:13 59:16 60:8 75:4 80:15 108:14 110:17 113:11 117:23 118:9
absence 64:8
absolutely 27:19 35:19 51:18 76:20 78:22 80:15 88:16
Abstain 17:23 22:3 23:4 55:23 64:21 73:14 93:8
accept 11:15,17 44:2 70:22 120:20
acceptable 10:11 58:16 60:13 64:6 65:21 115:23
accepted 35:14,17 93:5
accepts 47:8
access 52:15 118:13,14
acknowledge 6:17
acting 90:16
action 3:5 34:14 93:12
actively 90:9,11
actual 8:14 95:16 96:24
acute 68:22 69:18,19,25 106:15
ad 120:18
add 13:9,17,20 14:20 42:4 56:15 69:21 70:4 71:8 78:19 81:21 82:9,13,20 83:18 92:18
added 4:8,10 10:6 42:2
adding 30:24 61:25 72:15 79:2
addition 22:7 62:6
additional 4:8,11 7:19 9:23 11:17 13:13,17 14:4 15:6 28:22 41:16 64:25 78:14 100:15 103:7 112:12
Additionally 56:18
additions 64:13
address 3:5 113:18
addresses 115:18
adds 112:12
adenosine 57:7 76:19
adjourn 126:4
adjustment 75:6
administer 4:11 32:13 65:23 84:5,9 108:3
administered 25:4
administering 9:17 65:22
administration 29:6 50:23 53:24 66:10 67:15 77:25 78:9,25 83:20 88:5 90:19 108:2
administrations 25:7
administrative 21:5 64:2
admit 125:15
admitted 121:10
admittedly 72:16
adopt 19:11 22:8 48:5
adopted 18:24
adopting 4:23 21:22 22:22
adopts 114:13
adrenal 74:5
adult 10:7,7 11:12 13:11 25:5 91:7
adults 27:6 75:13
advanced 6:2,5,6,20,21 13:7 19:12 20:11,12,14 48:21,25 49:14,19,21 50:8 51:8 52:25 53:6,15 55:5,5,7,10 56:2 64:17
adverse 67:17
affirm 125:7,8
afraid 115:10
afternoon 15:13
age 10:6,18,20,21 13:16 67:12 67:20,24 75:8 83:11 124:21
agencies 38:23 39:7,10,10 42:13 50:19 51:3,25 61:19 63:13 75:14 81:3 116:24 117:2,12 120:8,11
agency 28:22 86:12 115:19
agenda 3:4 34:19
agent 74:15 80:3
agents 94:9
agitated 80:5,11
ago 3:8 45:18 54:19 101:7
agree 24:5 30:22 31:2 48:20 63:21 66:15 108:22 109:7 118:21
agreed 20:20
agreement 9:11 62:12
ahead 10:24 11:12 12:23 41:18 93:17 107:5
aim 15:23
air 14:19,19 33:12
airway 6:2,5,6,20,21 12:13 13:7 14:3,6,7,8 44:17 48:21 49:2 49:19,21 50:8 52:25 53:6,15 55:6,7 56:2 64:17 84:18
airways 49:14

Albany 35:6 42:2
albuterol 68:5 72:8,13,14 83:24 84:3
algorithm 119:8
algorithmic 35:4
allow 24:10 105:12 116:9
allowed 10:7 33:25 35:23 83:20 83:21 84:3,5
allowing 112:16 116:19
allows 26:15
altogether 68:23 86:21
ambiguity 103:25
ambulance 32:10 91:21 92:8 121:9
ambulances 24:14 123:20
amend 125:10
amended 73:12 93:5
American 3:6 17:19 18:17,19,24 19:11 21:22 22:22 44:3
amiodarone 56:18,19,22 57:5 58:16 79:5
amount 28:22 32:12 97:21
analgesia 65:24
ancient 124:8,9
Andrew 22:15 23:10
Andy 2:12 5:18 18:5 40:4 52:15 59:21 114:5,11,17 120:25
Andy's 52:7
anecdotally 88:7
angst 21:11
announcement 47:11
answer 38:14
answered 118:21
antiarrhythmic 78:9,14 79:16
antiarrhythmics 77:21,25
anticholinergic 80:7
antiquated 52:8
anybody 6:15 8:20 17:13 19:23 22:11 36:10 59:8 61:3 66:25 71:22 79:17 81:7 87:4 90:7 95:17 97:13 102:23 114:4
anymore 12:21
anyway 123:22
apologize 35:10
appear 12:22
appearance 12:5
appeared 76:22
appears 11:20,24
application 50:22
applications 63:15
applied 41:4
appreciate 27:5,9 30:13 41:12 85:13 112:17
approach 29:4 30:4 124:8
approaches 124:9
appropriate 31:3,7,22 41:6 50:4 55:8,10,11,12 60:20 112:13 121:5 122:24
appropriately 31:9 50:11 118:25
appropriateness 52:19
approval 37:19 42:7 54:7,11,13 114:16
approve 36:16,18 39:22 64:3 91:11
approved 5:6 23:20 25:6 36:15 64:16 66:16
approving 17:18 21:6 22:16 73:11 99:6
Approximately 38:25
area 8:17 24:15,18 32:15 61:19 68:14 87:8 113:16 117:15
areas 8:12 42:15 113:10,20,21
argument 72:2
arguments 100:20
arm 94:12
arrest 6:10,11,12 7:3,4,5,22 11:21 12:5,6
arrived 70:2
art 15:9,9,10 77:17
article 26:15 89:4 95:15 98:13 98:15,16
articles 9:19
asked 94:14
asking 33:3
aspirin 3:23 4:2,5,25
assessing 12:8
assessment 47:2 49:25 50:2
assist 50:22 83:20,21,25 84:2,4 84:5,12 94:11
assistant 100:12 101:16,24 106:10
assistants 102:14
assisting 84:7
Associated 128:6
Association 3:7 17:20 18:17,20 18:24 19:12 21:23 22:23 44:3
assume 11:4 13:4
assumed 14:2
assuming 10:25
assurance 117:2

assure 27:17 87:17 117:9 120:7 120:13
assuring 116:24
atop 46:14
atrial 56:13
atropine 81:24 83:2
Atrovent 72:14,21
ATTENDEES 2:2
attending 107:19
attenuator 11:11
audit 26:9 27:17 118:6
August 2:13 18:8,10,13
authority 54:16
authorize 54:5
authorized 119:25
Automatic 86:9
automatically 84:24
availability 51:10
available 7:11,15,18 8:4 9:7 10:8 11:12 31:6 63:11 65:12 75:22 88:13 107:2 111:11,17 111:22,23
avoid 49:5 69:12 70:13
avoids 103:25
awake 4:15
aware 12:11 106:13,14
awful 97:22
awhile 3:7 20:5
awkward 45:8,17 102:15,20
aye 17:20,21 21:24,25 22:25 23:2 64:18,19
A.C.L.S 20:11 22:7 44:8 60:21 76:14
A.E.C.L.S 21:24
A.E.D 7:10,15,17 8:3 11:10,10
A.H.A 8:13 10:17,18,24 12:4 18:9 20:18 21:14,15 56:17 57:19 75:8 76:13,20 77:23 114:12,13
A.J 67:19
A.L.S 3:12 16:24 18:16,21 19:25 21:14 22:10,24 25:6 39:9 62:22
a.m 1:11,11 3:2 66:21,22 126:5
A.P.E 69:23
A.T.V 86:4,8,13
A.T.V.s 85:25
A.V 83:3

B

baby 67:16 69:8
back 3:14 7:6 13:15 19:14 27:10 31:8 34:22 45:14 47:24 49:11 49:15 53:23,25 54:2 56:3 59:15 61:11,22 62:11 64:2 66:19 67:4 70:7 72:19 73:2 74:13 88:5 92:8,9 95:12 99:24 107:2 110:6 114:3,6 115:17 117:12 120:5 123:14,24 124:24 125:21
background 38:4
backing 123:20
backup 50:20 51:3
backwards 48:9
bag 15:16 86:14 89:12,13 91:3 92:3,3,5,6
bagging 14:9
bags 63:18 91:24 92:4
bag-valve 14:8,19 82:8
BAILEY 87:7
Banquet 1:12
bargaining 59:5
based 74:12,24 81:15 112:25 113:6
basically 10:10 12:7 23:23 24:11 25:4 42:9 65:7
bear 97:23
bedside 112:11 116:3
beginning 3:19,20
begun 48:14
behest 108:2
believe 3:20 11:25 24:23 36:10 64:12 66:5,8 67:8 79:24 84:4 85:3 86:10 118:23
believes 41:8
beneficial 40:10,15
benefit 40:12,17 71:25
benzodiazapine 62:5,5
benzodiazepine 64:5
benzos 80:7,19
best 11:8 44:6 77:3 90:2 120:20 122:17
better 25:17 27:14,16 42:15 48:4 49:20 53:5 72:4 88:8 89:14
beyond 46:2
big 14:25 23:23 24:4 27:3 28:15 51:25 60:13 95:18 118:21 122:19
bigger 12:9

biggest 3:6
bilateral 85:22
billing 120:4,6
biphasic 11:2,7
birth 10:22
bit 3:4,21 4:3 6:4,7,12,19 7:25 10:17 11:22 26:8 36:6 47:3 53:22 74:20 84:25 91:20 98:15 123:18
block 18:24 21:7 22:12,14 83:4
blocker 62:3,4
blockers 56:12
blocks 82:3
blood 4:12 89:6
blow-by 14:12,14
board 4:4 8:3 88:15 91:15,21 92:24 118:3
body 36:15 47:8 59:11 63:6,16 64:3 66:3,7 79:13,21 91:10 97:18 119:13
bolus 56:21 60:5 85:4,5,7 88:7 91:22
bolused 92:6
boluses 89:17
borders 46:2,11
Boston 33:16
bottom 53:19 81:25 84:9 85:2
bounced 108:9
box 31:16
bradycardia 81:24 82:25 83:2,5
bradycardias 14:5
brain 26:2 43:3
break 66:18 67:3
breaking 63:14 75:19
breath 12:25
breathing 12:13,22,23 14:17
brief 41:3
bring 22:18 51:4 52:11 74:13 81:8 95:12 96:14 97:23 99:20 110:5 114:5 115:24 125:7
bringing 27:10 38:14 39:17 122:9
brings 21:7
broach 84:11
Brodell 32:5
Broderick 74:13
brought 34:20 44:11 63:22,22 90:13 117:20
builds 119:25
built 116:8
bureau 8:11,13 23:14 26:24,25 29:15,17 63:16 76:8,9 90:16 94:9
bureaucratic 27:23
Bureaus 90:17
burn 68:12 70:6,25 71:4,17,22 72:3
burns 2:6 23:11 27:19 29:20 30:14 32:4,24 46:16 48:6 49:22 52:6 53:7,11 54:7 68:18 69:14 70:23 73:7
business 93:13 114:8,8,21,22
butt 25:13
bylaws 96:23,23 97:2
B.L.S 3:10,11,18 4:10 14:25 16:6,21 17:12,12,19 22:7,10 22:24 38:10 40:6 41:13,13 43:15 49:10,13 53:14,16,24 69:15 71:14 72:7,10,15,17 73:8 78:24 82:5 83:19,19
B.N.E 26:8 28:6 31:21,24 32:25
B.S.N 2:8

C

calcium 56:11 62:3,4
call 6:23 26:18 45:25 53:20 54:17,20 56:4 58:3 70:3 78:10 96:22 100:2,23 121:12 123:24
called 55:3,19 117:25 124:4
calling 54:23
calls 113:6,7 123:21
capabilities 50:2
capability 16:7 107:6,7,7
capacity 111:23
caption 128:3
cardiac 6:11,12 7:5 11:20 20:11 67:17 81:25
cardiologist 79:19
cardioversion 79:10
care 4:19 13:25 27:3 30:25 31:11,14,16,22 32:23 33:12 34:24 43:19 44:8 49:9 72:18 95:19 106:15 111:15 112:3 113:23 115:8 116:9,18 117:10 117:22,25 118:23 119:7,23 121:2,16,17,17 122:8,18 125:5
careful 107:23
caring 65:22,23
Carl 2:11
carried 17:24 22:4 23:5 55:2,24

64:22 73:15 93:9
carries 17:25 23:6 55:25 64:23
carry 31:19,25 64:5
carrying 63:13
case 65:21 68:25 69:2
catch 87:14
caught 87:12
cause 14:4,4,5,15 28:24 128:2
caused 21:17
causing 9:3
cautious 107:8
central 20:17,20 124:16
certain 31:25 32:11 117:4 123:12
certainly 27:9 50:22 51:7,24 62:19 72:23 78:6 80:8 81:13 97:10 102:7 111:18 117:12 120:19
certainty 40:9
certification 3:13
certify 127:24
Chair 2:9
chance 114:7
change 6:7 7:6 12:14,20 17:3 19:24 22:18 29:16,20 35:3,3 43:24 47:23 48:13 59:10 67:4 69:7 78:10,10 86:18 91:11 96:23,23 102:18 104:11,13 114:14 119:7,20
changed 6:3,19 7:9 10:16 45:20 68:4 105:12
changes 3:21 5:21 6:11,16 8:11 8:16 12:9 13:22,23 17:9,11,19 18:22 19:8,14,18 20:12 21:9 21:11 23:9,17 27:2 34:16 35:2 67:7,8 76:13,14 92:22 114:12
changing 43:17 47:21,22 68:21 73:5 92:24 101:19
channel 56:11 62:3,4
chart 117:3 121:24
charts 116:12
check 28:20
checks 12:8
chemical 79:25 80:12
chief 124:21
child 13:17 14:8,13
childbirth 17:7 82:6
children 27:7
chin 104:7
chiropractors 104:16
Chiumento 2:8 3:19 4:18 5:6,8 5:13,17,22 6:18 8:20 9:21 10:5,15,19,23 11:4,25 12:11 13:21 15:10,12,18,20,22 16:2 16:5,8,13,15,21 17:3,15 19:19 35:21 36:6 49:9,13 56:10 57:2 57:6,10,13,17,22,25 58:6,17 58:19,22,24 59:21,24 60:3,9 64:12,25 65:3,6,14,18 66:5 70:6 71:12 72:6 77:6,9,19,21 78:11,23 81:19 83:24 84:2,14 85:11,14,19 86:8,10,16,22
choice 80:8
choose 54:15 84:11
chose 62:13
circulation 7:14 9:3 12:12 77:22 78:13 93:23
circulations 8:6
circumstances 107:23 110:11
city 66:19 67:7 70:12,22 71:4,4 73:5,12 93:14,21
clarify 105:21 106:5 107:23 109:2
class 56:17 66:9
classes 18:6
cleaning 23:15
clear 10:10 14:8 43:8,23 46:18 52:9 84:18 92:3,4 98:2 103:15
clearer 6:8
clinical 40:18
clinically 71:20
clinician 122:13
clinician-friendly 116:13,14
close 33:20 118:18
closed 117:6 118:17
closure 117:3
cocks 89:18
cocktail 89:4
code 98:17 112:5
cold 71:23,24
collaborative 77:13 81:14
colleagues 30:21
collect 120:6
color 16:12
coma 89:4
come 8:14 12:3 18:9 25:17 30:5 30:7,15 31:4 45:14 59:10 63:17 66:19 78:19 97:16 98:9 98:18,19 99:8 112:10 114:3 115:4,10 116:5 121:9 123:15

124:17 125:18
coming 20:4 21:16 31:8 34:16 35:9 43:14 64:2 88:5 124:23
command 90:2
commenced 3:2
comment 8:9 16:11 19:17 30:22 51:19 56:15 71:16 75:11,11 80:13,14 81:21 103:21 123:4
commentary 90:16
commented 71:13
comments 4:6 6:15 8:25 9:23 10:2 13:19 17:2,10 21:3,19 22:11,15,19 34:11 35:21,22 38:21 50:13 52:4 56:7 64:15 71:11 73:4,21 77:18 92:15,17 93:2 95:20,20 110:7,7 114:2
commission 122:21
Commissioner 23:21 25:9 27:8 46:18 47:9,10 52:21 54:8,13
committee 1:7 47:12,13 67:9 70:12 71:9 72:19,24 95:16,19 96:5,9,12,20,20,24 97:17,19 97:25 98:6 99:13,13 101:8
committees 97:2
communication 122:22
community 29:24
company 30:20
compared 72:14
compartment 90:20
complaint 124:22
complete 115:20 123:23
completed 128:6
completing 116:24
complex 51:7 76:19 79:5,9,15 88:17,19
complexities 88:12
compliance 26:10 76:8
compliant 29:5,9
complicated 16:22
complication 36:23 39:16
complications 36:21 81:9 87:18 90:18
comprehensive 85:10,17
compression 7:16
compressions 7:11,17 9:8,16 12:13,19 82:11
compression-ventilation 17:6
computer 20:18
concentration 87:20
concept 20:21 48:12
concern 28:14 29:22 60:7,8 67:17,20 112:7,17,22
concerned 23:11 36:7
concerning 114:10
concerns 21:20 22:19 47:3 63:22 74:3 92:16 93:3
concluded 126:5
concrete 8:18
conditions 24:2
conduction 83:3
conference 6:23 100:2
conflict 113:18
confuse 71:19
confused 68:2 104:21
confusing 83:6,8 104:6 108:23
confusion 7:12 68:25 79:23 87:18 101:20
consensus 79:13
consent 117:17
conservative 27:8 29:4 30:4 67:16
consider 55:4 62:19 72:23 78:24 79:2 80:2,2,9 122:15 123:17
considerable 7:12
considered 37:22
considering 46:10,19
consistent 4:4 53:15 69:14 79:23 82:4 101:9,11 114:15
consisting 128:4
constituents 97:19
constitute 37:25
constructs 116:9
consultants 115:4
consultation 25:11
consuming 112:11
contact 69:24 123:11
contingent 124:16
continue 5:20 9:8 27:25 31:5 60:25
continued 77:24
continues 94:2 95:3
continuity 117:25
continuously 18:12
continuum 122:23
contradictory 71:7
contrary 44:14
control 25:7 65:20 66:2 87:9 92:19 93:25 95:8,9 99:25 100:4,11,19 105:2 106:2 107:5 108:9 109:5,9,17,19 111:7

112:14,16,20 113:6,7,11,24 119:18 123:11,13
controlled 26:15,19 27:16 29:8 32:9 81:4 108:2,4
convenience 106:22,24
conversation 96:15 114:10
conversations 28:6 32:24
convert 79:14
converted 79:9
cool 61:13
cooled 93:24
coolers 61:11
Cooper 15:9
copied 73:25
copies 19:4,7 59:19
copy 19:3,6,15 65:7 77:8,12 115:12
copying 26:13
coronary 69:20,25
correct 6:9 35:19,19 37:6,14 49:10 55:5 77:4 104:13 105:11 106:4,17 114:17,18
corrected 87:9
correctly 8:22
cost 111:12 119:7
Council 1:5 54:5 96:5
count 39:9 57:9
Country 51:22 81:3
County 51:16
couple 9:18 30:6 33:8 34:15 67:23 68:3 74:3,10 81:19 86:25
course 3:6 53:23
cover 77:17
coverage 106:9 112:8 113:4
CPAP 36:7,11,20 37:4,15 38:3,10 38:13 39:14,22 41:3,6 43:10 43:15 44:17 46:14,25 47:4 48:22 49:3 50:9 51:10,12 55:4 55:5 56:2 64:16 69:19
cranky 89:21
create 68:17,24
creative 25:2
credit 23:17 123:14
crews 69:10
crisis 43:20 92:6
criteria 75:9 82:25
critical 33:12 44:8
croup 84:22
cuff 43:16,18
cultural 121:25
culture 122:8 125:14
curiosity 38:22
current 49:22 55:8 60:21 66:9 69:17
currently 24:8 39:21 51:6 52:17 59:4,20 61:18 72:7 84:3 109:6 120:15
curricula 3:12,13 45:20 49:23 52:14
curriculum 3:13 16:10 22:8,9,23 35:24 36:4,9,9,17,24 37:5,18 42:2 43:9,14,14,17 44:21 46:23 47:25 50:5 52:25 53:16 53:17 55:13,14 70:7,8 86:2,11 92:10
curriculums 22:17
Cushman 2:3 28:13 54:3,9,14,17 61:20,22 62:8 63:22 79:24 81:15 115:24 117:19 118:16,19 121:23
cut 24:17
cycle 71:6
cycles 82:16,16,17 86:13
Czapranski 96:3
Czapranski's 96:12
C-care 6:6
C.C 35:23 36:3,9,16,17 37:16
C.C.s 55:9
C.F.R 22:16,24 70:7,7,10,23 73:6,7
C.F.R.s 68:12,14 71:4
C.M.E 123:11
C.O.P.D 68:3
C.P.R 9:18 82:9,14,15 83:6,9 118:11

D

Dailey 2:5 9:2 20:3,9 23:17 26:23 28:25 30:13,23 35:13,13 40:24 49:7 50:19 54:12 58:25 59:3,16,19 61:2,5,8 62:25 63:3 73:17,19 74:7,16,18,24 75:6,14,17 76:2,6,15,18 77:3 77:10,12 78:6,22 79:11,19 80:13 81:13 83:23,25 84:7 85:9,13,15 86:6,9,12,17,25 87:4 89:2,16 90:2,10,13 91:10 91:14,17,19 93:11,15,17,18 94:6,8 97:15 98:10,12 99:3,9

99:12,16,22 107:12 108:22 112:17 118:10 119:14 125:10
Dan 32:5
Daniel 2:14
dare 62:21
data 25:17 27:10 42:11 47:7 52:14 81:8 89:22 97:24 101:3 116:11 117:10,24 118:2
date 1:10 22:18 93:24 115:21 128:10
Davidoff 2:9 30:22 34:3,6 44:2 51:2 73:22 74:15,17,19 75:5 75:10,16,21
day 19:16 47:24 101:5
days 124:2
day-to-day 119:23
dead 12:6,6
Deavers 2:10
December 20:16
decide 46:11 99:21
decided 7:21 8:14 32:19
deciding 68:15
decision 40:24 43:16 70:14 81:11 113:4
decisionmaking 76:23
decisions 62:24 114:19
deeper 38:7 121:23
defer 57:23
defibrillated 10:7
defibrillation 9:4
defibrillator 11:2,3,9,10
define 11:21 48:7 53:5 75:8
defined 46:22 104:17,18
defining 49:19,20 53:3,6 101:23
definitely 9:4
definition 55:7
definitive 9:6
defunct 34:20
degree 82:2,3
Delagi 2:6 21:5,18
delayed 115:23 123:21
delaying 12:17
delays 21:16,17
deliberations 62:21
delineated 25:5
delirium 80:6,11
delivery 44:18 51:16 65:25 66:11
delta 118:4,6
demo 86:4
demonstrate 45:5 87:24
demonstrated 86:14 87:24
demonstrating 46:4
demonstration 38:9,13,16,19 39:21 40:7,23 41:3,10,20 42:9 43:6 44:4 45:4,9,24 46:3,11 47:25 49:6 52:18 53:20 54:10 72:20 73:3 88:22 94:7,8
departing 115:19
department 1:2 19:3,7 24:12 28:24 29:4,7 30:10 34:21 52:11 71:3 77:8 105:23 113:2 118:24 119:10,18,23 123:7
departments 120:23 122:2
department's 24:9 119:21
departure 115:22
depended 7:12
dependent 21:15
depending 8:7 13:16 68:18 89:7
depression 66:12 83:14,16
depth 7:25
der 6:23
designated 123:8
designee 52:22
despite 96:17
deteriorate 59:7
determinants 118:6
determines 118:4
determining 112:25
DeTraglia 2:10 32:5,13 33:19 34:9 42:24 43:2,11,18,25 108:7
develop 25:15 121:5
developed 89:20 99:25
developing 88:12
development 94:11
device 44:17,18 50:23 55:6 56:2
devices 55:7
devised 45:3
dextrose 87:15,20 88:6,10,13 89:14,23 90:24
diabetic 91:7
diastat 83:19,20 84:5,8
dichotomy 108:5
dictated 44:20,22 45:19
dictating 69:9
differ 10:17 37:18
difference 23:23 27:3 69:22 71:21 72:17
differences 24:4

different 15:5 40:20 41:14,15 44:16,17,18 45:5 46:7,23 57:8 60:11 62:16 63:23 74:15 80:3 91:20 107:13,22 108:23,24,25 109:24,25 115:11 119:14
difficult 39:25 41:11
difficulty 114:25
diligently 23:13
diltiazem 56:11 60:15 61:12 63:4,8,10 81:22
direct 25:7 95:8 100:4 105:2,25 109:18
direction 14:24 15:5 74:21 100:6,8,11,25 101:15 102:4,21 103:10 105:19 107:19 108:17 109:14,24
directly 97:17 98:18
director 24:5,11,21 26:6 28:21 33:4 37:2,8,9,10 50:11 90:16 100:17,17 109:19
directors 7:20 26:13 30:19 49:5 69:9 90:17
disagree 39:24 49:18 52:23
disappeared 116:3
discovered 14:3
discuss 8:17 22:13 29:14 31:25 40:4 98:20 120:18
discussed 4:3 7:25 27:13 40:8 63:5 90:14 109:14 110:3
discussing 3:23 18:18 86:19 96:7 110:4
discussion 5:5,16 7:19 10:24 19:23 20:13 28:19 45:23 49:8 55:16 59:23 69:8,13 73:20 74:12,24 79:18 90:12 91:5 95:7 105:15,18 108:21 110:20 112:15 113:20 124:6
discussions 18:22 31:24 59:14 88:15
disease 71:18
dismal 26:11
disposition 117:20
dispute 52:6,9
disseminate 63:17
dissemination 94:12
diverted 31:6
doc 24:16
docs 113:22
doctor 104:24 112:5 123:2,13
doctors 122:23
document 77:13 85:17 114:6 116:11,14,14 117:25 119:2,11 121:14,16,16,20
documentation 31:4,9 115:20
documents 8:13,19
dogmatic 26:13
doing 9:18 12:20 13:13 14:13,14 17:4,5 26:8 30:8 31:9,17 32:11,16,16,17 33:10 35:24 38:9,18,19 40:5 41:17 48:5 50:23 51:5 52:20 53:3 64:8 72:23 85:4 104:25 108:16 111:7 112:5,10 116:5 117:13
Donald 2:11
dopamine 91:25
dosage 60:14
dosages 59:14 60:19
dose 4:10 34:2 58:15 60:14 78:15 79:4 87:11 88:9 89:8,9 89:11
doses 4:9,14 63:8,14 68:22,23 76:6 79:2 90:5 92:18 103:7
dosing 74:4 87:10
double-edged 90:23
download 117:16,21
downloadable 124:21
downloaded 117:15
Dr 3:3 4:15,19,21,24 5:3,4,7,9 5:14,20 6:15,23 8:25 9:2,11 9:15,25 10:25 11:18,19 13:19 15:7,8,11,14,19,21,24 16:3,11 16:14,16 17:2,10,16,16,22,25 18:4,15 19:20,25 20:3,7,9,9 20:10,24 21:19 22:2,5,19 23:3 23:6 25:3,9 26:23 27:8 28:13 28:25 30:13,22,23 32:5,13 33:19 34:3,6,9,11,18,23,25 35:12,13,14,16,17,19,20 36:5 36:13,19 37:3,6,7,10,12,13,20 37:22 38:17,21,24 39:2,6,18 40:3,14,21,24 41:19 42:16,21 42:22,24,25 43:2,11,18,25 44:2,14 45:22,23 46:9 47:11 47:15,15,16,16,20 48:19,19,20 48:23,25 49:7,8,18 50:3,7,13 50:15,16,19,25 51:2,13,13,15 51:17,18,19,20,21 52:4,22,23 53:10,12,13 54:2,3,9,12,14,17 54:19,20,22,23 55:3,14,18,25 56:5,6,24 57:5,8,11,16,18,23

58:4,11,12,13,14,15,18,21,23 58:25 59:2,3,12,16,17,18,19 59:25 60:7,18,24 61:2,5,6,8 61:10,14,16,17,18,20,21,22 62:7,8,10,25,25 63:2,3,3,20 63:21,22 64:7,15,20,23 65:2,5 65:13,16,19,20 66:14,23 67:6 67:8,14,15,18,19,22 69:6 70:10,11,15,16,19,20,21,25 71:11,15,16 72:5,9,11,25 73:16,17,19,21,22 74:7,13,13 74:15,16,17,18,19,24 75:5,6 75:10,14,16,17,21 76:2,3,6,10 76:11,12,15,16,18,25 77:3,5,7 77:10,11,12,18,20 78:6,22 79:11,19,24 80:13,13,16,20,22 81:2,5,7,13,15,17 83:23,25 84:7 85:9,13,15 86:6,9,12,17 86:20,24,25 87:3,4,5,5,7 88:21 89:2,3,15,16 90:2,10,13 91:6,10,13,14,16,17,18,19 92:10,12,15 93:10,11,15,15,17 93:18,19,20,22 94:5,6,8,16,18 94:19,20,21,23,24 95:2,5,22 95:23,24,25 96:3,3,8,21 97:3 97:5,8,10,15,15 98:4,10,11,12 98:22,23 99:3,3,5,9,10,12,15 99:16,20,22,23 101:13,14,21 101:22 102:2,3,6,10,11,12,13 102:15,16,20,23,25 103:10,11 103:12,14,16,17,19,21,21,23 103:24 104:8,10,14,15,17,19 105:3,5,6,7,8,9,11,16,19,21 106:5,8,12,13 107:12 108:6,7 108:15,22,22 109:3,13 110:13 110:21 111:3,9,10,18 112:3,17 112:24 113:9 114:9,10,17,20 114:21,23 115:16,24 117:14,19 118:10,12,16,18,19,20,20 119:14 120:25 121:8,23 122:19 123:5,17 124:10,13 125:3,7,10 125:13 126:3
draconian 26:17 29:11
draft 23:15
drawing 44:19
dressing 70:24 71:2 73:6
dressings 70:8 71:10
drip 56:18,19,22 58:10 60:6,8 79:15
drips 78:16
drug 29:23 31:16 80:5,17 87:17 87:17,18,22 88:3 91:15 92:3,9
drugs 27:17 29:6,25 31:13 64:9
dry 68:13,14 70:8,24 71:2,9,16 73:6
due 83:3
dug 32:18
duplicate 99:6
duty 100:21,22 111:21,21
Duvall 2:11
D-fifty 87:16,25 88:14 89:6 90:19 91:4 92:24
D-five 88:18 91:20 92:7
D-five-W 91:9
D-ten 87:16,19,25 88:4,14,17 89:10 91:3,8,11,14 92:24 116:18
D-twenty-five 87:16
D.O 2:11,14,14
D.O.H 31:4,8,20 42:6 101:9

E

E 2:7,15
earlier 28:6 114:11
early 51:10 96:4
ease 112:19
easier 19:5 69:3
easily 91:4 104:21 120:9
East 33:7
eating 106:20
echo 47:20 118:4,6
echoed 63:6
echoing 47:17
edema 68:22 69:18 94:2
editors 87:13
educate 37:7 44:24
education 15:6 35:25 41:3 44:20 45:19 48:15 50:4 94:13
effect 80:10 119:6
effecting 119:19
effective 61:24 97:24 119:5,10 119:11
effectively 45:6
efficacy 46:4
efforts 66:11
eight 6:5,21 10:6 11:14 13:14 68:4,15 75:8
eighteen 12:18
eighties 15:21
eighty 83:6

eighty-one 4:24
eight-county 39:7
either 8:7 12:6 29:6 34:10 67:25 70:3 79:12 80:4 82:11 97:11 106:10
either/or 8:6
Elbow 33:7
electronic 19:6,15 25:18 115:2 116:20,23 118:3,10 121:19,24 123:6,18 125:24
electronics 19:5
elements 118:2 119:15,20
eleven 71:19
eliminated 68:23
EMA 7:20
emergency 1:5 43:21 94:13 100:15 111:5 113:2 119:18,21 119:23 120:23 121:16,25 125:16,25
emphasis 53:4 80:19
encourage 29:2,7 62:2 80:9 120:21,22 123:10 124:7
encourages 123:14
encouraging 23:21
endotracheal 50:4,9
ends 118:3
energy 11:13,17
Enforcement 23:14 26:25 29:15
enforcing 124:19
enhance 122:7
ensure 37:14 98:25
entails 122:24
enter 112:21 113:7
entertain 47:9 126:4
entire 43:14 107:4
entirely 27:23
environment 75:15
environments 28:15
epi 65:11,15 84:4
epinephrine 67:16
equipotency 87:25
equivalent 36:24
error 7:8 87:17 112:12
errors 62:2,8 92:3
especially 8:16 42:12 113:10 123:19
essentially 100:9
establish 25:19
Estimates 125:24
Etomidate 74:5 76:5,6 92:19
evacuation 51:23
event 68:15
events 67:17
everybody 3:24 9:11 41:23 69:3 69:4 114:7
everybody's 122:20
everyone's 4:15 47:17 119:3
evidence 8:23 76:21 77:24
evolution 46:21
evolve 99:14
exactly 8:15 19:11 74:16,18 79:21
exam 8:16 21:8
example 45:11 53:23 65:22
examples 120:17,19
exams 21:11,14
exceed 24:9
exceeds 100:13
exception 16:19
exceptions 111:17
exchange 120:11,24
exchanges 120:15
excited 80:6
exclude 110:21
excluded 30:20
excuse 42:24 94:9
exist 113:17
existed 121:15
existing 23:24 120:15
expand 24:7 53:13 72:17
expect 18:5 21:8
expectation 75:3
expected 15:14
experience 29:24 68:19 115:13
extent 25:15 30:17
extra 33:17 34:2 35:25
extravasated 91:2
extravasation 90:19
extreme 68:9
extremely 29:3 63:4 98:3 120:7
eye 85:4,5,6,6
e-mail 18:12 96:2
E.D 103:8 110:16 115:21 117:7
E.M.S 8:7 26:24 30:2 31:11 32:8 45:19 54:5 103:8,11 115:3 116:6,12 119:16,24,25 120:2 120:11,24 121:2 122:2,2
E.M.T 2:8 42:7,10 43:5 50:2 86:2,11 124:5
E.M.T.s 9:17 38:13 51:6 52:17

E.R 101:12 113:13,22
E.T 65:10,10,15,15 66:6 84:18

F

face 107:12 120:4
facilities 98:16 106:23 109:4 109:15 111:19 120:17,23
facility 105:22 106:18 107:4 108:4,9 109:13
facsimile 115:19
fact 31:25 33:6 41:10 46:19 77:23 96:18 109:4
fail 120:18,19
fair 32:22
fairly 25:23 42:12
Fantastic 70:15
far 60:12 101:11 106:13
farther 124:13
fasciotomy 90:20
fashion 27:5 116:25
faster 90:24
favor 17:18 21:22 22:22 30:25 51:11 54:23 55:20 64:18 73:11 93:4
favorite 53:23
faxed 117:7
fear 91:19
February 96:4
feedback 45:6 119:24
feel 12:21 38:2 72:4 124:17
feeling 8:20 13:12
feels 71:9
felt 4:2 64:4 88:8
femur 85:22
fentanyl 23:9,12,24,25 24:6,22 25:4,10 27:14 29:16,19,21 30:25 31:18,18 34:12 74:20,22 76:7 92:19 103:7
Ferris 1:12
fibrillation 56:14
field 100:4 109:7
fifteen 45:21 60:15 82:15 88:6 89:23 111:20 113:23
fifty 56:21 58:2,16,20,23 60:4 60:5 84:16 87:10 89:12,13,17 91:24
fight 4:16
fighting 90:22
figure 31:15 48:3 122:7
filed 115:9
fill 121:18,20 124:24
final 19:2,15 23:15 28:9,20 77:7,12
finally 18:23
finances 113:25
financial 120:7
find 46:2 67:22 75:12 115:17
finding 8:10,11
fine 13:20 30:18 33:19 47:8 55:12 68:11 71:10,24 73:3 93:18 104:10 106:21
finish 66:24
fire 71:3
first 3:11,22 4:10 11:8 12:12 12:19 13:24 14:19 34:16 45:2 71:22 73:22 87:8 98:9 101:18 104:11 108:19 109:11 119:20
fiscal 120:3
five 4:13 6:4,20 7:23 13:15,15 13:16 68:3,4 82:16 91:9 92:5 92:7 113:14 124:6
five-minute 66:18
fix 114:3 125:23
floor 8:22 9:13 17:21 18:3,5,10 18:14 20:16 21:25 23:2 46:7 50:14 53:25 54:10 55:4,12,13 55:17 60:14,23 61:4 64:19 72:9 81:3 88:20,23,24 89:12 89:25 90:5,7,8 92:11,14 94:25 106:4 111:25 112:6 116:16
flows 72:23 91:4
flutter 56:14
focus 122:16
folks 80:11 123:19,19
follow 20:21
followed 77:14 114:17
following 57:19
forced 88:3
foregoing 128:2,4
forever 89:9
forgotten 67:25
form 115:18 124:21
formal 115:20
format 20:19 35:3,5,5 45:16
forms 84:22
formulary 80:11,14,18 81:11 91:23
formulation 88:13
forth 7:4 51:4 59:15 62:2 101:12 122:9

fortunately 80:24
forty 121:9
forty-five 33:9 52:2
forum 29:14
forward 3:15 19:4 27:9 34:16 39:17 46:21 52:11 63:22 78:19 112:16 124:11
fought 4:17,22
found 13:3 14:14 26:10 44:12 87:22 88:4 89:22 120:25 125:23
four 4:24 5:10,11,15 50:19 68:22,25 69:3 70:2
fourteen 36:8
fractures 85:22,22
frankly 25:21 30:17 41:10 84:7 84:9 89:19 122:11
Freese 2:4 67:6,8,15,19 69:6 70:15,25 72:9,11 93:15,20,22
frequency 90:18
frequently 9:9
front 35:10 75:19 111:15,15
fruition 116:6
frustration 126:2
full 12:5,5 88:6 89:24
fully 119:2
function 59:7
functional 119:16
Funk 96:3,8
further 3:21 4:3,7 6:13 49:20 53:3,5 55:16 69:12
F.R 39:9

G

gap 119:5,7
Garden 1:12
Gary 26:8
general 33:11
generic 67:5
getting 12:7 28:16 30:2 89:6 103:5 105:4,9 107:8 109:5 113:12,12,14 114:25 120:4
gift 47:5
give 14:18 45:6 52:10 64:14 65:24 68:25,25 69:2 70:9 78:14 79:15 82:18 90:3,6 93:15 105:12,25 107:5,10,24 115:12 120:12 122:3 123:8,10 123:12,14,15 125:12
given 67:19 69:17 72:12,13,22 74:22 80:7,10 83:4 87:16 109:11 124:16
gives 21:11 47:10 54:16 124:21
giving 34:21 56:11 84:15 89:9 89:11 100:24 103:6 104:25 107:16,18 112:20
glad 85:11 125:23
glass 89:25
glucose 42:2
go 3:14,15 7:6 8:2 9:5 10:11 11:12 12:23 13:4,15 19:9,13 19:16,24 24:23 28:25 37:19 41:18 44:22 47:24,25 49:11,15 53:23 59:24,25 62:11 63:25 79:21 88:20 93:17 99:24 107:4 117:2,24 123:7 125:21
goal 91:14
goes 45:2 103:6
going 4:16 8:10,15 9:7,7,24 14:7,24,25 15:4,5,15 18:7 25:16 26:14 28:20 32:18,19 35:25 38:9,10,12 39:2,16 43:13 44:15 46:20 47:6,13,19 47:23,24 51:4 56:4 59:5 60:25 61:22 62:22 68:6,8,17,17,24 71:20 72:4 76:4 81:17 88:19 91:8,24 92:23,23 94:10,17 95:11 96:16 100:25 104:4,5 107:17 109:10,21,24,25 110:13 110:23 111:13 113:4,24 115:12 116:23 119:5 124:6,11,19 125:20
Goldfrank 89:5
good 8:23 16:5,12 24:25 26:11 26:19 27:10 28:24 30:25 40:9 47:5,19 48:12 71:11 73:25 74:6,14 75:24 76:21 80:5 85:17 90:4 93:19 96:21 114:20 119:25 120:2,14 122:16 124:10
Goodman 2:11 34:18,25 35:14,17 35:20 36:5,13,19 37:6,10,13 45:23 46:9 56:5 71:16 94:18 94:20,23 95:2 101:14,22 102:3 102:10,12,15,20 103:10 110:21
gotten 85:16 87:12 88:9 124:3
gram 88:7 91:2
grams 88:5,6 89:13,23 90:24
great 20:24 25:15 27:20 29:24 30:17 38:3,6 74:7 80:10 99:22 125:13

greater 32:14
great-distance 32:11
Gregory 2:15
ground 33:12
group 3:17 6:23 45:7 61:23 81:12 90:10 98:12,18,20,21 100:3 121:10 122:15,17,21
grouping 107:20
growing 125:15
guess 4:18 30:12 39:2 98:15
guidance 78:21
guideline 35:2 62:22,23
guidelines 3:7 4:23 7:13 18:18 18:24 19:12 20:14,19 21:23 22:8,23 29:5 44:8 57:19 58:16 58:17 60:22 62:12 77:23 82:9
gun 74:19
gurgely 90:3
guys 34:17 93:15

H

Haldol 79:25 80:5,9,21,23 81:4 81:9 92:20
half 45:24
hand 5:15 6:16 28:23 54:24 55:20 73:12 93:6
handing 118:25
handle 36:23
handling 29:6
handoff 118:23 119:11,11 121:6 121:6 122:24 123:16
handoffs 122:18,20,22
hang 88:17 89:12,12
happen 47:23 90:21
happening 44:25 117:6
happens 32:10
happy 20:22 66:3
hard 31:4,8 101:14
harder 118:8
harm 40:11,25 62:9 71:25
Harvard 122:22
hate 28:10
Haydock 2:12
head 14:2 28:11 48:14 85:6
heading 74:21
head-on 87:2
Health 1:2 24:8,12 116:7
healthier 11:16
hear 76:16 86:6 122:4 125:13
heard 45:23 122:4
hearing 110:9
hears 123:2
heart 3:7 11:15 17:19 18:17,19 18:24 19:11 21:23 22:23 44:3 82:3 83:7
hearts 11:16
help 34:3,6
helpful 59:15 70:11
Henry 2:5 41:19 44:14 47:20 50:16 51:17 89:3,15 96:4 112:24 114:23 121:8 125:7,13
Henry's 118:20
hereto 128:3
hiding 23:19
hierarchy 11:8
High 15:21
higher 32:22 43:22 94:3
highlight 100:7
Hilton 1:12
HIPAA 119:25
history 45:18 56:16 81:22 115:16
hit 71:5
hold 28:2,2 53:25 54:2 94:9,14 95:9
holding 84:8 86:13
home 43:4,19 71:22
honestly 24:20,23 29:22 30:20
hook 123:7
Hoosick 1:13
hope 24:25 75:17 92:2 96:10,14
hopefully 16:24,25 23:15 51:4
hospital 24:18 32:12 33:21 52:3 70:3,5 100:3 101:12 106:14 107:10,16 108:8,10 109:18,23 111:5 112:19 117:10,20,21,21 121:3 125:4
hospitals 32:7,9,13,15 33:8 100:21 101:4 106:8,14,16,16 109:16 111:12 112:7 116:19 120:5,11,13 123:21
hospital's 32:17
hour 33:22 41:24 45:13 52:2 106:9
hours 32:15,21 33:20,22,25 41:25 101:5 123:11 125:25
Howard 127:24 128:9
Hs 82:20
Hubbard 127:24 128:9
Huffman 47:15

Huffner 2:7 4:15,19,24 5:4 19:25 20:7,9 48:19,20,25 49:18 50:3,7,15 52:23 53:13 54:2,19,22 70:11,16,20 76:11 76:12,16,25 77:5 98:23 99:4 104:15 108:22 114:9,20
huge 12:19 74:9
hugely 23:21
human 25:23
hundred 3:25 4:25 5:2 15:17 24:9,17,18 28:7,14,18 39:7 54:19 56:21 58:2,18,19,21 61:19 63:13,14 82:10 91:9,24 92:5,7 93:24 106:15
hurdles 42:8
hyperoxia 14:15
hypoglycemic 88:8
hypotension 83:10
hypothermia 38:17 61:11 71:17 74:4,10 79:22 93:14,16
hypothermic 71:17
hypoxia 14:15
H.R 119:3

I

ice 71:23
idea 9:8 16:5 20:2 21:6 24:20 26:19 41:12 74:6,14 76:21 88:17 96:22 100:10
identified 118:2
identify 41:21 110:14 122:17
identifying 117:9
ignorant 32:8
III 2:15
imagine 111:22
immediate 94:3
immediately 7:16,17 13:25 14:13 21:10
immensely 34:4,7
implement 21:10
implications 72:21
important 9:3,9 27:2 31:5,13 54:4 63:4 64:4 98:3 115:25 118:23 120:3
improve 9:4
improved 27:11
improvement 88:2
include 16:16 18:20 19:9,14 48:22 49:2 83:15 84:24 97:19 102:8 104:15 110:23,24,24
included 18:25 55:6 77:22 95:15 103:3,13
includes 50:8 53:3,6 55:8 119:22
including 64:16 118:2
inclusive 59:11 128:5
inconsistencies 8:12
incorporate 35:2 76:13 114:12
incorporated 77:2
increase 24:13 32:20
increased 83:3 93:25
increases 39:12
increasing 61:25 62:6
independent 101:19 102:4,6,13 104:13 108:18
independently 50:24 108:3,25
indication 65:25
indicator 16:12
individual 18:19,22 49:5 50:10 63:15 80:6 86:12 116:15,16
ineffective 81:25
infant 10:12 14:4 16:17,25 83:5
infants 11:9
infinitum 120:18
inflate 75:18
information 5:25 25:19 52:14 63:17 98:24 116:8,20 118:9,22 118:25 120:6,10,15,16,24 122:12 123:4
informed 6:24
initial 18:7
initially 69:7,8
initiate 110:18
injuries 85:5,24
injury 85:4,6
Inn 1:12
input 100:2 116:20
inputting 118:13
inserted 72:12
insignificant 101:6
instance 84:21
institution 109:20
instructors 8:15
instrument 25:16 26:4
integrate 117:10
integrated 98:25 119:3 120:16
integrating 116:6
intended 60:10
intent 102:3
interact 123:13

interest 20:23 70:18 72:18
interested 77:15 95:3
interesting 12:16 48:6 81:10 107:25
interestingly 23:18
interfacility 33:10 35:8 95:13 95:14,14,17 96:5,11,18 97:22 98:5,8,14,17,18 99:18
intermediate 36:15,18,21 39:4 39:11 41:13,14 42:7,10,13,20 43:16 49:25 50:19 51:2,15,25 53:2,17 88:16 91:8,16 92:8
intermediates 38:3 41:8,21 50:16,18 51:24 52:17 53:8 55:9 87:19
intermediate-only 38:23
interregional 109:22
interrupting 7:11
intervention 76:24
introducing 38:2
intubate 44:15 50:12
intubation 65:11
intuitive 25:23
Int'l 128:7
invariable 21:7
involve 40:25 120:10
involved 30:19,21,24 37:8,11 59:14 89:18 112:10
involvement 37:2
in-depth 27:15
ipratropium 68:5 71:14 72:7,10 73:7
irregular 57:6 81:20
irrelevant 72:3 122:11
irrespective 116:2 117:5
ischemia 68:21
issue 6:24 24:3 27:19,24 51:25 52:12,20 62:17 66:5 68:17 69:13,14 70:6 84:10 96:16 100:3 106:22,25 109:8,13,17 113:9 114:24 115:13 121:21,25 122:19 123:17,25
issues 3:14 14:4,5 37:13 40:7 61:13 80:24 81:6 109:17 110:3 116:23 117:17
item 18:16 114:9
items 3:5 74:12 93:13 125:11
It'll 124:22
I.C.U 107:2
I.L.S 49:10
I.M 80:4
I.N 80:4
I.R.B 42:6,6
I.V 57:3 85:4,5,5,6,7 90:22 91:2,18

J

Jack 2:9 3:15 17:14 50:25 74:7 76:2 85:20 87:5
Jacobi 125:16
Jagt 6:23
JAMA 89:5
James 2:10
Jeff 41:8,12 45:9 53:9 61:20
Jeffrey 2:14
Jeremy 2:3 25:15 117:14 120:14 125:14
job 74:2 110:6
jobs 112:18
John 2:4,10 23:20 52:12
Johnson 2:12 8:9 9:23 10:13,16 10:20 12:4 16:6,10 18:7,11 20:4 21:13 22:16 28:19 31:23 36:14 37:17 38:8,22,25 39:4 42:5,18 43:8,13,20 44:6 49:11 49:15,24 50:5 54:16 57:15 101:8 106:21 114:18
joint 122:21
Joseph 2:15
Joshua 2:13
judgment 24:21
juice 89:25 90:3
jump 32:5
jumped 74:19
June 18:8 95:4
justified 46:12

K

Kauffman 17:16
keep 16:24 24:21 32:16 61:12 110:5
keeping 69:11
ketamine 29:21 30:11
kidding 23:7 30:14
kids 15:16,25 89:11
kilo 28:16,17 87:11
kilogram 60:16
kind 14:2,22 16:23 23:11,14 25:12 39:16 44:24 46:20 71:5 73:24 105:20,22 124:7

kinds 29:25
knew 14:23 32:25
know 12:2 13:25 15:15,16,19,24 22:12 24:16,16,19 25:24,24 28:14 29:10 30:6,11,12 32:25 33:2,2,5,6,7,8 37:25 38:3,5 38:20 39:25 41:3 42:3,5 44:18 45:11,11 46:3 47:4,6 48:9 56:18,22 57:19 58:6,8 60:9 62:4 65:14 67:2 68:9 69:2 71:21,23,25 72:9 76:17 77:16 80:7 85:19 88:21 89:3,8,10 90:6 96:8 104:7 105:22 106:19 107:14,20 109:11,23 110:15 111:8,23 113:3,6,22 114:5,23 114:24 115:4,6,13,25 116:22 117:13,22 118:10 120:17,18 121:4,7,8,11,13 122:14,14 123:3 124:8 125:21
knowing 109:21
knowledge 38:4 44:6
Kugler 2:13 47:15,16 51:13,15 51:18 103:21,24 104:10,17 118:20

L

lag 45:2
laid 75:24
Langsam 2:3 111:9,10
language 95:10 99:25 100:7 102:16 103:13 110:5,22,23 114:2,3
large 35:7 51:15,24 63:8 71:17
larger 30:24 31:13,22 88:9
largest 51:16
latest 67:19
latex 75:18
laws 101:10
lawyers 52:12
lead 106:3
leading 90:19,20
lean 120:7
learn 124:5
leave 8:2,21,24 9:24 10:3 42:17 42:18 68:11 69:10,12 71:9 76:22 102:18 104:6,8,8,10,19 104:20,20 107:24 115:19,21 119:10 121:2 125:21
leaving 79:21 118:24
Lee 2:6 23:10 26:23 33:14 48:20 52:24 96:8,8
Lee's 74:24
left 31:16 115:3,15 116:2 124:18
legs 66:19 84:8
Leinhart 2:13 74:13 80:13 86:20 105:21 106:5,12 110:13 115:16
length 88:11
letter 24:16
let's 4:8,25 5:19 6:14 13:5 26:11 43:11,25 78:23 95:2 97:5 125:10
level 1:12 4:10 16:6 18:21 26:5 26:6 31:25 32:22 35:23 36:7 36:11,15,16,17,18,21 37:4,23 38:10,15 39:5,22 40:17,20 42:7,13,20 43:15,22,22,22 45:5 46:4 49:16,17 71:14 72:7 72:15 73:8 88:16 91:7,8,16 109:10 117:2
levels 11:13 37:16 49:2 51:11 55:8
Lewis 2:9
liability 109:18
liberalization 29:2
license 103:4
licensed 101:19 102:4,6 103:4 104:3,13 108:18
lidocaine 78:16
life 19:5,12 20:11,12,14
lifolize 63:9
lights 5:9
liked 75:24
likes 72:19
line 13:9 21:13 53:19 75:7 76:19,22
lines 82:23
list 36:2 82:18
listen 12:21,25 125:19
listening 67:4
lit 5:15
liter 92:5
literally 102:25
literature 9:15,20 46:3
little 3:4,21 4:3 5:7 6:7,12,19 7:25 10:17 11:21 16:22 19:5 24:21 26:7 36:6 39:15 46:25 47:3,20 48:17 49:25 53:18,22 56:15 64:13 69:20 74:20 81:21 84:25 90:14 91:20 98:15

123:18
loaded 80:16
local 49:4
locally 21:10
LOCATION 1:12
locked 118:17
logic 52:7,18
long 4:11 18:22 21:10 24:15 30:18 33:16 34:7 35:9 41:22 45:12 47:8 61:2 84:14
longer 11:20 13:24 14:6,11 29:19 63:11 77:22 78:14,16
long-distance 31:12 32:2 33:10
look 3:9 12:20,23 21:2 27:9 28:24 34:10 36:12 43:9,13 44:22 46:2,10 48:15 52:15 58:7 81:10 84:22 91:22 92:23 101:2 107:21 108:19 114:8 115:2,17
looked 3:17 101:9,10 106:15
looking 12:23 18:8,13 21:14 27:21 40:5 72:22 87:24 122:20 122:20,22
looks 84:19
lorazepam 62:15
lose 123:3
lot 3:5 13:22 14:23,25 15:5 18:18 19:8 40:7 41:19 51:8,9 64:7 69:8 80:24 96:16 97:23 97:23 110:3 115:7 122:15 123:3 124:5
loud 63:6
loudly 29:7
low 15:21 39:15
lower 38:15 43:22 49:17 111:14
lunch 106:20
lung 49:25
L.I.P 104:12,18
L.M.A.s 44:15

M

main 116:23
maintained 4:12
major 35:3,3 92:22
majority 71:3
majors 92:25
making 29:18 68:9 70:3 79:8 83:8 88:14 107:21 117:5
managed 69:23
management 29:3 48:21 49:2,19 49:21 50:8 52:25 53:6,16 76:7
managing 69:17
mandate 119:9,12
mandatory 16:8
manpower 124:20
manual 11:8,10
manuals 8:14
March 1:10
marginally 27:22
Mark 2:5,8 115:17,24 119:17 125:10
marked 12:14
Marshall 2:9 3:3 4:21 5:3,7,9 5:14,20 6:15 8:25 9:11,25 11:18 13:19 15:7 17:2,10,16 17:22,25 18:4,15 19:20 20:10 20:24 21:19 22:2,5,19 23:3,6 34:11,23 35:12,16,19 37:3,7 37:12,20 38:21 39:18 40:14 42:22,25 45:22 47:11,16 48:19 48:23 49:8 50:13,25 51:13,20 52:4 54:20,23 55:3,14,18,25 56:6 58:11,13,15,18,21,23 59:2,12,17,18 60:18,24 61:6 61:14,17,21 62:7,10,25 63:2 63:20 64:7,15,20,23 65:2,5,13 65:16,19 66:14,23 70:19,21 71:11,15 72:5,25 73:16,21 76:3,10 77:7,11,18,20 80:16 80:20 81:2,7,17 86:24 87:3,5 88:21 91:6,13,16,18 92:10,12 92:15 93:10,19 94:5,16,19,21 94:24 95:5,22,23,24,25 96:21 97:3,5,8,10,15 98:4,11,22 99:5,10,15,20,23 101:13,21 102:2,6,11,13,16,23 103:12,16 103:19,21,23 104:8,14,19 105:5,7,9,16,19 106:8,13 108:6,15 109:13 111:3,18 112:3 113:9 114:21 120:25 122:19 124:10 125:3 126:3
mask 41:4 43:5 46:25 86:13
MAST 75:11,12,15 85:19,20 86:20
master 43:15
MASTs 92:20
material 44:3,5
materials 18:9 21:16 76:20 94:11 128:7
matter 77:23 102:8
maximum 68:23

mean 11:6,23,23 12:20 15:5 29:20 35:25 44:18,20 45:8,8 46:25 58:6 59:13 60:6,10 61:8 62:13,14 66:2 68:7 83:21 89:3 90:5 101:16 102:7,21 104:5,12 104:18 105:24 112:24 121:4,24 122:20 125:15,23
meaningful 25:15,19 30:7,16
means 32:20 35:14,17 81:5 100:12
meant 75:20
measure 46:12 72:22
measuring 72:20
meconium 82:7
med 66:2 80:10 112:16
medical 1:5,7 7:20 24:4,11,20 25:7 26:5,13 28:21 29:24 30:18 33:12 37:2,7,8,10 49:5 50:2,11 65:20 69:9 70:12 92:19 95:8,9 97:12 99:8,25 100:4,11,17,17,19 103:10 105:2 106:2 107:5 108:8 109:5 109:9,17,19,19,24 111:7 112:14,20 113:6,7,11 115:8,9 115:14,19 116:15,20 117:11 121:16 123:11,13
medication 32:12 61:13,24 62:2 62:20 64:4 83:23 84:2 92:2
medications 31:6 32:3,14 59:14 60:20 62:6,14 63:19,24
medicine 34:3,6 47:22 125:16
meds 33:18,21 62:15
meet 60:21 86:25
meeting 1:7 3:2 38:11,12 47:12 51:5 59:7 66:22 69:11 75:8 95:12 114:7,11 126:5
meetings 18:23 20:18 29:15
meets 100:13
member 97:24
members 97:19
memo 115:18
mention 82:15
mentioned 37:9 39:19 76:4 81:16 81:20 83:13 85:20 87:15 109:20
mentions 92:12
merge 41:12
merged 42:11
message 112:4
met 20:17
method 65:12 66:6
mic 94:21,22,24,25 95:5
Michael 2:5
microgram 28:17
micrograms 24:10,17,19,24 28:7 28:14
microphone 5:11 111:15
microphone's 5:9
mics 87:10
midazolam 62:15
middle 31:15
midstate 32:6
mid-level 112:9,14,18 113:5
Mike 23:17 25:14 76:12 82:18 90:7
milder 84:22
milligram 4:25 28:16 57:3 63:13 63:14
milligrams 3:25 60:15,16,17
milliliters 89:17
millions 43:4
mind 7:3
mine 67:14
Minnesota 46:5
minor 7:5 67:10,23 83:12 86:23
minute 57:3 124:6
minutes 4:13 7:22,23 8:5,21,24 9:6,12,13,24 10:2,3 33:9 43:5 45:12 47:14 52:2 82:16 124:6
missing 43:2 64:9
misspelled 7:9
mistaken 92:5
mistakenly 71:19
mix 9:19 68:10 69:10 70:19,20 70:21 73:6
mixed 68:10
mixing 68:5
mls 92:7
models 120:14
modify 75:2
MOLST 118:3,10
monophasic 11:2
month 45:14
months 27:15
moot 48:22
Morley 23:20 25:3,9 27:9 52:12 52:22
morning 3:3
morphine 70:4
motion 17:24,25 22:4 23:5,6

48:25 49:7 54:19,20 55:2,4,24 55:25 56:3 64:22,23 73:15 80:17 93:9 126:4
move 4:6 12:2 14:20 15:3 19:21 58:9,22 70:4 76:6 78:4 87:2 92:19 95:2 114:22,25
moved 5:25 19:4 45:4 50:14,15 78:25 97:21
movement 48:7 87:15
moving 18:15 22:6 23:9 27:5 40:19 43:21 48:16 49:16 52:19 52:24 88:15 115:10
multidose 63:18,18
multiple 62:15 63:23 86:15
Murphy 2:4 123:5
Myers 2:14 16:11,14,16 51:19,21 53:10,12 56:24 57:5,8,11,16 57:18,23 58:4,12,14 59:25 60:7 61:10,16,18 63:3,21 65:20 105:3,6,8,11 109:3 118:12,18
mylar-encased 91:25
myocardial 68:21
M.D 2:3,4,4,5,5,7,9,9,10,12,13 2:13,15,15
M.F.I 74:11

N

naloxone 65:8,9,15,25 66:10
name 56:19 57:13 124:21
Napping 111:24
Narcan 83:13,13 94:6,6,8
narcotic 103:17
narcotics 23:14 26:25 29:15 108:13
Nassau 51:16
national 48:7,15
nature 27:8 29:23
nebulized 72:13
necessarily 40:14 46:17 51:23 118:5
necessary 24:22 108:8 114:14
necessity 24:12
neck 47:2
need 3:5 5:4 13:8,12 14:7 17:17 19:9 24:24 31:22 33:6,21 34:20 43:6 46:2,6,10,14 47:24 48:3,4,11 49:5 64:5,6 65:24 66:25 69:21 75:2 80:12 82:8 84:10 86:3 88:21 92:7 103:14 110:4,24 112:22 114:16 115:12 119:9 121:15
needed 7:24 8:17 91:11
needs 7:5,9 41:22 44:11,23 45:11 82:7
negative 79:12
negotiated 28:5
NEMSIS 116:11
neodecompression 36:22
neonatal 65:4,8,16 82:4,12
neonate 15:15
neurologist 115:4
never 7:3 28:11 116:17 117:8 123:2
new 1:2,4,13 10:17,21 20:17,20 21:9 27:10 37:22,23,23 38:2 38:15 42:14 43:14 44:2,4,8 46:7,9,22 47:7 48:10,15 49:20 51:21 52:16,24 66:19 67:6,20 70:12,21 71:4,6 73:5,11 76:13 82:5 85:23 93:14,20 94:24 101:3,4 102:8 106:8 114:8,21 117:15 124:16
newborn 13:21,23 65:11
newborns 66:12
newer 10:25 123:19
nice 23:8 94:5 124:11
night 39:15 43:4
nine 11:14 68:16 71:19 72:2
nines 70:10 71:7
nineties 15:21
ninety-four 15:22 16:2
nine-thirty 47:12
nitrates 69:18,18,18,20,20,21
nitro 4:9 83:22 84:3
nitroglycerin 68:20,23 69:16
nitros 70:2 78:25
nobody's 124:23
Nope 4:6
normal 7:7 13:10 82:6 98:11 115:5
normalcy 89:2
normalized 89:23
normally 57:25
North 51:22 81:3
note 38:8 81:24
noted 34:23
notes 85:9,9
novel 20:2
nuisance 29:11

number 32:22 33:15 57:9 74:8 80:3 101:6 128:5
numbers 39:12 40:9,13 42:14
numerous 8:12
nurse 100:12,13,22 101:16,17,24 101:25 102:8,14 104:3,3,23,24 105:6,10,13,14 106:10,17,18 106:19,23,25 107:4,9,14,15 108:16,17 110:10,16 113:13,15 113:16 122:25
nurses 110:18 122:4,23 125:25
N.P 106:7 109:10
N.P.D.S 118:4

O

o 68:3,4
object 101:18
observations 69:5
observer 121:14
obstructed 14:7
obstruction 84:20
obstructive 82:7
obviously 74:20 118:7
occur 9:4 63:25 94:2 120:13 121:6
occurred 13:22,23
occurring 103:8
October 21:14
odd 108:5
office 26:8 117:8
offline 114:10
off-mic 9:14 60:14,15,16,17,23 94:18,20,23
Off-the-record 5:16 59:23 73:20 79:18 90:12 91:5 105:15,18 108:21 110:20
oftentimes 122:12
oh 5:7,13 6:25 26:11,19 57:10 76:3 86:10 112:3
okay 4:8 5:14,24 6:18 7:10 9:12 10:3,5,24 13:5,8,20 17:2,10 17:14 18:15 21:4,22 22:22 23:9 34:15 35:12 37:3,20 42:21,23 43:25 51:13 52:4,5 53:11 54:2 56:3,10 57:10 60:18,25 61:17 64:15 65:2,19 66:16,23 67:6,15,18 71:15 72:25 73:11 75:5,10 76:10 77:6,8,9,11 78:23 81:2,7,17 81:18 84:11,16 85:14 86:16 87:7 91:13 92:15,17 93:2,4,12 93:19 95:7 96:21 97:3 98:4,5 98:7,22 99:20,22 102:2 104:8 113:25 114:3,7,20 125:9 126:3
old 10:14 25:13 93:13 114:21 124:2
older 11:2
Olsson 2:14 10:25 15:8,11,14,19 15:21,24 16:3 37:22 38:17,24 39:2,6 40:3,21 42:16,21 67:14 67:18,22 70:10 80:22 81:5 124:13
once 79:9 88:12 124:8
ones 4:11 64:12 76:18 92:25 100:24,25 107:22
ongoing 6:6 79:7
online 25:17 95:8,8 99:25 100:4 100:10,16,17,18 105:2 110:18 112:14,20
on-site 110:14,16
open 77:14
operating 109:25 111:4
operationally 24:22
operations 119:18
opportunity 3:8 71:6 106:19 120:5
opposed 17:22 22:2 23:3 48:8,17 54:25 55:21 56:6 58:18 64:20 69:19 73:13 91:18 93:7
opposite 117:24
option 49:2 52:11 58:9,10 65:21 66:2 72:17 78:3,5,20 79:8
optional 53:2 69:10
options 24:18 92:20
orange 89:25 90:3
order 3:4 74:20,23 94:15 107:15 107:16,18,24,25 108:13 110:11 112:4 113:15
orders 23:25 24:7 25:5,10 27:6 27:7 103:7 104:24 105:6,13 107:10 109:7 110:18,19,22,24 111:2
organization 34:20 116:8
original 103:12
originally 87:23
outcome 41:20 42:3
outcomes 9:5 45:10 53:22
output 116:11
outside 40:12 44:7,12 46:11 47:7 99:2 118:6

overall 30:16 73:23
oversight 30:4,16
ownership 96:17
oxygen 14:12,14,20 15:3,15 16:18 44:18

P

P 2:8
pack 71:23
packet 35:7
PAD 22:17
pads 75:15
page 36:2,8,8 56:10,24 57:2,8,9 57:15,16 65:3,7,19 82:19,21 82:21,24 84:16 86:8
pages 128:5
pain 25:12 29:3 38:2 47:2 76:7 87:9
painful 39:19
painfully 37:24
PALS 83:11
Pamela 2:4
paper 19:4,7 116:2,3 121:7,18 121:24 122:6,11 123:9
papers 124:7
paperwork 29:9
paragraphs 108:24
paramedic 22:17 36:16,24 37:5 37:15,18 39:10,12 47:4 50:20 51:3 60:7 65:22,23 91:7 110:25 111:2,4,5,7 125:17
paramedical 31:12 44:7
paramedics 55:9 89:20,21 90:14 125:16
parent 84:8,12
parents 84:9
part 7:2 13:7,25 33:24 40:24 46:23 50:24 53:16,17 61:12 76:23 115:8 118:23 120:3 122:23 123:17
participants 41:5
participated 122:21
participating 59:6 77:15 95:3 120:23
participation 99:3
particular 28:22 46:24 62:17 80:6 101:21
particularly 11:9 13:11 26:18 32:6 50:21 51:21 59:8 72:14 75:14 117:19
partnering 40:22 94:10
partners 23:13
pass 67:2 86:23
passive 117:9
patches 10:8,8
patient 4:5 7:22 11:20 12:9 14:17 25:18 27:3 30:25 31:14 31:17 40:16,25 44:23 56:16 62:8,19 63:15,21 65:24 69:23 70:18 71:17,25 72:4,18 79:14 80:5 81:22 86:15 90:21,24,25 91:3,22 92:6 101:2 107:17 108:11 109:10 114:25 115:2,15 115:22 117:10,20 119:23 122:9 122:16,17,19 124:15 125:3,5
patients 9:10 25:5,9 27:4 28:15 33:15 41:4,6 43:19 51:9,12 69:24 72:16 75:7,9 81:25 82:2 84:17,20,20 88:5,18 89:2,23 90:8,10,11 93:24 97:21 109:6
patient's 116:15 117:11
pediatric 10:8 11:11 25:9 75:7 75:9 82:12,14,25
pediatrics 6:18 13:11,12 75:4 76:8 92:19 100:3
peds 75:12
peek 72:23
pelvic 85:21
Pennsylvania 51:6
pens 84:4
people 3:17 5:10,11 6:8 29:5,8 29:23 32:17,25 39:14 43:3,3,4 44:14,16,24,24 45:11 48:9 89:9 100:18 114:25 115:3 121:9,10,11 123:5 125:9
people's 50:17
percent 15:17 16:2,18 68:13,14 68:16 71:19,20 72:2,2 94:3 101:3 121:9
percentage 70:9 72:16 123:12
perfectly 71:24
period 19:17 44:21 67:9 70:8 93:25 117:4
permission 118:5
permitted 23:25 117:16
personally 47:4
personnel 100:5
perspective 21:6 117:3 118:8 120:2
pertain 19:12 21:23 22:9

pertains 119:22
pertinence 50:21
petition 28:23
pharmacists 23:18 25:3 30:6
pharmacy 32:17
Philadelphia 33:16
phone 70:3 100:23 112:11
phonetic 32:5 63:9 83:11
phrased 67:11
physical 121:7
physician 24:20 25:11 58:9,10 76:23 78:3,5,20 79:8 100:5,6 100:8,11,12,12,21 101:5,16,16 101:16,18,23,24,24 102:14,21 102:21,22 103:2,2,4 104:2,5,8 104:9,11,12,12,20 105:23 106:2,6,9,10 107:18 108:10,17 109:6 110:16 111:2,11,17,20 111:21,22 112:8,9,18 113:3,5 113:5,11 117:22 123:14
physicians 94:13 101:15 105:25 111:14 122:4 125:25
physician's 78:21 104:2 110:11 117:22
physician/medical 33:4
Ph.D 2:3
pick 67:12
picked 116:16
piece 32:4 47:2 103:18 121:7,18 121:24 123:9
pilot 37:25 46:6
pilots 45:25
Pittsburgh 33:16,19
place 4:13 6:2,6,21 13:7 82:11 83:16,17 89:7 90:6 121:8 125:6 128:3
placed 9:7
places 60:5 105:25
plan 18:7 33:5,9,11,17 71:4 76:7 125:6
please 6:16 56:24 57:11 92:18 95:6
pleased 79:20
podiatrists 104:16
point 14:18,21,25 27:7 34:25 39:13 46:20,21 60:16 63:3 66:3 69:21,25 71:2 80:15 84:13 88:24 95:20 96:19 108:25 114:11 115:12,14,25 118:20 123:12 125:18
points 9:15 120:14
poke 30:12
policy 23:16,23,24 24:10 30:11 95:10 113:19 120:25 121:5 125:3,8,23
political 70:13
poll 61:19
polymorphic 57:7
pool 40:6
populated 116:15
population 13:24 94:4 101:12
portion 95:18 97:18
position 67:19 107:25
possibility 111:18
possible 9:9 96:9
possibly 19:6
post 78:12
postconversion 79:5
potential 40:25 79:2 87:17
potentially 90:23 119:16,19 120:22
practical 21:8
practice 9:6 38:18 42:19 43:10 43:12 44:7,13,21 46:22 48:8 48:11,17 72:18 108:13
practiced 52:17
practices 98:24 120:21 122:17
practicing 124:2
practitioner 100:12,22 101:17 101:19,24 102:5,7 104:3,13 106:11,18,24 107:15 108:18,18 110:17 113:6,13,16
practitioners 102:8,13
predetermined 125:5
predict 11:14
predominance 51:23
preexcitation 81:23
preexcited 56:13
prefer 5:3 11:6 66:4 77:16 109:8
preference 102:19
prefers 8:8
prehospital 18:21,25 19:13 20:19 21:24 47:5 49:3 56:22 57:20 69:17 81:9 95:19 100:23 100:24 107:11 109:11 110:12
prehospitally 80:19,21
premature 16:17,25
premixed 92:2
prepared 128:6

prescribe 108:3
prescribed 48:17
present 30:20 47:7 52:16
presented 17:20 64:11 93:5
preserved 31:7
pressure 4:12
presumed 69:19
pretty 15:24 25:8,22 26:12,17 26:20 43:18 52:5 74:9 100:9 101:14
previous 72:12 88:8
previously 35:5
pre-hospital 113:24 115:8 116:9 121:2,17
primary 17:8 83:3 107:16 112:8 112:9 116:18 117:22
printer 123:6,8,8
prior 9:4 65:24 67:25 93:25 115:22
probably 13:17 18:8,13 21:14 32:20 39:2,8,14 51:9,16 69:21 75:21 80:5 85:15 95:19 98:21 125:14
problem 16:23 20:7 33:15 34:23 113:21 123:20 124:25 125:24
problems 14:15 56:16 80:23 107:12
procedure 48:18 51:8
procedures 24:3
proceed 36:25 40:22 99:21
process 37:19 41:11 64:2 86:13 98:11,25 99:6 109:5 112:19,20 112:21 113:8 114:16
produce 121:20
professional 100:13 101:17,25 102:14 104:23
profile 72:14 80:10
profusion 6:25
program 41:9,13,13,13
prohibited 63:16
project 38:9,13,16,19 39:22 41:11 43:6 44:4 45:9 46:3,12 46:17 48:2 49:6 51:5 52:18 54:10 72:20 73:3 88:22 94:7,8 124:12
projects 40:8 42:10 45:4,24 53:21
prolonged 51:22
prophylactic 77:25
proposal 103:9
protocol 3:14 10:14 17:12,12 19:17 20:2 24:6 34:16 38:18 50:21 57:11,13 59:3,4,20 61:2 62:23 67:7 68:12 69:15 79:3 79:25 80:16 81:14 84:21 85:23 91:6,7 114:16
protocols 3:10,11,12,17,18 16:22 17:19 18:16,21,25 19:10 19:14 20:4,22 22:7 25:6 28:2 34:15 35:2,7,8 40:4,22 44:22 44:23 56:7,8,20 59:20 62:11 63:24 64:10,16 67:11,25 69:23 70:23 73:12,23 74:9,11 75:2,3 76:13 77:13 78:18 82:5 86:20 87:4,9 92:17 93:5 96:19 98:8 98:8,11,13,17 99:6,7,11,14,18 109:23 110:2 114:13,15
prove 52:18 124:18
provide 15:3 31:22 32:9 36:2 51:12 71:24 100:10 109:17 112:14,16
provided 109:21 124:20 125:4 128:7
provider 40:20 68:6 107:3,8 110:12,15,16 116:18 118:24
providers 15:2 41:14 79:23 83:8 100:23 110:19 112:18 118:9 119:24 120:6,24 122:2,3 124:17
provides 95:8 100:4
providing 9:18 26:3 31:3 100:18 109:14,18
provision 33:17
provoke 96:15
prudence 120:4
pull 40:3,21 72:19 73:7 117:24
pulling 72:25
pulmonary 68:22 69:18 94:2
pulse 7:6 12:8 13:2 57:14 58:5 60:2,3
pulseless 7:8 79:15
pulses 13:2,10,14
purposely 103:24 125:15
purposes 16:14
pursued 91:12
push 71:7 120:12
pushing 89:18,19
put 20:19 43:5 50:3 64:5 71:23 72:8 75:6 78:19 81:24 82:25 99:23 102:7,13 114:5 123:6

putting 7:10 45:16 46:25 52:7 107:9 111:14
P.A 100:22 104:3 106:6,18,20,24 106:25 107:16 108:17 109:9 110:16 112:16 113:13,16
P.A.D 22:9,24
P.C.R 116:2,3,23,24 118:13,14 118:16 119:12,22 121:20 123:3 123:18 124:25
P.I.A 121:11
P.S.A.P.S 111:6

Q

qualities 80:7
quality 31:14 88:2 117:2 120:2
quantities 31:13,22
quantity 51:24
quarterly 25:16,20,21 26:4,10 27:13,21,21 29:10,11,17,18,21 30:11
question 11:19 18:3 21:7 27:12 38:14 41:22 54:17,21,24 55:17 55:18 74:7,10 86:3 108:7,12 108:13,15,19 114:23 117:14 118:20
questions 26:22 34:11 37:3,20 67:10,10,12 109:22 110:8,9 115:3
question's 55:3
quick 5:6 10:9 11:19 47:11 93:16
quickly 42:12 59:10 70:4 87:2 91:3
quiet 125:19
quite 25:21 29:11,22 46:13 85:7 89:21 122:11
quits 58:3
quote 89:4
quote/unquote 64:3
Q.A 47:12,13
Q.I 88:24 89:16

R

radio 111:16
raise 5:15 6:16 54:24 55:20 73:12 93:5
ramifications 70:14
range 3:23 89:6
rare 65:21
rate 5:25 6:9 13:10 39:16 83:7 94:3
rates 17:4 93:23 94:4
ratio 17:6 82:10
ratios 82:14
reactivate 96:10
read 10:9 25:22 108:24
readily 48:5 107:2
reading 7:13 84:21 101:23 102:25
reads 102:15
ready 38:11,11 95:4
real 24:3 26:2 27:24 30:3 47:18 112:23
reality 48:12 112:19
realize 54:3
really 3:19 5:13 8:17 11:4 12:4 24:21,25,25 26:3,19,24 27:2 27:20 28:6 29:25 30:3 40:9,13 41:7 47:21 51:11 52:16 53:21 58:25 59:10 71:6 72:3,21 73:23,25 74:6 75:16,24 78:9 85:16 87:2 96:25 99:16,17 106:19 107:21 108:12 115:25 116:5 118:22 119:19 120:20 122:7
real-time 118:14
reason 63:23 65:24 69:22 91:10 101:21,22 122:13
reasonable 28:14 29:13 41:2 78:6 97:14 98:21
reasons 80:3 111:13
recall 18:23 45:18
receive 25:10 109:10
received 4:5
receives 108:11
receiving 100:23 101:2 107:17 108:8,10 109:6,20 125:4
recess 66:21
recognize 9:3 33:6
recognized 66:6
recommend 15:20 16:3 55:25 56:14 60:19 66:13 72:25 98:5 101:18 104:22,22 105:12
recommendation 11:6 19:10 56:17 62:23 67:3 79:7,7,12 97:11 104:11
recommendations 9:22 18:19 57:24 59:12 64:10 81:19 84:25
recommended 17:11 65:9,10 66:11 78:14,17 82:20 83:14 109:14

recommending 14:10,12,16 16:18
record 25:18 28:25 76:12 115:5 115:8,9,15,20 116:15 117:11 117:23 124:15 128:5
recordkeeping 119:21
records 34:21 114:25 115:2 116:20 117:17 123:6 124:14 125:4,24
recoup 53:21,21
redefine 48:21
redefining 50:7
redundant 103:24,25 104:6
reference 15:9 16:3 56:11,12 70:6
references 86:21
reflect 122:12
reflective 21:9
refute 77:24
reg 52:7,8,9 54:4
regard 23:24
regarding 44:5 45:23 68:5
regardless 122:5
regards 15:14 110:23
region 19:8,13 32:7 35:6 37:16 38:9,18,19,24 39:8 40:5 50:21 51:4 62:18 77:7,15 78:20 80:20 87:21 95:4 106:23 109:25 112:2,6,15 114:13 116:4,24 121:12
regional 18:16,21,25 25:6 26:5 55:6 99:10 109:16,16 114:16 116:7,25
regions 19:2 20:17,20 21:2 35:6 58:7 62:11,14,23 64:7 77:14 78:3 96:18 114:11
registered 100:13 101:17,25 102:14 104:23 105:6,10,13,13 106:25 107:4,9 110:10 113:15
regs 115:7
regulating 29:24
regulation 32:8 33:2 43:23 46:18 47:10 49:12,15 53:15 100:6 111:19 113:19
regulations 39:20 43:24 101:10 112:25
regulatory 30:4,9 48:13
related 35:22 83:2 84:17 122:16
relatively 91:3 116:13
relay 104:24 110:11,18 112:4,4 112:12
relaying 105:4 107:15 110:22,23 111:2 113:15
REMAC 34:19 56:4,7,7 61:6,8 64:3,10 67:4,5
REMAC's 64:15
remain 29:3 120:8
remaining 64:12
remember 8:22 49:24 67:11 68:2 82:19 86:2,4 89:4
remind 6:8 20:10 31:20,21
REMO 20:4 66:19 73:17 93:4,14 95:4
remove 6:3 29:8 65:15 74:14 76:4 81:11,13,14,17 82:5 92:18
removed 66:14 76:3 80:17
removing 80:2 86:20 92:20,20
REMS 34:17,19,19
repeat 46:17 76:6 92:18
repeated 74:4,17
replaced 112:18
replacements 75:21
report 25:20,21 27:15 30:7,10 30:11 54:15 63:12 96:11 97:17 116:9 117:21 121:2 122:3,5 123:2,9,15
Reporter 128:9
Reporters 128:6
reporting 25:16 26:4,11 27:11 27:13 29:10,11,17,21 97:12 98:6
reports 27:21,22 29:18 74:5
representation 97:20 98:2
repurposed 116:10,13
request 76:8 95:13
requested 19:2 96:4
require 25:7 36:17,23 38:15 42:6 51:8 70:16 113:3 118:6 121:2
required 26:9 51:12
requirement 24:2,8 29:12,13,17 30:9 100:16 115:15 119:21
requirements 19:17 29:9 100:14
requires 48:13
requiring 69:24
Rescue 33:7
research 12:17
residencies 125:17
resident 103:2,3 104:5 107:18 112:8

residents 68:15
resolved 121:13 122:10
resources 40:6 94:15
respirations 12:18
respiratory 6:10,10 7:3,4 66:12 83:14,15 84:17
respond 14:13
responds 39:11
responsibility 98:16
rest 20:21 59:6,11 85:3 86:22
restored 13:10
restraint 80:2,4,12
result 71:17 96:2 97:22
results 45:14
resumed 66:22
resuscitation 65:8,17 66:11
resuscitative 16:14
return 13:9,14 77:21 78:13 93:23
returned 7:6
returns 6:25
reversals 88:9
review 3:8 35:11 54:6 60:19 67:9,22 87:4 97:2
reviewed 35:12,15,18 44:10,12
Reviewers 73:21
reviewing 23:21 76:20 98:13
reviews 74:8
revise 95:11
revolves 92:9
rewrite 110:14
re-devise 47:25
RHIO 116:6,10,12 117:15,25 119:3
rhythm 78:8,12 79:15
rhythms 56:13 81:20
right 9:5 10:23 12:23 16:13,15 17:15,17 18:12,15 21:13 22:6 23:9 25:8 35:14,17 42:16 45:3 51:13 55:19 57:16,22 59:7 62:7 65:13,18 66:16 71:2 75:19,23 78:11 79:3,20 84:2 89:8 91:23 99:9,15 102:18 103:10 105:5,7,20 106:12 108:16 110:7 113:9 117:23 123:9,10
risk 9:17 61:25 62:8 112:12
RN 103:5,6,8,13,20 105:25 107:24,25 110:11,24
RNs 108:13
Robert 2:6
robust 116:7 119:4 120:2
Rochester 116:7 117:13 119:4
roll 18:5
rolled 37:15
rolling 48:16 63:24
room 14:19,19 39:14 59:5,9 66:11 79:14 111:5
rouse 12:2
routine 14:10,12 43:19
routinely 83:4
rubber 75:19
rule 16:19 33:11 70:10 71:7
rules 39:20
run 23:16 71:22
running 121:19
runs 33:16
rural 24:15 28:23 32:2 75:15 100:2,20 101:4 106:16 109:15 109:15,15 113:10,20
R.O.S.C 79:5

S

s 67:19 112:16 116:3,23,24 119:3,22 121:11 123:18
sacrificing 23:17
safe 9:16 72:17
safely 27:18 31:7 45:5
safer 86:15
safety 27:10 46:4 62:19,20 63:21 70:18 72:13 81:15 84:10 92:9 97:7 122:15,16,19
saline 91:24
saturation 15:15
saving 111:13
saw 67:10 88:16
saying 12:7 14:6 29:2 58:6 84:11 118:12 122:10
says 11:7 24:16 32:8 54:4 66:10 68:7 70:8,17 77:23 84:17,18 85:6 104:2
scenario 107:21
scenarios 108:23 113:17
schedule 64:3
scope 42:19 43:9,11 44:7,12 46:21 48:7,11,16 72:17 98:23 108:12
se 119:12
second 24:7 47:21 49:7 60:5 82:2 108:12,15 119:24

seconds 6:4,5,20 12:18 13:3,14 13:16 14:20 124:22
secretary's 117:8
section 6:2 13:6 32:8 57:14 82:12 100:14
security 110:6
sedation 74:11,17
see 4:8 5:17,19 6:14 7:8 8:15 10:10 13:6,7 21:11 26:11 28:7 41:5,6 42:14 47:5,5 57:14,20 59:4,16,20 71:20 78:23 86:17 101:22 111:12 120:9,10
seeing 21:4 64:18 93:4 107:9
seeking 36:20
seen 38:17 56:19,21 59:3 60:4,4 60:6,11 63:12 90:15,18 116:17
sees 113:14
seize 90:7
seizing 90:9,11
SEMAC 26:8 36:15 54:15 96:23 97:11,17 98:2,6,7,19 99:20,21 113:19 114:19 119:16,18 120:12,21 125:8
semantic 54:4
semantics 54:3
semi-annual 26:10 27:22,23 30:10,18
SEMSCO 1:5 2:1 3:1 4:1 5:1 6:1 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1 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 96:22 97:1 98:1 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1 121:1 122:1 123:1 124:1 125:1 126:1 127:1 128:1
send 19:2,6 20:25 77:7,12 85:10 85:11 92:23 114:4,6
sends 24:16
sense 30:5 43:7,8
sensitive 109:3
sent 115:6
sentence 13:18 94:2
sentences 93:22
separate 96:5 99:2
separated 120:10
separately 22:13
series 46:22
serious 26:20 121:25
service 24:5,6,11,13 26:5 29:16 32:10 33:4 49:5 51:16 109:20
services 1:5 25:17 26:12,18 27:17 30:8 31:3,8,21 33:11,12 33:14 36:25 61:14 94:12 100:15 109:16 113:10 120:10
services's 25:22
service's 50:10
session 59:5
set 18:17 36:22 37:23 40:2,4 41:15,16 46:14 60:8 96:5,9 97:6 99:13
setting 7:20 19:13 21:24 28:23 49:3 56:22 57:21 81:9 96:19
settings 107:13
seven 68:4 94:3
seventy 83:10
seventy-one 86:8
shake 28:11
share 20:22
Sharon 2:8 3:15 11:19 17:14 56:9 77:4 84:7 86:7 92:21
sheet 66:25
sheets 120:4
shifts 48:4 113:3
shock 9:17 85:21,24
shockable 78:8
shocked 22:21
shop 122:25
short 69:11
shortage 63:4 87:23
shortages 63:25
short-term 66:8
show 12:17 24:11 40:15,16 59:18
showing 40:11
shown 11:13 40:18
shudder 46:20

sicker 121:10
side 31:11 38:8 47:20 80:10
sign 66:25
significant 97:21 101:6,6
sign-in 66:25
sign-out 124:4
silver 92:3
similar 79:4
similarly 81:23 83:10
simple 16:24
simpler 68:17
simplifies 80:14
simply 48:21 71:8 72:15 116:20
single 77:13 87:20
site 106:2,6
sites 110:19
sitting 111:7
situation 43:21 92:8 105:3 121:17
situations 112:13
six 6:4,5,21 13:14 20:16,19 27:15 28:7,17 116:16 118:2
sixty 83:7,9
sixty-eight 65:3,5,5,6,7
sixty-three 65:19
size 101:12
skill 36:22,22 37:23 38:2,15 40:16,19 41:15 43:22 45:4 46:4,24,25 49:16,20 52:16,19 52:24
skills 21:8
skipped 13:6
slapping 124:23
slash 85:6
small 40:12 72:3,16 92:4 107:16
solution 122:6
somebody 35:15 44:10 46:12 71:19,21 102:21 112:12
someone's 104:4
somewhat 96:7
soon 7:10,15,18 8:3 43:15 118:16,16
sorry 33:22 34:5 35:16 36:14 57:12 58:25 61:20 73:24 86:7
sort 42:2 44:25 45:17 48:8 76:21 119:9
sound 53:21 92:22 97:14
sounds 12:25 67:14 88:23 90:3
south 40:12
space 116:4
speaking 21:5 63:7
specialty 31:11
specific 22:11 24:2 110:10 116:10 121:3 123:6
specifically 16:12 53:7 104:2 111:11
specifics 115:22
speechless 22:21
spell 83:16
spelling 7:8 32:6 63:9 83:11
spend 125:25
spending 12:8
spent 18:18
spirit 69:11
spoken 42:6
spontaneous 77:22 78:13 93:23
spontaneously 14:17
spot 124:13
squad 33:8 103:11
squeezing 86:14
stable 81:20 82:22
STAC 97:19 98:3 123:21
stacked 123:21
staff 112:25 113:24 115:21
staffing 112:19
standard 43:19 69:17 111:15 114:14
standardization 96:17 99:17
standardized 27:15
standards 1:7 48:15 70:12 86:18 97:12 99:8,13
standing 23:25 24:6 25:5,10 27:6,6 74:20,23 96:20
standpoint 40:6,19
start 14:9 25:24 27:21 75:19 111:13
started 12:24 66:23 124:2 125:17
starting 7:16,16 12:2,2,3,19 90:22 116:5
starts 62:6 83:9
state 1:2,4 3:10,13 8:16 19:15 21:11 22:23 27:11 32:15 35:6 36:11 44:4 46:8,9,22 47:7 54:5 63:12 71:8,8,18 72:13 74:8 80:18,19 81:11 96:4 101:3,4 102:9 106:8,16 113:18
stated 128:3
statement 11:20 23:16
states 51:7 52:14 90:17 100:9

statewide 17:12,18 19:25 20:6 20:14 22:8,9 62:22
State's 85:23
statutory 48:13
stay 18:11 101:11
stellar 53:22
step 47:20 67:16 117:4
steps 4:12 69:8 114:14
stepwise 27:5
stick 62:5 70:24 71:2
stimulate 70:4
stimulation 14:18
stock 32:19,20
stood 86:4
stop 75:7 76:7,18,22 89:18
Storm 2:7
story 125:19
strain 26:2
straws 44:19
Street 1:13
stress 53:5
Stretch 66:18
stridor 84:23,23
strike 34:18 66:3
strong 8:20
structured 91:23
structures 120:16
struggle 31:15
student 8:14
students 21:12
studied 87:22 88:11
studies 86:15
study 37:25 88:2,12,25 89:16
stuff 48:10 122:16
subcommittee 97:11 98:2,7
subject 54:7,11,12
submission 115:23
submissions 26:9
submit 19:15,21 118:15
submitted 73:24
subsequently 104:18
substances 26:15,19 27:16 29:8 32:9 81:4 108:2,4
substantive 67:23
substitute 64:4,6 74:15
substituted 63:9
substitution 88:3,14
substock 24:7,9,13 28:8 30:24
substocks 24:22,25
successfully 42:12 46:13
suction 14:6 15:3 82:5
suctioning 13:24 14:2,10
suffer 63:5
suffering 51:9
sufficient 14:20
Suffolk 95:3
sugars 89:6
suggest 64:13 70:16 76:21 78:4 79:8 83:8 97:15,16,18,25
suggestion 83:17
suggestions 21:19 92:21 95:21 110:8,14 114:4
supply 32:14
support 19:13 20:12,12,14 21:6 77:24 97:10
supports 9:20
supposed 115:9
suppression 74:6
sure 4:4 8:4 20:11 28:4,8 36:10 50:11 54:14 60:12,20 61:18 62:11 63:7,17,18 72:22 73:19 77:4 83:19 85:7 117:3,5 125:10,11
surgery 43:3
surprise 14:22
surprising 13:23
surveillance 30:17
survival 94:4
swallow 90:2
sweat 25:3
switch 30:18
sword 90:23
symptomatic 83:15,15
symptoms 122:10
syndrome 69:20 81:23 90:20
syndromes 69:25 121:12
Syracuse 33:19
system 40:2 89:19 116:6 117:9 118:7,19 119:16 120:2,4 121:19
systems 95:16 96:12 97:12 110:25 115:11 123:22
S.P.O 16:7

T

tablets 4:25
tachycardia 57:13 59:25 76:19 79:6,9
TAG 3:16 8:10 44:11 95:14,14,15 95:20 96:10,11 97:7 98:6

Takats 2:15 87:6
take 3:4 8:21 10:9 29:4 31:16 33:17 34:7,23 41:22 47:20 49:9 52:15 66:18 88:19 95:5 103:19,20,22 104:4,7 105:16 108:8 114:14 123:18 124:22 125:12
taken 20:18 33:15 65:9 66:21 128:2
takers 17:13
takes 123:2
tales 89:3
talk 3:11,16,18 5:11,12,14 26:7 33:23 67:6 74:4 95:13 124:5
talked 7:15,19 61:23 96:8 100:16
talking 5:10 6:24 39:8 43:21 47:18 48:14 52:2,12 53:7 103:5 105:22 107:14,14,15
taped 70:2
taught 15:2
teaching 8:15 14:25 84:13 125:15
teamwork 122:8
technically 38:15 111:4
technique 48:17
technologies 48:10
technology 39:25 40:18 47:22,23 48:4 120:16
telemetry 69:24
tell 26:14,14 30:8 45:12 125:18 125:19
telling 88:7
temptation 15:16
ten 5:2 13:3 36:8 43:5 45:12,20 47:12 68:13,13,16 72:2 82:16 88:5 89:11,23 124:6
tend 30:21
term 63:10 101:18
terms 3:10 22:7,23 30:4,16 36:20 40:11 45:2 50:20 81:15 99:17 121:5
test 21:9 25:22
tested 41:5
tests 53:20
thank 17:14,14,16 18:2,14 20:24 21:18 22:5 23:6 26:24 28:18 30:13 35:20 36:5 47:16 55:19 56:5 63:20 72:5 75:25 77:5 86:10 93:10,11,19 94:5,16 114:20 126:4
thanks 66:20 73:16 76:2,10 86:24 93:18 95:5 126:4
therapeutic 61:10 74:3,10 79:22
they'd 51:17 111:23
thing 3:22 5:7,24 9:2,9 11:8 12:13 13:5 14:10,11 19:6 30:12 42:3 48:6 63:3 64:8,25 65:14 66:8 71:12,22 72:6 78:23 79:4,24 84:15 85:20,25 86:19 87:14,18 99:24 109:11 124:4
things 4:16 6:22 18:12 27:12 35:22 36:3 39:16 41:14 46:23 61:23 62:16 63:5 67:23 77:19 78:16 83:12 85:22 86:22,23 87:8 90:15 101:8 120:9 125:20
think 4:21 9:2,5,6,25,25 13:6 13:16,22 14:23,23 16:8,11,23 17:3,6,8,8 19:3,8 20:24 23:22 25:16 26:18 27:2,3 28:4,13 30:24 32:10 34:13 38:3 39:18 39:19,22 40:2,14,17,19 41:19 42:9,11,14 44:17,24 45:25 47:17 48:3,14 49:6 51:9,17 52:20 53:4,14 57:8,18 62:14 62:17,21 63:6 64:7 69:6,11 70:25 71:12,24 72:2,11,20 73:25 74:14,19,22,25 79:3 81:10 82:22,24 83:7,16 84:9 84:12,14,16 85:8 88:21 89:10 93:12 95:9,17 96:21,22,22 98:3 99:5,7,12 101:14 102:3 102:16 103:12,20,24,25 104:3 104:10 105:21 106:5,21 107:22 110:21 112:13,17,19,21,22 113:21 115:14,17,18,24 116:22 118:21,21 119:2,4,9 120:11,13 121:15,23,25 122:5,7 123:17 124:3,10 125:13
thinks 44:10
third 82:3 93:25 120:3
thirty 14:20 19:4,7,16 39:3,4 84:16 124:22
thirty-day 67:9
thirty-eight 82:19,22
thirty-four 16:17,18
thirty-nine 82:24
thirty-plus 42:13
thirty-seven 82:21 93:24

thirty-three 67:13,20,24
thought 3:24 7:24 25:3 30:3 39:17 46:20 48:23 69:16 72:12 75:23 89:9 96:12 99:7 103:13 112:21 113:8 115:11
thoughts 20:3,9 50:17 51:5 95:17 97:13 98:4 102:23
thousand 24:24 111:20 113:2,14 113:23
thousands 43:3
three 3:25 5:3 6:20 13:16 17:5 32:15,21 33:20,22,22,25 34:15 41:25 56:17,21 58:2,18,19,21 63:13 66:9 67:10,10 68:12,21 77:14 78:25 79:2 82:10 93:22 107:13,20,22 110:15 119:14,20 120:9
three-hour 5:4
throw 9:19 31:10 38:5
thrust 99:12
tie 85:15 119:15
till 123:23
Tim 96:3,7,12
time 1:11 5:12 12:8 15:19 18:18 19:3 21:13 29:2 34:14 35:9 42:4 47:22 53:14 55:8 66:3 73:2 78:15 89:17 92:6 112:5 112:11 115:5 117:4 119:6 121:12 122:10 123:18 125:5 128:2
timeframe 121:3
timely 116:25
times 4:17 11:14 51:23 74:10 104:24 116:16 117:3 120:7
timing 71:5
Timothy 2:12
title 56:6 100:14
today 48:5
tone 83:3
top 41:16
topic 22:6
total 88:18 89:11
totally 9:16 15:4
tough 72:21 111:3,5
town 40:12
toxicologists 89:5
track 124:20
tracked 116:25 118:7
train 43:5 45:12
trained 48:9 50:12,12
training 36:24 37:5,14,23 38:4 39:15 41:9,16,23 49:4 51:8 55:10,11,11 71:6 86:12 96:17 100:17,18 101:11 125:16,17
training's 55:12
transcription 128:4
transfer 32:11 35:8
transferred 124:15,15 125:5
transfers 32:2
transitioned 35:4
transitions 122:8
transplants 82:2
transport 31:15 32:14 33:25 86:9 95:18 96:6,11 98:6,18
transported 116:17
transporting 33:21 39:9
transports 24:15 31:12,12,12 32:2,21,22 33:8,10 34:7 95:15 98:14 99:19
trauma 85:6 92:8 97:22
Treanor 2:7
treat 44:24 68:13,18
treatment 14:12 21:24 80:8 85:21,24 119:7
tremendous 73:23 118:8
tried 44:22 101:10
trouble 68:15
trousers 75:12
Troy 1:13
true 16:15 59:18 97:8 123:15 128:5
truly 107:10
Trust 37:25
try 12:25 13:2,2 38:10 47:19 71:6 109:2 110:13
trying 5:17 25:18 31:15 46:12 101:9 113:18
Ts 82:20
tube 50:4 84:18
tubes 50:9
tuned 18:11
turn 89:14 94:21,22
turned 25:14
twelve 68:16
twenty 5:2 45:18 60:15,16,24 82:10 106:15 113:2
twenty-eight 68:12
twenty-five 3:25 60:24 87:10 88:6 89:13,24 90:24 91:2 101:3

twenty-four 5:3 56:10 57:2 101:5 106:9
twenty-two 125:25
two 4:11 7:22 8:4,21,24 9:5,11 9:13,24 10:2,3 16:7 20:17 24:3,9,16,18 28:14 39:7 41:14 42:9 61:19 62:13,16 64:6 82:2 82:15,16 87:7 89:12,13 91:24 106:15 108:24 113:3,5,22 125:11
two-person 82:15
type 37:13 82:2 98:24
types 97:2 110:15
typewritten 128:4
typical 15:24
typically 116:3
typo 85:8
typographical 87:8
typos 87:11 92:21

U

Uh-huh 5:8 10:15,19 16:5 65:18 77:20 91:17 94:19
ultimately 119:15,22
underlying 71:18
understand 27:7 30:2 102:10,12 125:24 126:2
understanding 77:3
undertaken 37:14
unfortunately 42:18 89:20
unlicensed 107:18
unlimited 69:4
unresponsive 57:7
unstable 82:23
unusual 13:22
unwitnessed 7:22 8:5 9:12
update 18:12 93:16
updated 21:15 35:9 55:13,15
updates 12:10 93:13
uploaded 119:6
upper 49:16
Upstate 51:21
urban 24:18 28:15 113:21
use 8:3 11:10,12 24:6,21 27:16 29:3,24 31:8 36:16,20,23 37:18 38:13 39:14,25 41:23 43:10 44:15,16 45:7 49:3 56:20 57:25 71:24 72:3 78:15 79:25 80:23 81:5,9 83:2
useful 25:19 26:4 27:22
uses 118:5
usual 35:21
usually 40:10 56:20 57:20 60:3 84:8
utility 27:13
utilized 31:7
Utilizing 34:3,6

V

vagal 83:3
vague 8:12,18
valuable 59:8 89:22 97:24 118:24 123:4
Van 6:23
vasoactive 91:25
vendor 116:10
vendors 115:10 116:12
ventilate 6:4 66:12 82:8
ventilating 6:9,9
ventilation 5:24 7:7 13:10 17:5
ventilations 12:18 13:13
ventilator 86:9
venturing 38:7
verapamil 61:3,7,9,15
verbal 110:18 124:4
Versed 80:4,22
version 23:19,20 28:9,20 63:10
versus 5:2 11:2 62:13 69:6,7 71:16 93:25
veterinarians 104:16
vetted 98:20
viable 120:8
vials 63:18
view 108:25 115:14
visits 111:20 113:2,14,23
voice 63:7
void 116:4 118:22
volume 35:10 88:18
volunteer 39:11
volunteers 95:23
vote 5:23 17:17 20:5 22:13 36:17
voted 66:17

W

wait 5:22 8:14 12:24 18:9 27:25 94:14
waiting 89:18,19 94:9
wake-up 26:18
wake-ups 116:18

waking 89:2
want 3:16,18 4:2,24 5:14,20 8:4 9:13 10:9 20:5 23:10,16 25:9 28:3,7,11 30:22 31:24 34:25 36:12 37:18 39:13 40:15,16 45:25 47:20 53:20 60:9 61:8 62:13,16 67:6 68:11 69:2 73:2 73:18,18 78:24 79:2 81:24 82:9,13,25 93:15 99:5,21,24 117:13 118:11 122:3,4 125:21
wanted 7:21 8:2,2 28:22 35:10 36:25 45:7 58:9 60:12 74:13 76:16 78:4 87:14 122:13
wants 33:23 45:15 78:20 115:4
wasn't 8:18,23 42:3 44:21
watch 112:22
water 71:23
waters 38:7
way 7:25 8:7,21,23 10:11,13 11:4,6 14:8 37:17 39:20 40:2 45:3 47:23 48:3 60:10 68:18 84:18 86:19 91:23 98:16 102:24 104:20 108:23 123:24 124:19
ways 117:9 122:7
week 116:17
weeks 16:17
weigh 52:21
weight-wise 11:15
went 3:7,10 70:7 80:22 101:11 112:15 115:6
weren't 38:11 63:8
west 123:22
western 42:13 117:15
wet 68:13 71:16
we'll 3:9,9,9,11,11,14 6:16 9:25 10:3 13:20 20:22 26:7 32:20 34:7,17,23 40:22 52:15 67:2 69:12 70:23 73:7 75:6 86:20 95:11 99:20,21,21 104:7 110:5 114:3,5,6 115:17
we're 4:16 9:22 12:20,21 15:4,4 17:4,5 18:8 20:21 21:14 23:7 24:10 25:13,16,18 26:3,3,20 28:19 31:18 32:18,19 33:14 38:2,6 39:8 44:19,19 46:12,14 47:18,18,21,22,24 48:5,16 49:18 50:7 51:3,4 61:11 71:2 71:5 72:22 74:21,21,25 104:21 107:13,14,15 109:4 115:10 117:23
we've 4:10,17,21 8:11,13 12:14 19:4 20:17,18 23:13 25:14 26:12 30:5 32:19 33:15 38:17 42:7 45:3,17 48:8,8,9,13 59:13,14,16 60:11 61:2,23 78:2,18 80:23,24 81:6 85:16 90:15 93:24 105:24 117:13 121:11 124:3,20
wild 24:23
William 2:7
willing 25:8 81:13
wind 103:6
Wisconsin 46:6
wish 114:12
withdraw 42:16,17
withdrawal 42:17,22,22 66:7
withdrawn 42:23
withhold 41:7
withholding 27:6
Wives 89:3
wonder 68:24 74:5
wondered 56:20
wondering 38:6 68:16
word 11:23 26:11 34:18 47:10 104:12
wording 6:3,7,19 10:5,9,16 64:13 68:4 84:25
work 24:5 33:20 41:9,11 50:17 72:12 95:10 101:14 109:4 110:4 115:7 120:20 124:9,11
worker 115:8
working 20:21 23:13 25:14 26:3 26:25 27:25 30:6 93:18,20,22 94:25 103:4 110:5 112:9 113:13,16 117:23
works 24:19 117:9 118:19
worry 68:6
worse 31:14
worth 68:9
worthwhile 3:24
wouldn't 20:7 46:16 50:23 69:3 98:19,21 103:22
wound 4:22
Wow 22:21
wriggle 53:18
wrist 124:24
writing 25:2,2
written 21:9 33:5 57:4 74:22 75:3 98:17 125:6

wrong 45:3 55:5
Wronski 115:18
wrote 89:6
W.P.W 56:14 81:23

X

X 117:20,21,21

Y

Y 76:19 79:5,9,15
yeah 5:22 7:2 9:21 12:4 18:11 28:4,17 29:20 33:14 37:12 39:18 44:2 54:22 57:16,18 59:2 60:24 61:16 62:7,10 63:20 64:7 65:6 71:15 74:19 77:20 79:19 80:20 81:8 89:15 95:2 97:3,9 99:11 102:6,6 104:19 105:16,19,20 107:8 109:13 112:4 114:3,22 125:13
year 45:24 80:17 87:23 111:20 113:14
years 15:2 45:18,20,21 54:19 101:7 115:25 116:5
Yedidyah 2:3
yesterday 28:21
Yes-ish 76:15
Yes/no 106:6
yield 89:22
York 1:2,4,13 10:17,21 20:17,20 27:10 42:14 44:4 46:7,9,22 47:7 51:21 66:19 67:6 70:12 70:21 71:4 73:5,11 85:23 93:14,20 101:3,4 102:9 106:8 117:15 124:16
young 2:15 9:15 10:12 11:16,19 102:25 103:11,14,17 114:10,17 117:14 123:17

Z

Zeek 2:8 33:14,24 34:5 95:22,24 96:2,25 97:4,6,9

0

0801 124:14

1

1 128:5
10 100:14
10:17 66:22
11:38 1:11 126:5
12180 1:13
126 128:5

2

2005 10:17 18:16,17 19:11 66:9 114:19
2010 3:7 12:9 21:23 35:2 44:9 60:21
2011 1:10
235 1:13
28 98:16
29 1:10

3

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 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 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1 121:1 122:1 123:1 124:1 125:1 126:1 127:1 128:1
30 95:15 98:13,15
33 26:15

4

405 103:16 104:21
405-Bs 119:17 120:12,22
40519 100:14 101:10 102:17

8

8:36 1:11 3:2
80.75 33:24

9

9:58 66:21
9501 95:11 100:5,9