9/16/2026 – SEMAC Meeting – Troy, N.Y.

NEW YORK STATE
EMERGENCY MEDICAL
ADVISORY COMMITTEE MEETING

DATE: September 16, 2026
TIME: 11:30 a.m.
CHAIR: Donald Doynow
LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

Reported by Danielle Christian

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APPEARANCES:

Albert Shih, Finger Lakes REMSCO
Amy Eisenhauer
Arthur Cooper
Brian Clemency
Brian Walters
Chris Fullagar
Daniel Olsson
David Afienko
David Kugler
David Violante

Donald Doynow, SEMSCO CHAIR
Donald Duvall, Jr.

Donald Hudson
Doug Isaacs
Erick A. Eiting
George Stathidis
Howard Huth
Jason Winslow
Jennifer Goldman
Jerry Rubano
Jonathan Berkowtiz
Jonathan Washko
Kathleen Hallinan

Kirby Black
Maia Dorsett, Monroe Livingston REMSCO

Mark Hennessy, Deputy Director DOH
Mark Papish

Mary Ann Portoro
Michael Dailey
Michael McEvoy
Michele Forness
Naveen Seth
Richard Brant
Robert Crupi
Ryan Greenberg, Director
Steve Kroll
Theresa Allen, Secretary
Tiffany Bombard

Timothy Egin

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(The meeting commenced at 11:30 a.m.)

CHAIR DOYNOW: Welcome back everybody back after the summer, I hope everybody had a good summer. If you do speak, if you please state your name for the people who are doing the transcriptions, it'll make things much easier. If I can have everybody stand for the Pledge of Allegiance.

ALL: I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one Nation under God, indivisible with liberty and justice for all. Thank you all. Theresa, if we can have a roll call.

MS. ALLEN: Sure. Dr. Afienko?

DR. AFIENKO: Afienko, here.

MS. ALLEN: Dr. Berkowitz?

DR. BERKOWITZ: Here.

MS. ALLEN: Dr. Black?

DR. BLACK: Black, here.

MS. ALLEN: Dr. Bombard?

DR. BOMBARD: Bombard, here.

MS. ALLEN: Dr. Clemency?

DR. CLEMENCY: Clemency, here.

MS. ALLEN: Dr. Coates Dr. Cooper?

DR. COOPER: Here.

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MS. ALLEN: Dr. Dailey?

DR. DAILEY: Here.

MS. ALLEN: Dr. Dorsett?

DR. DORSETT: Here.

MS. ALLEN: Dr. Doynow?

CHAIR DOYNOW: Here.

MS. ALLEN: Dr. Goldman?

DR. GOLDMAN: Here.

MS. ALLEN: Dr. Gomez? Dr. Hallinan?

DR. HALLINAN: Here.

MS. ALLEN: Dr. Isaacs?

DR. ISAACS: Here.

MS. ALLEN: Dr. Kugler?

DR. KUGLER: Present.

MS. ALLEN: Dr. Olsson?

DR. OLSSON: Olsson, here.

MS. ALLEN: Dr. Papish?

DR. PAPISH: Here.

MS. ALLEN: Dr. Weybridge? Dr. Rubano?

DR. RUBANO: Here.

MS. ALLEN: Dr. Seth?

DR. SETH: Here.

MS. ALLEN: Dr. Shih?

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DR. SHIH: Here.

MS. ALLEN: Dr. Walters?

DR. WALTERS: Walters, here.

MS. ALLEN: Dr. Winslow?

DR. WINSLOW: Here.

MS. ALLEN: Aiden O'Connor? Mary Ann Portoro?

MS. PORTORO: Portoro, here.

MS. ALLEN: Mike McEvoy?

DR. MCEVOY: McEvoy, here.

MS. ALLEN: Steve Kroll?

MR. KROLL: Kroll, present.

MS. ALLEN: And John Washko?

MR. WASHKO: Washko, present.

MS. ALLEN: And I didn't hear Dr. Afienko.

DR. AFIENKO: Here.

MS. ALLEN: Here. Okay. Thank you. We have quorum.

CHAIR DOYNOW: Excellent. Thank you. Can we have someone to make a motion for approval of the main minutes? We have one. Go ahead. We have a second? All in favor, raise your hands, please. Anybody against? Any abstentions? Okay. That

passes. All right. Ryan, if we can have the division report.

DIRECTOR GREENBERG: Sure. The first thing in the division report is an introduction. I would like to introduce the Assistant Deputy Commissioner, Dr. Eiting.

DR. EITING: Good morning. My name is Erick Eiting, and I joined the Department of Health two months ago in July in my new role as Assistant Deputy Commissioner in the Office of Health Care Delivery. I'm really excited to be part of this.

I am an emergency physician by training, trained in the Bronx Med School in Brooklyn. So I've been all over New York City, also spent some time working at Rikers Island doing some work with E.M.S. and trying to transport patients, which was really exciting work. And I also served as the Medical Director at Mount Sinai Beth Israel for seven years before that hospital closed.

So very excited to be here and be part of this discussion. And I'm looking forward to being able to -- to meet many of you throughout the day and throughout the meeting. Thank you.

DIRECTOR GREENBERG: Thank you, Doc.

All right. So some just quick updates on things, and then we're going to do one presentation. Actually, let's start -- is Amy at the table yet? Oh, just couldn't see her. Okay. Amy, why don't we start with Vital Signs and this year's E.M.S. award winners?

CHAIR DOYNOW: You're muted.

MS. EISENHAUER: Okay. Here we go. So, thank you, Ryan. For everyone, obviously Vital Signs is coming up in Niagara Falls November 10th through the 14th. The E.M.S. awards and innovation awards will be awarded Friday morning, Friday the 13th at nine thirty in the morning. So if any of you are there, please feel free to join us.

So for this year, I'll read off the award and then the recipient. So for 2026, the Basic Life Support Provider of the Year is Robert Lunde. He's from the Westchester REMSCO. The 2026 Advanced Life Support Provider of the Year is Michael Pugh. He's from the Midstate REMSCO. New York State E.M.S. Agency of the year is Pittsburgh Ambulance from Monroe Livingston. The New York State E.M.S. Educator of Excellence is Gene Iannuzzi from the Westchester REMSCO.

Excellence in E.M.S. Quality and Safety is Drew Anderson from the Hudson-Mohawk REMSCO. The Harriet C. Weber E.M.S. Leadership Award has been awarded to Matthew Sproul from the Finger Lakes REMSCO. E.M.S. Communication Specialist of the year, we are giving out two awards. They worked as a team on a very impressive call, so Katie Caffee and Khalika Flemming from the Wyoming-Erie REMSCO. Our Clinical Partner of Excellence, so previously this was nursing provider of excellence. But we have expanded this award this year to include P.A.s, N.P.s, to include a variety of different clinical partners, is Lindsay Gubala, and she is from the Big Lakes REMSCO.

This year's Physician of Excellence is Dr. Matthew Harris from the Regional E.M.S. Council of New York City. And our Youth Provider of the Year is Hunter Stoll from the Hudson Valley REMSCO.

DIRECTOR GREENBERG: Congratulations to all the winners. Amy, did you want to talk about Vital Signs for a minute? Now is your spotlight.

MS. EISENHAUER: I would love to talk about Vital Signs. So, we have a variety of returning additions to the conference. So, yesterday

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I spoke about our -- working with the pre-hospital care research forum. This past year we had our second P.C.R.F. here in New York State, in New York City, with a variety of projects that came from that. I believe it was eight different projects that came from that P.C.R.F. I know many of them have submitted for our Vital Signs research forum. That forum, applications are still being accepted for abstracts till Friday at eleven fifty-nine. So if any of you physicians, other partners that have joined us, have any abstracts and you'd like to submit, we are still accepting and would love to see your research on E.M.S.

We are also having our third annual E.M.S. Games. So last year I believe we had twelve or thirteen different teams. And we expanded to include not just basic life support, advanced life support, but like an advanced advanced life support because we had a lot of critical care teams joining. So, we now have three different levels at the games. And if you're curious, the cups are right outside. So you can see what you can take home for bragging rights right here. So I know that that is also open for registration, and it's free to compete. So

there's not any extra fee for that. Please join us and show us your skills.

We do have a variety of new pre-conference sessions. We are hosting the F.B.I. Resilience -- Resiliency Officer course. So we're excited to work with D.C.J.S. on delivering that three-day course. Many of us at the division have taken it. And having a background in E.M.S. and first responder mental health. It is comprehensive, and I was really impressed with the content provided for providers to take home. So we're hosting that as one of our pre-conference sessions.

We've also added on an administrator class and I'll let Ryan talk to specifics about that because he's very excited to share.

DIRECTOR GREENBERG: So particularly for your E.M.S. medical directors who are out there who are, you know, you have an agency, you have a new chief who came into office or something else that maybe they didn't come up to the ranks or they were the last man or woman standing in a situation, this is an eight-hour course. It's true, Dr. Dailey, I know it happens on occasion.

This is based on asks and we put

together a one-day E.M.S. administrative course that will talk about part eight hundred, the C.M.E. program, how to fill out, you know, narcotic paperwork. So, it's really just trying to give, you know, a little bit of that support to our E.M.S. leaders. It is being beta tested at Vital Signs this year.

It's a one-day course on the day before the first day. And -- and then if it goes well on everything else, we'll make some tweaks. But if it goes well, then it will hopefully go around the State. So we do hope that it will be a resource and a great course for people on the State. They also could take the two-day leadership class the two days before that and then roll right into the administrative course, very different too. The administrative course is formality of how to do certain paperwork and understanding rights and statutes and all that component, too.

MS. EISENHAUER: Thank you, Ryan. So, we also added a new track and a new pre-con for emergency preparedness. So, working with Office of Health Emergency Preparedness and their partners, there will be some pre-conference sessions that are

being loaded in currently and will be available by the end of the week for registration. But we also have eight classes throughout the main conference on emergency preparedness and different topics associated with it. So, we're excited to add that to our offerings this year.

DIRECTOR GREENBERG: Anything else you can find out on the Vital Signs Conference website located at www.vitalsignsconference.com.

MS. EISENHAUER: Absolutely. And if you have any questions, I'll be right over there.

DIRECTOR GREENBERG: All right. Thanks so much for everything and thanks. And again, congrats to all the E.M.S. award winners. So a couple of things. So the E.M.S. Memorial was in May, thank you for everybody who attended. We had a, you know, very strong attendance this year. This year was also, you know, marks twenty-five years since the 9/11 attacks. The State Department of Health actually put out a video this year related to 9/11, highlighting our Vice Chair, Al Kim over here, somewhere and -- very moving. It is up on the D.O.H. website. If you haven't seen it already, it was shared.

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I also just wanted to share a little bit of news. So one of the new things to the memorial this year is the kiosk that was added in. And the kiosk lists all the names that are on there. It has a picture, a little bit of the background about the honoree who is on there. And we didn't know how much engagement it would get, but we felt it was a really important piece to put in, and we were very happy about going in. We are seeing twenty-five to fifty people a week interact with the kiosk, you know. And so, we think that's really just amazing to see as many as we are, you know, going to the memorial, seeing it and then actually spending a few minutes and -- and interacting with the kiosk, so happy to see that one.

Important update related to Council Ops. Our December meeting, the location for our December meeting which was December 8th and 9th, unfortunately had to cancel. So we have to move our December meeting by a week. So the December meeting for 2026 will now be December 15th and 16th, still in the Saratoga area. We are just finalizing the location. But it is now one week later on the Tuesday and Wednesday.

We know that -- we want to make sure that we have quorums and everything else, so we are going to send out a survey to everybody to please make sure you respond to it. Just the yes or no, or tentative, we understand that some schedules are, to make sure that we're going to meet quorum. But the new dates for committees and for SEMAC and SEMSCO will be the Tuesday and Wednesday, December 15th and 16th in Saratoga. Questions on that? None. Great.

All right. Regulations and Med Standards are going to be out by the end of this year for public comment period. The blood -- the blood regulations, I am hoping come out in the next couple of weeks. They're in that final component of it. Community paramedicine regs are out. They have, I think, five days left to the public comment period. Is that right? Five days left, and so next up in Georgia's world will be the systems and quality regulations under the System and Agency Performance Standards.

There are two important additional things. The A.E.D. regs were updated. Thank you to all the docs who helped -- had some feedback on that one. So, that happened through a governor's

initiative last year. There's also a big program that will be coming out, and you'll hear more about it in the next couple of months related to cardiac survival in New York State, it's going to include greater involvement with the CARES Registry, it's going to include, you know, programs around the state related to hands-free C.P.R., A.E.D.s programs going out there, and so we're excited about that one, as well as an update to the A.E.D. registry process. So right now, it goes through the regions, we're going to streamline it through the States. As it comes in through the State process, it will automatically still go to the regions, but it will also be accessible to all the nine-one-one centers and everything else.

We know that there are some national programs that are out there, and we are looking at all of them in that process to see what will be in that registry that goes along with it. The A.E.D. section of -- of the statute that was updated, that won't have regulations to it. That's just the -- the statute was updated for that component.

The other one that we get a lot of questions for is related to D.E.A. and narcotics

licenses, and especially for this group with the physicians. We are aware that D.E.A. has updated certain rules of theirs. We are in conversations with them. We meet them right now about every three to four weeks on these conversations that we're having with them. Essentially, it is business as usual.

Even for the A.E.D. and the PAD programs, it's business as usual, meaning don't change your process until we announce to change your process. We've spoken to D.E.A. We said, hey, you know, what do we do? You have these new rules, things like that. They've even said they're working through their processes of it, naming certain things from the state in order to make it possible. And so all of that is happening right now. So both for how you register in the A.E.D. and how you handle your narcotics, it is business as usual. Please do not change the process or how you're doing things.

We know some hospitals related to narcotics has brought up, you know, the different rules and things like that. If we need to speak to them, please, by all means, feel free to reach out to us. We're happy to have those conversations, too.

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Any questions on that? Great.

We had the pre-hospital care research forum. I know Amy spoke about it a little bit, and might later. That happened in Manhattan in June 23rd to 25th. Thank you for everybody who attended in the poster projects that are coming out from it. We'll be talking a little bit later on about the mental health and well-being symposium, but as well as a really valuable E.M.S. toolkit that came out, that I think Chief Bracadda (phonetic spelling) is going to be speaking on as we move on later.

And that brings me to the last thing, which is county E.M.S. plans. And Theresa, if you can bring up the presentation that I'm going to try and go really -- really fast on. All right. So, I know some of you who were here yesterday might have seen this already, and some of you have not. And for those of you watching at home, might be a little bit of news to you too. County E.M.S. plans, this is -- for those of you who would like the more detailed version of this, this is -- the presentation is also located on the -- we did this presentation on the New York State Association of Counties, and so there is a longer version there. So this will be a super-fast

one.

So general municipal law changed, 122-B, as well as Public Health Law 3019 related to county E.M.S. plans. And the 122 says every county has to write a county E.M.S. plan, 3019 talks about the framework of what the county plan should include. The county plan will talk about delivery models. It will talk about identifying, very specifically the legislation talks about you need to identify service gaps or problem areas. It will talk about E.M.S. structures, all the structures of E.M.S. So, fire departments, non-profits, commercial-based, hospital-based, whatever that may be in your county.

Coordinated decisions, how are things happening? How are, you know, mutual aid plans working? Things like that. And then the submission of your county E.M.S. plan. It was enacted on June 19th. It goes -- submissions are required by December 19th. So we're about halfway, you know, about halfway through or almost halfway through. And we meet -- the division meets weekly with the county E.M.S. coordinators. They've been great, lots of good questions, lots of things going on. And we're hoping that they're meeting with you as well. And if

they're not, please reach out to your county E.M.S. coordinator.

Once they're submitted, it will go to the Department. It will come to the council and it will go to the regional councils as well. The county plans have core plan elements and expanded plan elements. The core plan elements are things that should be in your plan, every single plan. The expanded plan elements are things that would be nice to be in your plan, but maybe you don't have that data, maybe it's when you do a revised plan. We hope that these become living documents. It's not just a one and done situation. And so that's how the plan is laid out. These are all different sections of the plan. And we're going to jump into that really quickly at a very high level.

It's going to talk about your county -- county overview and E.M.S. system. What does your system look like? What's -- what's your county look like? What's the geographic size and description? What's the municipal structures? What's the residential population? And then any high-level description of your models. What are you using in your model? And it doesn't matter what your model

is, it doesn't matter if you're volunteer, you're paid, you're careered, you're hybrid, all that doesn't matter. It's just talking about what is in your county and how is E.M.S. delivered in your county.

Under the expanded side of things, in this particular section, it might talk about, well, during the daytime, there's a larger population because of workforce or things like that, or where air medical falls into it, again, if you have that information. It will talk about E.M.S. resources and coverage analysis. We're going to be providing some of this information to them, some of the stuff that counties are going to have because they run county, not only dispatch, but it talks about E.M.S. service areas by municipalities or geographic zones, identification of both the primary and the backup E.M.S. providers by municipalities. We'll talk about organizational structures and then, you know, staffing availability and different things that come along there.

Under the expanded side, you might have maps or coverage maps in there that are -- that are add into by the county E.M.S. coordinators, talk

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about overlapping responsibilities, and then the cost of readiness is always a big discussion. But again, might not be available for this particular run. We talk about the workforce and the practitioner analysis. So, will talk about how many providers you have in the area to the best of our ability, we will provide that information. I say to the best of our ability because we -- our -- our data is based on where the person lives, not necessarily where they work. It will talk about staffing models. So, that's a part where the county E.M.S. coordinators talk about those staffing models. It will talk about identification of workforce challenges.

And then in the expanded side, we talk about retention and turnover. We talk about, you know, advanced life support availability or mutual aid and different things on that side. The next section talks about call volume, demand and dispatch. So, what is your call volume in the county? How is it handled? Is there E.M.D. done? Is there not E.M.D. done? How do you determine who goes to a call? And then calls and times on tasks. And this is important because every county might have a different time on task for, say, different things

because the rural county is going to have a longer call than, say, the more urban county or different things that come along with it.

The expanded side of things we'll talk about -- did you look at the E.M.D. utilization? Did you look at mutual aid activations or interoperability capabilities? On the operational capacity and system side of things, we'll talk about staffing response models. It'll talk about patterns by time of day, identification of operational challenges impacting the reliability of the E.M.S. system, and then for this group, description and medical oversight structure. And so please, as medical directors, get engaged. Be a part of your county E.M.S. plan. We really want it there. This is your opportunity to make those suggestions and what the system needs and what should be put into it.

And we talk about out-of-shoot times, it'll talk about time on task, A.L.S. availability, when it's actually requested, and then quality assurance programs. Under the education, training, and workforce readiness, It'll talk about training availability, so do you have the training in your county. It'll talk about what agencies are doing for

training and what they can be possibly doing for training. It'll talk about the workforce impact and how that affects the system and the system being operational, as well as the coordination and improvement opportunities.

Under the fiscal side of things, how is your E.M.S. system funded in your county? Maybe it's completely funded by billing. Maybe it's completely funded by a county. Maybe it's com -- you know, funded by a mixture of things or an ambulance taxing district. Whatever that might look like, this is what that's looking there. This is the first time that we've ever started to look at any of these things at a county level and really putting it into it from -- you know, each county doing something similar.

So it'll talk about operating funds. It'll talk about strategic fiscal reserves, and what's the sustainability of the E.M.S. agencies that are out there that are providing the care. It'll talk about, you know, cost of service and readiness if it -- if under the expanded side of things, and then capital needs and oversight.

Under the emergency preparedness and

system resilience, it'll talk about county response expectations, are there county response expectations or are there not, right? Is it, hey, what you get to, you get to. Or by the way, as a county, we have a metric that we're looking at. It will talk about collective input from different groups. It'll talk about system reliability and capacities, their ability to go to the first call that they're dispatched to. We understand that a lot of agencies, the first call they can get to, no problem. But when they have the second and third, it becomes much more problematic, and so looking at that.

It will talk about emergency preparedness and surge capabilities, and then under the expanded side of things, a couple more things here on consistent –- consistency -- continuous system readiness and what those opportunities are.

Under the next section, it talks about community programs. What are we doing for that outreach? Are there hands-only C.P.R. programs? Are there naloxone programs? Are there bleeding -- stop the bleeding programs? What are you doing to help on your high utilizers to reduce the, you know, some of the high utilizers on the E.M.S. system to, you know,

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kind of be pro -- proactive towards things? What are the opportunities on existing alternative response models? Are you using treatment in place? Are you using non-transport protocols? Are you using nurse navigation? You know, we're seeing success big time in -- in Buffalo and Rochester and Syracuse on our nurse navigation programs, you know.

And again, for any county who might be out there saying, you know, well, we want to know more about that because we might want to put it in our plan, now is the time to call and ask, right? Call into any of these other counties that are using it and see what it's about. Where's the barrier? What's the opportunity that's there?

The last part, kind of one of the most important parts in my opinion, the system assessment, the gaps in the strategic direction. So identifying the strength, we want to know what the strengths are. We want to know what the strengths, as well as the limitations are because if you're really strong at something, you may be doing something or have an opportunity to show someone else why that's so strong in your county and be able to share that story.

Identification of service gaps, like

the -- the statute asked for, so it's identifying those service gaps, the geographic areas, the areas that are having problems. Maybe it's only a problem during the daytime. And then then also identifying what it might cost to fix those gaps, to plug in the -- the areas that are there. And then strategic direction and priorities of those actions and the fiscal costs that come along with it.

The last part is in -- like I said, in my part in this section is one of the most important. It's provide five short-term, twelve to twenty-four month system improvement opportunities and then provide five long-term, thirty-six to forty-eight month system improvement opportunities. And so this is really an opportunity to identify different things that are out there. And so we're, you know, excited to see what that is, and we absolutely believe that will be a little bit different for every county that's there.

The last part is the appendix. Please, please, please, if your agency that you work with or agencies for medical directors that you work with have not filled out their agency survey, please fill out your agency survey. It takes about fifteen

minutes if that. If they're having problems with it, please reach out to our county E.M.S. coordinators. I know every county E.M.S. coordinator who I've spoken to is happy to help with that front. And you know, big shout out to our core sponsors who all have, we have like ninety five percent responses from our core sponsors. So thank you for everyone on that one.

So just back to that first slide, which is enacted on June 19th. They're due in by December 19th. I did ask our county E.M.S. coordinators. Anybody going to get me that early? Pretty overwhelming no. So, this will be my Christmas reading present, I guess. All for this council as well too. So, if you're looking for things to read during your winter Christmas break, we will have some plans, if you would like to. Just let me know which ones you would like me to forward off to you.

It is all being submitted via the portal. Any questions you have are being submitted via the portal. Everything is there. It then channels directly to the county E.M.S. coordinator that we have on file, as well as to our office. If

you're looking for any of this additional information, if you go to our website, this is a picture of our website, and that yellow box on the left-hand side is the State Programs, Councils and E.M.S. Reports. You click on that, it brings you to this page. You click on County E.M.S. Plans, and it brings you to everything we just spoke about.

We're also going to throw this PowerPoint up there, too. But the PowerPoint is pretty much the framework, which is one of the first documents that's on there. Any questions, go to the E.M.S. Forms page to the drop-down to County E.M.S. Plans, and it will go from there. And that is my summary of County E.M.S. Plans super, super quick. Any questions? Awesome.

You're going to hear a lot about it today. Why? Because this is one of the most, I think, significant things that we've done in New York State history in a very long time. Having every E.M.S. county come together, write -- write a plan, put the plans on paper, bring them together different groups. Your REMSCOs and your REMACs should be participating in these county discussions as well. If they're not, please reach out to them and, you

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know, find out when those meetings are, so that you can be a part of it.

This has, you know, an opportunity to be a really big, you know, kind of push forward on things. Our legislative bodies have already said, hey, you know, when are we going to see this? We explained the end date and things like that. So, your electives are already looking for this information. And so this is your opportunity to put great things in there, ideas, even if they're a long shot, to try and, you know, move the system forward.

If you're watching online, again, same thing. Hopefully you got a little bit closer review of the presentation, and I am happy to take any comments, questions, or concerns. Terrific. Mr. Chair?

CHAIR DOYNOW: Okay. Thank you, Ryan. And this is probably the closest yet we've gotten to E.M.S. being an essential service. Let's move on to subcommittees. Medical standards, it's going to be Dr. Walters for Dr. Weybridge.

DR. WALTERS: Thank you, Dr. Doynow. So I -- first I'll just bring up, we have one second in motion from medical standards coming forth to the

SEMAC regarding, there was discussion on, and the motion is about codifying the timeline for collaborative protocol changes and the collaborative protocols. And Theresa, if you could put the motion up, please.

So, the motion is to recommend to SEMAC to include the detailed timeline and process in which the protocols are changed in the collaborative protocol document and not in a bureau policy. Some of the discussion, just to summarize, revolved around the collaborative group is a group of regions that all have statutory authority in developing advanced life support protocols.

And so the appropriate place would be to put this timeline in that protocol document rather than in a bureau policy. So, that comes forth to the SEMAC as a seconded motion.

CHAIR DOYNOW: Okay. Theresa, we'll need a roll call vote, please.

MS. ALLEN: Dr. Afienko?

DR. AFIENKO: Dr. Afienko, yes.

MS. ALLEN: Dr. Berkowitz?

DR. BERKOWITZ: Berkowitz, yes.

MS. ALLEN: Dr. Black?

DR. BLACK: Black, yes.

MS. ALLEN: Dr. Bombard?

DR. BOMBARD: Bombard, yes.

MS. ALLEN: Dr. Clemency?

DR. CLEMENCY: Clemency, yes.

MS. ALLEN: Dr. Cooper?

DR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Dailey?

DR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Dorsett?

DR. DORSETT: Dorsett, yes.

MS. ALLEN: Dr. Doynow?

DR. DOYNOW: Yes.

MS. ALLEN: Dr. Goldman?

DR. GOLDMAN: Dr. Goldman, yes.

MS. ALLEN: Dr. Hallinan?

DR. HALLINAN: Yes -- yes. Sorry.

MS. ALLEN: Dr. Isaacs?

DR. ISAACS: Yes.

MS. ALLEN: Dr. Kugler?

DR. KUGLER: Kugler, yes.

MS. ALLEN: Dr. Olsson?

DR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Papish?

DR. PAPISH: Papish, yes.

MS. ALLEN: Dr. Rubano?

DR. RUBANO: Rubano, yes.

MS. ALLEN: Dr. Seth?

DR. SETH: Seth, yes.

MS. ALLEN: Dr. Shih?

DR. SHIH: Yes.

MS. ALLEN: Dr. Walters?

DR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow?

DR. WINSLOW: Winslow, yes.

MS. ALLEN: Motion passes.

CHAIR DOYNOW: Okay. Thank you.

DR. WALTERS: All right. And then that was the only seconded motion to come forth. I'll just highlight a couple of things we discussed. We had some reports out on some things, including technical advisory groups. I know Ryan already discussed the blood implead -- implementation regulations and those coming along in the process. Dr. Dorsett updated us on some of the workings or the clinical data integrity TAG. And we also had an update from the specialty care transport TAG. They are working on developing a readiness tool for

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agencies to use, as well as some template protocols that are in line with the collaboratives and hoping that those will be out for review by summer.

We did have some discussion on the Keppra Pilot Program. I'm going to skip through that because that comes up later on the agenda here on the SEMAC. And I do think -- there's a couple of other things I just want to bring up. The collaborative protocol rollout update, we had some discussions. There were a couple of clerical errors and critical dosing errors that have been corrected and recently put out in -- online in a bureau policy statement. Those revolved around oxytocin dosing and epinephrine drip rate. So those are out and available already. And I think Dr. Fullagar will, after I'm done, will speak about some other proposed changes to the collaborative protocols or things coming up.

We did have some brief discussion that David Violante gave us updating the TAG for the E.M.T.C.C. sunset group, and they've been working and working with a bunch of stakeholders. And it sounds like they've been having some good discussions and coming to some consensus. They've met with the Deputy Commissioner to try to ensure that they're

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working in line with what the Commissioner is looking for. And once they hear back on that, it sounds like they have some good movement forward, and we'll bring that forth for discussion and a plan at the December meeting.

We also had some discussions that Director Greenberg gave us on medical aid and dying and a MOLST update, and those are in process by the larger Department of Health and should be available to provide some guidance to E.M.S. providers coming out soon.

Last two things. We did -- Dr. Winslow gave us an update on the B.L.S. I.M. glucagon pilot program going on with thirty-two agencies in Suffolk and Nassau County. We've got fifty-seven successful uses in which there were no A.L.S. on scene using I.M. glucagon for hypoglycemia, and it doesn't appear any adverse effects at this time, but he's going to give a full deep-dive report out at our December meeting.

And lastly, there was a conversation or a question and some discussion, which we've had here before, regarding inclusion of B.L.S.F.R.s in the B.L.S. I-gel program, and that is being addressed

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and moving forward, and hopefully we'll, like -- we'll have an answer and be moving forward by the December meeting. So I think with that, that concludes the report from Medical Standards. Thank you.

CHAIR DOYNOW: Thank you. Dr. Fullagar, if you want to mention the -- the changes.

DR. FULLAGAR: Hello, everybody. So, I just want to highlight a few of the changes. I understand that not all of these are necessarily substantive. I will preface what I'm going to say by saying that there was a fairly robust discussion in regard to the process of this. And one of -- one of the main areas of -- of focus is going to be to develop that and put that down on paper to try to minimize any mid-cycle corrections or updates.

So I'm just going to just briefly mention all six. Dr. Doynow now suggested that I -- I do touch on all of these. So just briefly, the obstetrics hemorrhagic shock protocol, originally it said ten units I.V. or I.M. This was changed to clarify that the initial dose should be I.M. only, and the reason being is because we wanted to minimize the possibility of hypotension, which might occur

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with a rapid oxytocin infusion.

The next is the prescribed medication assistance protocol. We wanted to clarify that that does not apply to medical aid in dying. There was a concern that the prescribed medication assistance protocol could be interpreted as permission for the E.M.S. clinician to assist in that process considering these are prescribed medications. However, that would certainly lead to some problematic issues from a legal standpoint, et cetera. So, we just wanted to specify that it does not extend to the medical aid in dying process.

For smoke inhalation, this is more of a clerical change. We did add altered mental status to the indications. Altered mental status was already described in key points, but for clarity it was suggested that we put it up in the body of the protocol as well.

The next one is the pediatric nausea, vomiting, and vascular access protocols. The reason for this change is that for advanced clinicians and for critical care clinicians, it is indicated that I.V. -- that the establishment of an I -- I.V. would only be for patients who are in extremis. We wanted

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to make sure there was not confusion to suggest that ondansetron I.V. would be an indication for -- for the establishment of an I.V. in a pediatric patient. So, I.V. ondansetron was removed from that.

For pediatric asthma and wheezing, there was a duplicated, quote-unquote, if-wheezing component that was just removed. Again, just to clean that up and to reduce any possibility of confusion.

Last but not least, in heat emergencies we just changed the terminology associated with the acronym TACO to match what is more common, which is tarp-assisted cooling with oscillation instead of cold water. And that's it.

CHAIR DOYNOW: Do we have any questions on any of those changes, or do we need to vote on them? Any discussion? Can we have a motion to vote on those changes?

DIRECTOR GREENBERG: Mr. Chair?

CHAIR DOYNOW: Yes.

DIRECTOR GREENBERG: Just for clarity, some of those things were done, right? They were immediate, which a vote is good, right? We'll just further codify it. But some of those things were

not. So can we just have clarification on how you hand -- how you want that handled?

CHAIR DOYNOW: Well, the -- the one that was felt to be emergent was basically oxytocin as I.M. rather than I.V. So, that was decided that that needed to be an emergent change. The other ones are all ones that will need to be up for a vote.

DIRECTOR GREENBERG: So it's just -- it's twofold. It was the oxytocin -- I think, epinephrine. But the -- the other ones, what is the timing for changing those? Are you doing in this -- are you doing them immediately or is it something that you're looking to do in the next protocol change?

CHAIR DOYNOW: Immediately.

DIRECTOR GREENBERG: Does everybody here agree with that?

UNIDENTIFIED SPEAKERS: Yes.

DIRECTOR GREENBERG: Okay. I'm -- I'm just making sure we're all on the same page. It's not -- this is just clarity so that we understand. So I think if you were to do everything as one, if you all agree that as one is okay, and then we can work on -- and -- and the motion there would be

something one wanted, you know, to be updated in the protocol manual, we will update the change logs as well and then to put that there.

There is one other that I do not see up here that did come up that it was that -- that did come up that did come up, and if you're going to make these changes, you might want to make the other one too, and that is to pediatric fluid dosing in multiple protocols. I think it was changed in one, help me, Dr. Dailey, but it was -- we were told it was intended to be possibly in more.

And so if these other updates are happening, this might be the right time for that to happen, too. It is consistent that it would be in the others, but it is -- if you're making these, we can add that change as well.

DR. DAILEY: There are actually a couple of others that -- that should have been discussed, and I don't know if they all got discussed this morning. One was the pediatric fluid administration making consistency for the second bolus, as you said. The other was the increase in dosing for electricity in wide-complex tachycardia to parallel the narrow-complex tachycardia. Were those

discussed at Med Standards this morning?

CHAIR DOYNOW: They were not.

DR. DAILEY: I -- I think more than anything else, this highlights some of the process things that we were already talking about. Where the source of truth actually lies in this, how we're going to make sure to maintain that, since the protocols themselves are a legislated requirement for the regions, and ultimately the State is serving as the sort of repository for those, and how the process is going to work back and forth in order to make sure that we have a single source of truth we know where the changes are being made. We know how the changes are being made.

And they're being made in a way that isn't going to -- to, you know, use an old phrase, nickel and dime the poor clinicians who are trying to keep up. We need to make sure that we're going to do this as -- as effectively as possible. And I think right now we're having some significant challenges.

CHAIR DOYNOW: So I guess the question for the group is, do we want to make these changes now? And Dr. Dailey, if you want to add those other two to this group, or do we want these to go out to

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December, at which time they'll be voted on in December, and then we're not going to the protocols until next July, if we're going to stick with the timeline that we've suggested rather than making changes every few months, which is what seems to be happening.

DR. FULLAGAR: So, I just have a couple of things. So, these were suggestions to come up for immediate change. We did have some other discussions, particularly on the wide complex tachycardia. In the notes from the meeting, we -- that reflects that we were considering them for implementation for the next year. But if we want to go ahead and change that, that's fine.

But again, I think this underscores the need to have a much better and codified process, so that we don't run into these issues. My suggestion would be to -- to move on what we've discussed here and then save for possibly the -- the pediatric fluid bolus because that sounds like that is just making it consistent among the protocols. I would probably save anything else that is substantive for the next cycle.

DR. DAILEY: I agree with Dr.

Fullagar. You know, maintaining the consistency is important. There is further discussion on the other, which actually is different than A.C.L.S., and we need to make sure that we're aware of those changes and then effectively give guidance to the clinicians.

And probably the single most important of the changes that we're doing is the one that remains on the board right now to get that I.V. oxytocin right off the list of interventions, so we don't get a bolus of oxytocin and really hurt somebody. So, I would go with these four, leave the other two, and go from there.

CHAIR DOYNOW: Dr. Dailey, would you like to make a motion to approve these? So, let's go through all of them again.

DR. FULLAGAR: Okay. So we have the obstetrics, the hemorrhagic shock. We are moving the I.V. oxytocin to I.M. We have the prescribed medication assistance, that's a clerical addition to exclude the medical aid in dying. We have smoke inhalation to add altered mental status to the indications as opposed to just in the key points. We have the pediatric nausea, vomiting, and vascular access to specifically exclude an indication for an

I.V. placement for I.V. ondansetron in children, specifically for advanced and E.M.T.C.C. clinicians. We have the pediatric asthma and wheezing. We're going to strike the I.V. wheezing under the E.M.T. slash A.E.M.T. because that is a duplicated reference to wheezing.

And we have the heat emergencies where we are changing the terminology of the acronym TACO to Tarp-Assisted Cooling with Oscillation. And then Dr. Dailey, I don't know if you wanted to add the pediatric fluids to make that consistent among all of the protocol, but that's what I have.

DR. DAILEY: Yes, please.

CHAIR DOYNOW: Okay. Do we have any discussion on these? Then can we have a motion to accept all of these as one group? And it will become a seconded motion going to SEMSCO. Okay. We have a --

DIRECTOR GREENBERG: Just -- I apologize, one thing. Was the -- was the epinephrine infusion rate correction in that change?

CHAIR DOYNOW: That, I would say was more of a -- a clerical error than the change per se.

DR. DAILEY: That was a clerical co --

correction.

DIRECTOR GREENBERG: Okay. Just -- just -- I'm just doing a quick --

DR. DAILEY: Yeah, no -- no.

DIRECTOR GREENBERG: -- scanning. Okay. Thank you.

CHAIR DOYNOW: Okay. We have a motion on the floor. Do we have a second?

We have a second. Okay. If we could have a roll call, Theresa.

MS. ALLEN: Dr. Afienko?

DR. AFIENKO: Afienko, yes.

MS. ALLEN: Dr. Berkowitz?

MDR. BERKOWITZ: Berkowitz, yes.

MS. ALLEN: Dr. Black?

DR. BLACK: Black, yes.

MS. ALLEN: Dr. Bombard?

DR. BOMBARD: Bombard, yes.

MS. ALLEN: Dr. Clemency?

DR. CLEMENCY: Clemency, yes.

MS. ALLEN: Dr. Cooper?

DR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Dailey?

UNIDENTIFIED SPEAKER: You say yes

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now.

DR. DAILEY: I say yes now. Yeah.

MS. ALLEN: Dr. Dorsett.

DR. DAILEY: It's a good thing I have a surgeon to guide me.

DR. DORSETT: Dorsett, yes.

MS. ALLEN: Dr. Doynow?

DR. DOYNOW: Yes.

MS. ALLEN: Dr. Goldman?

DR. GOLDMAN: Goldman, yes.

MS. ALLEN: Dr. Hallinan?

DR. HALLINAN: Yes.

MS. ALLEN: Dr. Isaacs?

DR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kugler?

DR. KUGLER: Kugler, yes.

MS. ALLEN: Dr. Olsson?

DR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Papish.

DR. PAPISH: Papish, yes.

MS. ALLEN: Dr. Rubano?

DR. RUBANO: Rubano, yes.

MS. ALLEN: Dr. Seth?

DR. SETH: Seth, yes.

MS. ALLEN: Dr. Shih?

DR. SHIH: Shih, yes.

MS. ALLEN: Dr. Walters.

DR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow?

DR. WINSLOW: Winslow, yes.

MS. ALLEN: Motion passes.

CHAIR DOYNOW: Okay. Thank you. All right. Moving on, if we can have a report from education.

DIRECTOR GREENBERG: Before you go to education, just one thing on the protocols. I don't know if he got voted in or missed a meeting or how it happened, but I do want to -- I think it's important for everyone around the room to know the name too, and to say thank you for the work that he doesn't know what he signed up for but Dr. Fullagar has now agreed to -- well what was told, not told, I'm not sure which one, to lead the pro -- the collaborative protocol group. And so, thank you for -- for taking that on and thank you for putting together changes and all that's to come in the future, so thank you.

And -- and I do truly mean that the collaborative protocol group does a phenomenal amount

of work in putting together A.L.S. protocols in streamlining what was at one point eighteen individual protocol sets as probably many people around this table even remember to a certain degree. And, you know, to be there and be in that position, it's a big kind of move forward on -- on medicine and where we're going. And so thank you for everyone who's part of that.

CHAIR DOYNOW: Don, if you can give us a report.

DR. HUDSON: Yes. Good afternoon, everyone. Don Hudson. So I'll be giving an expanded report about training and education at SEMSCO, but for the SEMAC, I know it -- since it initiated here, there was a, what we phrased, a robust and passionate discussion at the July 13th virtual training and education meeting. We meet monthly virtually in between the in-person meetings.

So that discussion revolved around the ongoing and open monitoring and awareness of state exam results at all levels. So, the committee did vote and wanted this read off more as a resolution and a position statement than any action item. But that reads, (reading) a motion was passed to support

the State E.M.S. exam writing process with an understanding that the current perceived student exam concerns are based in educational causes and not exam difficulty.

This passed by a vote of six, four, zero against, and three abstentions. So in conjunction with our partners from the division and P.S.I. and other parties, you know, we're -- we're looking at the exam results and monitoring that, I anticipate having some statistical data probably for the December meeting so that we can look at that as a group. Of course, medical direction and our physicians need to be heavily involved in that, I suggest respectfully. So I -- I bring that here just for your awareness, but look for more in December. Other than that, happy to take questions and thank you.

CHAIR DOYNOW: Any questions for Don Hudson? Oh, Mike?

DR. DAILEY: One -- one question that comes up really quickly every time we look at question writing is why New York State persists as one of the few states that is not using the registry, where there is a well-validated exam that is used in,

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correct me if I'm wrong, I believe it's forty seven other states, that the lack of using the registry precludes our ability to be a part of the federal E.M.S. Compact, and it drastically changes our ability to get E.M.S. providers or clinicians from outside of our state, reciprocity into our state, and therefore it hurts our workforce. So, when are we going to stop writing our own questions and just go with the rest of the country for clarity?

DR. HUDSON: So, thank you for that. And -- and that is part of the discussion, which quite honestly I don't know that we've ever really asked officially in New York State, but now that we have, it's time to look at those options and weigh that. You know, in the interim, there is a registry to State pathway that is dramatically expedited. I understand it was announced earlier that that's gone from potentially months to weeks.

DIRECTOR GREENBERG: It wasn't months, it was weeks.

DR. HUDSON: Well, I was trying to make the week sound worse than it was so you could look good, but okay. So it's down to weeks?

DIRECTOR GREENBERG: It's down to days

now.

DR. HUDSON: Down to days, and those might be State days, so give some leniency there. But -- yes, thank you. So -- but part of that is now, rightfully in my opinion, an open discussion and something that we need to weigh the pros and cons and benefits of. You know, rather than express my personal beliefs, I would invite and welcome every physician that wants to be involved in that and, you know, looking at not only validity, but is it time to move the ball forward and join the rest of the country? I don't know. We're in New York. We don't always play nice with others, so we'll see.

DR. DAILEY: So, we've been talking about that here off and on since I got here. And -- and as some around the room would point out, I've been here for a little while. You know, it's nice to have it come front and center again. I think it's just plain time for us to really realize how we can do this, and the fact that New York, while we are incredibly special, we're not that different.

The fear was always that by becoming a registry state, first it would ex -- it would increase our expense. Really, the expense isn't

particularly significant. And secondary -- the secondary problem was that it would increase our clinicians leaving the state. But I think we see as much of a problem with clinicians coming into the state and us having different requirements than many other states do. You know, honestly, it's time.

DR. HUDSON: I don't disagree, but I think that needs to, you know, be on the table as it rightfully is officially now, and, you know, we'll let the process run itself. And if that's the resolution of the group, for the greater good, which, again, without expressing my personal opinions, I agree, should be heavily considered.

DIRECTOR GREENBERG: And if you're seeing a problem with registry -- or reciprocity into the State, please feel free to address that with me because we accept National Registry coming into the State as a validated, you know, pathway with it. A lot of times it still takes time because you have to validate the education and the components behind it, the same way that it's done in many other states.

Just a reminder too, you know, some of the problems that come into this one is, people will get their registry, but don't maintain it. So they

have it initially, but often once they're done with the initial, they'll maintain a state certification beyond that, and then we still have to go back to that state component to it.

And then I will -- I will tell you, you know, I think the Compact is a real thing. I think those are discussions we had. I think that's something that we're having at the national level as well. And not just a national level, but the NASEMSO level for the east region. If you look at the Compact component, you'll notice that it is, the -- the east region is not heavy into the Compact at the moment. I think over the next couple of years that might start to change. We had one State in the east region that went into the Compact, and then has since left the Compact. And so as State E.M.S. directors amongst the east region, we're talking like, well, why did you leave, right? Like, it's supposed to be a good thing and everything else.

We continue to find out, you know, kind of more information on that, and so that we can make well-educated decisions, and bring that information here. So, I think there's lots of those conversations as we continue to move the ball forward

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into the future.

DR. DORSETT: Can I probe a little bit on this we have to validate the education done in other states? So to take the National Registry exam at the paramedic level, you have to have graduated from an accredited paramedic program, at least for the la -- more than the last decade of time, which means that it's an accredited program.

To take it at the E.M.T. level, you have to have graduated from a State approved and sponsored E.M.T. program. So, there is a process within somebody's eligibility to even achieve their certification at the National Registry that has already had an agreed-upon educational standard by either a colleague in a different state, or COAE, an accreditation program.

So I think there are a lot of people who are getting caught up, like, we validate, or did you do a psychomotor exam in the last two years, or something. Like, as a physician, I have to prove when I come to the State that I graduated from a paramedic program and have my certification, and nobody goes and checks my residency records to make sure I met my core competencies and did a schedule.

So I think imposing those kinds of things and saying we have to validate that it's up to our standards, we've never proven that care in New York State is somehow better than care somewhere else, like, that's the theory. So, behind doing these extra requirements, and I think it's probably not actually true.

So I think we have to -- when people want to come and actually work and move in New York State, maybe we should be evaluating what those things are because the registry has those things in place. And if somebody loses their state license someplace else, or doesn't meet the requirements, they get notified, and they get it taken away. You know, like -- and it will show up that it gets taken away. So like those safety mechanisms I think are actually pretty robust through the maintenance of a National Registry certification.

DIRECTOR GREENBERG: And, you know, part of one of those things, and actually is working with National Registry from the NASEMSO side of things, and one of the things that they've actually, you know, identified is that every state's E.M.T. educational opportunities are different. It's up to

the individual state and how they do it, and that the registry would even like to see that streamlined, and that they're working with NASEMSO on some of the things to try and build around that, so that there is a standard. And I think once that's in place that might be more of an opportunity. The paramedic side, there is, you know, a standard to make sure that people are given, you know, education that also meets New York State standard on different delivery models. And so, those are some things that we currently look at. Happy to have further conversations about it, but that is kind of where we sit today and based on the regulations.

DR. DORSETT: I'd like to point out that, I think if we say, what is the standard for paramedic education in New York State, technically, I think it's lower than a registry state because it does not require accreditation of the paramedic program to take our certification exam. And accreditation of a paramedic program is actually what makes sure that you actually have a student minimum competency matrix, that somebody's externally validating that you're doing summative assessments, that you're actually using valid things.

So, if we don't actually use the registry exam as our initial certification, it means that we are allowed to have unaccredited paramedic programs. And I'd like to commend F.D.N.Y. for becoming accredited, which is awesome, but there still remain other unaccredited programs. I would argue that that standard is actually lower than the national standard, by providing an alternative pathway.

DR. HUDSON: And we're really excited about F.D.N.Y. becoming one too. There was a long discussion that we had with F.D.N.Y. One that did not go lightly is they sat there and, you know, kind of recognized the lift that it would take in order to achieve it, and appreciate that the amount of effort and time and -- and personnel that they put into it to achieve it, which by the way, just recently happened that they got their official COAE designation as an accredited paramedic program.

CHAIR DOYNOW: And Dr. Cooper.

DR. HUDSON: Sorry, go ahead.

DR. COOPER: Thank you, Dr. Doynow. As I have from the very first time this issue was brought before this body, I strongly support our

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moving in the direction that Dr. Dailey and Dr. Dorsett have suggested. Thank you.

DR. HUDSON: So to that, just to show the good faith effort and the acknowledgement of national standards and everything, which we talk about, but maybe haven't always excelled at achieving, you know, there is a counter, you know, a parallel project going on to look at our State C.M.E. requirements because neither our topics nor our hours align to anything nationally.

So, you know, that -- that acknowledgement of external and national and other organizations as far as standards and quality is there. And I will assure you as your current chair of training and ed that, you know this will be strongly considered in part of that discussion.

But just to lastly be clear, I don't want to see any of your residency paperwork as physicians; training and ed has no stake in that game. So, if you're been faking it until you make it to date, good luck. We wish you well.

CHAIR DOYNOW: Steve, go.

MR. KROLL: Hi, Don. I'd like to speak about this from a non-physician perspective as

the leader of a predominantly basic life support agency that is having tremendous success in recruiting at the E.M.T. level. So I'll talk about it as an E.M.T. skill, not a paramedic level skill.

I have been fortunate to have a robustly growing membership that is made up of mostly people between the ages of eighteen and twenty-five who all think -- who -- who I have to explain are slightly Byzantine process of becoming an E.M.T., too. And I think that Dr. Dailey makes a good point that we really should look at whether or not we are just going to use the National Registry exam and stop this. I mean, yes, there's a process for them to use National Registry and become in and get their New York State certification.

But it is not -- into what Dr. Dorsett said, is this -- is this a reasonable process that we need to do this when there is a established national standard and my membership. Because I'm in an urban area that they're mostly college students, they are coming from all over the country and they're scratching their heads is why they need two E.M.T. cards.

And further, I -- I also have to tell

you that this is not -- there's no empirical evidence in what I'm about to say, but I'm seeing pre-med college students that can barely achieve a seventy-five on the New York State exam that achieved much higher success on the National Registry exam.

And -- and I -- I have to question when kids that I know or, you know, have a four O or a three six or a three eight cum at SUNY or R.P.I. are barely able to get a seventy-five on the New York State E.M.T. exam. What does that say about our exam? I'm scratching my head. Again, I have no empirical evidence about that, but it seems to me that the National Registry exam has been vetted by a lot more people and a lot more academics than our New York State exam.

You know, my son just finished his E.M.T. class and he's asking me, why am I taking -- why am I -- why do I have to do all this? So I -- I bring that up just from a B.L.S. perspective, from a non-physician perspective. And my -- my -- my request to you, Don, would be can we make a time-limited process for the -- or -- or a time-started process for the Education Committee to consider this? Because even if we go through our regular process,

this is certainly the pros and cons and it's going to be a multi-year or -- or at least, you know, multiple phase set of meetings.

If we make a commitment to start that at the end of 2026 and the beginning of 2027, maybe we will have a horizon where we can reach a decision in 2027 or 2028. Thank you.

DR. HUDSON: And I will commit to -- I will come back and work with our division partners with some stats for historical state exam results by grade and by level, so that we can have a real great discussion in December to explore what that looks like. But I think a much broader conversation is this was one of the topics in the white paper, so it's only fitting that we're having this and it's real and it's -- it needs to be done. I agree.

CHAIR DOYNOW: Any other discussion? Okay. Moving on, E.M.S. for children, Dr. Cooper -- oh, sorry, Dr. Bombard.

DR. BOMBARD: I'd like to make a motion that we sunset the New York State Basic and Paramedic Certification Exams starting -- sorry, with a sunset date of January 1st, 2028.

CHAIR DOYNOW: Is there a second to

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that motion? Dr. Winslow is seconding it. So now we need a discussion, please.

DR. WINSLOW: Thanks, Tiff, for having the -- the courage to say that. Just to -- to get it on, maybe -- maybe we should look at it before we vote on it. And I kind of agree with what Don Hudson has in mind from education and training. But I think if you're going to make such a motion, it'd be for all levels, not just E.M.T. and paramedic, all four levels.

DR. BOMBARD: I'd like to amend the motion to all four levels.

CHAIR DOYNOW: Dr. Winslow, are you seconding that amendment? Okay. More discussion?

DR. AFIENKO: Dr. Doynow, if I could just ask a clarifying question as one of the more junior members of the SEMAC. Why are we still holding on to this to the New York State specific exam so tightly when it obviously is clear that everybody wants to move towards the National Registry? I don't know if that's a loaded question, a difficult question to answer in an open forum here. But as someone who is going to be asked to vote on this very soon, I'd like to know why we are keeping

the state specific exam as much as we are.

CHAIR DOYNOW: Don't have an answer for that. Don as you're Chair of the Education Committee.

DR. HUDSON: I think you're always calling on yourself when you say that, so feel free to answer, Dr. Doynow.

CHAIR DOYNOW: Ryan, do you have any comments?

DIRECTOR GREENBERG: To which part?

CHAIR DOYNOW: Why -- why we're holding on to the -- to the --

DIRECTOR GREENBERG: Why we're holding on? I mean, for starters I think Don, you know, read a statement from the educators and want to, you know, work on the creation of the exam and kind of the components that come to it. We have moved in a regulatory change to give anybody the option who doesn't want to take the state exam to take the National Registry as a pathway, and as Dr. Dorsett said has pointed out, to get certification within a matter of days as opposed to, you know, weeks or beforehand. Those are state days as illustrated before and to, you know, kind of move forward on that

process.

One of the biggest barriers to it before and not before but still today is the associated cost with the two exams and the price difference in the cost. And -- and what has come up with that before is we are often told, you know, that you can't have another expense or another this or another that, which is why we give people the choice today. If they want to take National Registry which is, you know, more money than the state exam that they have that option or they can take the state exam and giving people the option on that front.

DR. DORSETT: Can I ask a follow-up question? How much money does the State spend developing their own exam?

DIRECTOR GREENBERG: How much money do we spend to validate the exam?

DR. DORSETT: Yeah, it costs a lot of money to -- right. And I'm going to have a disclosure, right? I'm on the registry board, so I have a sense of how much it costs to develop an exam. So it take -- it costs a lot of money to develop an exam. You have to have the question writers, they have to -- even if they did that as a volunteer, you

have to pay the psychometricians, you have to do that. So even if P.S.I. isn't charging you, there's costs, right. Like the State of Michigan recently is trying to do this and it's costing millions of dollars to do that.

And I don't, right, in the -- in the pool of government money, they're probably in different buckets of where that money comes from. But I think we spent a lot of time talking about the increased cost of one exam versus the other, but there is literally money being spent on developing an exam. And could money being spent on developing the exam be used in another way to support our education programs or support people in taking a exam since we're spending that money anyway? Because it's not free.

DIRECTOR GREENBERG: Correct. So the exam writing, the psychometricians, the component that comes behind it for P.S.I. to administer it is funded through the exam costs of the exam fees.

DR. HUDSON: I mean, the irony of the discussion isn't lost on me simply because it used to be policy in New York State with, you know, to push the ball forward that all program -- paramedic

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programs had to be accredited and that was rescinded because not all were, you know, and kudos to F.D.N.Y. You know, I used to work there, this was a fifteen plus year process for them, and it's a huge win. And that was one of the reasons I believe that New York State requirement for an accredited program was repealed in acknowledgement that our largest core sponsor at the time wasn't -- were over that hump. So, this is a natural discussion and evolution.

I think, you know as far as funding goes, well as a State as we follow quite honestly the National Registry's lead in acknowledging that a lucky Saturday P.S.E. exam is not the validation of learning or the celebration of education that we thought it was. You know, we do have State P.S.E. funding that could possibly be rerouted to pay for alternatives or things like that.

So, I think that's all part of the natural discussion that we need to have. I just want to give you what you seem to need, which is the data and the correct information to weigh the pros and cons.

CHAIR DOYNOW: Mike.

DR. DAILEY: The other thing that's

out there too in terms of expense, and this is something that I know has been negotiated in other states, is that you can use the registry examinations and the registry process but without maintaining the registry itself. That actually leads to a lower expense in those states that have negotiated that. So that would be one other option, so at least we're moving to the standardized and validated tests that really is the national standard. But certainly just one more option for folks to think about as they're moving -- moving forward.

CHAIR DOYNOW: Any other discussion?

DR. DORSETT: Can I clarify where -- I assume -- I don't know if I understand what you said. I assume that you're talking about the difference between initial certification and the maintenance of certification, that there's a lot of states that use the registry as an initial certification but they do not require maintenance of certification over time. A provider can choose to do that, so that our C.M.E. recertification process could remain completely untouched to maintain certification. But they use it -- but they require it as the initial certification mechanism. Is that correct?

DR. DAILEY: No. You would take the registry examination, but if you check the box state only you get a state card, not a National Registry card. That was at least two or three states had signed on to do it that way in the past. But -- but this isn't something -- this part of the discussion is not -- not key for right now. That would be a discussion for the division of E.M.S. to have with the registry over the process of moving testing.

DR. DORSETT: Yeah.

DIRECTOR GREENBERG: I think the bigger picture here, you know, as you look at it, I mean, there's clearly a feeling around the room amongst it, you know. And -- and I think we've made a major step, like I said, with the regulatory change to allow for registry, to allow for that pathway. And that I think was the first step. And if the next step in that is to go completely to it, I think Don has brought up some excellent points on, you know, what that looks like, what those opportunities are, coming back with well-informed information, and then allowing the groups to, you know, kind of work towards that the same way we work towards some other changes, including, you know, allowing it as well as

the technology and things like that to integrate and kind of what comes with it.

I wouldn't make a -- you know, I'd make a decision in a -- make a decision in a timely process, in a timely way and then have a process of that transition in a timely way whatever that might look like along with it. And then, you know, as well as looking at the Compact and the other components that come with that, I think that's an important one I think, like I said, you know, the Compact. And for those of you who don't know what the Compact is if -- because there's not that much talk about it in the state, the Compact is something that we're seeing a lot in the Midwest. It allows somebody to be certified in one Compact state but then have the privilege to practice in other Compact states.

So if you're certified in that one state, you can then practice in the other State and kind of move forward kind of on that front. And this is an initiative that's moved from, you know, five states to ten states. And I think now there are twenty-six states, that sound right. Arizona just passed, I don't remember which number Arizona was. So I think these are some bigger pictures to look at

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and to put that group together to have that timely discussion with it.

DR. HUDSON: So, to move the meeting, can I suggest that maybe the division look at a presentation for December about what the pros and cons of the Compact is? And I'll do my work that we said. And I just want to acknowledge that both the director and the physician have both said they agree with Don Hudson. So, thank you.

DIRECTOR GREENBERG: I would have to check the minutes for that one, Don.

DR. HUDSON: For the record, we are on camera.

DIRECTOR GREENBERG: Yes. Yeah, we'd be -- we'd be happy to put together something in the presentation or a one-pager or something. Absolutely.

CHAIR DOYNOW: So, we do have a motion that's on the form been seconded. Do you still want to proceed with that, or do you want to table your motion until there's more information?

DR. BOMBARD: I want to proceed.

CHAIR DOYNOW: Okay.

MR. AFIENKO: I just want to clarify

though, my question wasn't exactly answered and we're about to vote, if we should sunset the exam but no one actually said why we still are holding on to the exam or why we want to. I hear all of the -- the information about collecting data and -- and moving forward and this takes time, but I just want to know why we unlike most other states don't want to move on faster. I'm just not here -- I just didn't hear that answered.

CHAIR DOYNOW: I'm not sure there is an answer quite frankly. That would be more for D.O.H. to answer, I would assume.

MR. AFIENKO: Okay. Thank you. I mean, you're just going to ask me in a few moments if I want to vote to sunset the exam, but no one can tell me why we should keep the exam, right?

DR. BLACK: As -- as another junior member of the SEMAC, I would say that we could always come back in December with information that makes us reverse this with a different motion and a different vote. But I think a fourteen month transition plan as proposed is probably a reasonable target that we could always discuss later on how to miss or hit later.

DR. DORSETT: I think there's one piece of important information, which is how many unaccredited paramedic programs are there in New York State, because that's the barrier, right. So if you say -- because there's a timeline I can't decide today to become accredited and be accredited in fourteen months, but they just need to have a letter of review and start the accreditation process through COAE but they are not eligible to take the registry at the paramedic level if they are unaccredited and do not have a letter or do not have a letter of review through COAE.

CHAIR DOYNOW: Howard.

MR. HUTH: Sorry. Hi, everybody. Howard Huth, I'm the Director of SUNY Cobleskill Paramedics Program. Just to add to the conversation I also do sit on the state exam writing committee. If we could not make a change currently, that would probably be great because you have some paramedic classes that have already started that might have cohorts that run longer than that, and you're going to change the terms of students who have already entered.

So we can just take a couple months.

I don't disagree with the conversation. I've texted half of you I feel like during the conversation. But maybe not doing this immediately would probably be good thing for the students that are potentially already enrolled.

DR. BOMBARD: Howard, the -- the motion was for January 1st, 2028. Does that not --

MR. HUTH: There are some programs that really run long.

DR. BOMBARD: Wow.

MR. HUTH: So like, even associates degree, if they come in for us for a two-year program, they come in under certain terms that we have to agree to and that's their contract as they come in on the college. So, like, if I -- if we brought somebody in now, they would finish their paramedic in August of '28.

DR. WINSLOW: If I may -- Winslow. If I could clarify, Howard. If you use the Reconnect program are you required to take the New York State exam to get your reimbursement?

MR. HUTH: We don't currently use Reconnect, so I'm not an expert on that. But Reconnect is about funding model and then placement

for jobs later. So, I don't think how that certification process happens probably ties into that.

DR. WINSLOW: Then it should make no difference which exam they take, because currently every paramedic can go through the alternate pathway today.

MR. HUTH: Correct. Except that when you -- like, when we bring an associate's degree student that just started this fall, they come in under certain policies and procedures. That -- that's their contracts. So, like, a college can't change how they have to go through coursework or what they do at the end. So if any other program, I'm not saying ours does, but we do, if any other program has it set up that, you know, they're going to take certain exams they list out a state exam you may have issues with students who are already enrolled.

I'm just saying if -- if you wait a couple months to kind of -- or a month to figure this out to the next meeting, it -- it probably catches a whole lot more stuff. And I think as you all know by having a conversation here, the more we talk about this we're more -- we're going to uncover that

probably none of this is really a great fit, and we just have to figure out what the best solution for this is.

CHAIR DOYNOW: I know it's a question on the floor, how many uncredited programs in New York State? Ryan, do you know the answer to that?

DIRECTOR GREENBERG: Currently one, and no regulation to require anybody to maintain it. Just putting it -- like, I think everybody would, but I think it's important to recognize that there's only one, and there's no current regulation to require that someone maintains it. So, could be an obstacle to things in the future. Could change, I'm not saying -- we can change that, but that's where it is today.

DR. DORSETT: So -- yeah, really. But you don't need regulation to tell them to maintain it if you require an exam that requires them to main -- to maintain it for their students to be eligible, which is the way that a lot of states do this.

I do think, you know, one potential modification is instead of saying the exact sunset date is actually get the information about that paramedic program how much -- how many students are

actually affected, when would they be graduating so that we don't put actual students going through a paramedic program in a bind. And if we get that particular information, which would give the Bureau time to come with data to potentially answer Dr. Afienko's question about the why, then they can vote on and have an informed sunset date.

So, I would suggest that it's about getting that right information, because the last thing I would want to do is take students who have decided to become paramedics and create a barrier for them to do that.

CHAIR DOYNOW: So, to do that you'd have to do something with your motion.

DR. BOMBARD: I'd like to modify the motion to make the sunset date January 1st, 2029 -- 2029.

DR. BLACK: Second the modification.

DR. WINSLOW: Yeah, that sounds right. Thanks.

CHAIR DOYNOW: And if we can to get the motion up on the screen, so we know what we're voting on.

DR. HENNESSY: Are we still in the

discussion phase? I'm just asking.

CHAIR DOYNOW: We can if there's more discussion to be had.

DR. HENNESSY: Just -- I just want to respond to the question that was asked on the other side of the table there. Maintaining a standalone testing system allows, and I think Ryan already talked about -- or Director Greenberg already talked about how it's lower cost to -- to the individual providers who are -- who are seeking to go through the system. The other thing that I think needs to be recognized is maintaining a standalone certification system and testing system that we have here in New York State allows for us to have some flexibility if there are issues with the national provider. And we have seen circumstances within the past few years where there have been problems with the availability of that testing and certification process.

So, I just want to make sure it's really clear that if you put all your eggs in that basket, you have to make sure there's no hole in the bottom of the basket. So, just keep that in mind as you make decisions on this. Ultimately, there will be a circumstance, we're going to make sure the

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providers can get online. That's really important to the Department of Health. I know it's important to all of you as well. And I want to make sure that we also maintain the ability to have that flexibility of an off-ramp when there are circumstances which are outside of our control with organizations we work with, like the ones that have been named previously. Thank you.

DR. RUBANO: Okay. So, can I just ask a quick question. I might be a little bit ignorant on this, but what -- does everybody else get grandfathered in then, or are we going to make the paramedics who haven't previously taken the national exam now take the national exam?

UNIDENTIFIED SPEAKER: They'll be grandfathered in.

DR. RUBANO: They'll be grandfathered in, no problem?

DR. DORSETT: So, I think the clarity is that it's for initial certification only. So if you're currently a practicing paramedic, there's no requirement that you use it for maintenance of certification, some states have that. But it's for the initial certification. So, I would -- I would --

are we allowed to amend yet? Can I make an amend -- no. What's the process?

DR. BOMBARD: It's the -- yeah, you're right. That was the sentiment of it. So --

DR. DORSETT: I think it needs to specify for initial certification.

DR. BOMBARD: Initial -- so before New York State?

CHAIR DOYNOW: Yeah, you're going to have to go back to start again. So, exactly how do you want to phrase it? Put up what was initial -- what Dr. Bombard initially said, and let's modify what's up on the screen. So, there's a motion that you've had for initial certification.

DR. BLACK: I second her motion for amendment.

CHAIR DOYNOW: If you're going to change your motion, then we'd need to second.

DR. BLACK: Yeah. I -- I second the amended motion.

CHAIR DOYNOW: Okay. Should that be certification -- certification exams?

DR. DORSETT: That should be the adoption of the National Registry exams for initial

certification, I believe. Yeah.

DR. RUBANO: While we're wordsmithing, would you entertain no later than, as opposed to the date? Because we're pushing the date out, but we might actually find conditions where moving it up sooner than more than two years from now might be appropriate.

CHAIR DOYNOW: I think we had a problem with students at -- Howard had mentioned would be put in jeopardy.

DR. RUBANO: I think that needs to be balanced on the overall pros and cons of the approach.

DR. BOMBARD: We can always look in to that and clarify some things.

MR. WASHKO: Some questions coming from our educators that they're sharing with me as part of the discussion, just for clarification, really has to do with concern -- just confirming this -- those that are currently New York State certified would be grandfathered. So that's right, it's just initial certification.

DR. BOMBARD: This has nothing to do with --

MR. WASHKO: What if they -- what if they lapse? So they lose their -- they lose their card, they miss their card by two months. Do they now have to sit and take the registry? These are some questions that are going to come up, right? So, I just think we need to think through some of this stuff because it has to be addressed.

The -- the assumption is all of this has to be worked on as part of this motion as we have to figure it out as well as, like, the C.M.E.s and aligning C.M.E., State C.M.E. along with registry C.M.E. that was brought up, Like, all this stuff has to be done. That would be part of the work that -- to get us to that date.

I just want to make sure everybody -- you know, that we're all on the same page, that we're -- we're talking about this is initial exam, and then those unintended consequence issues just to make sure there's a -- you know, a mechanism to address those, I think.

DR. BOMBARD: Yeah, we have till 2029 to iron this out. However, to answer your question, if it was -- if it's a situation where they would have to take the New York State exam and we don't

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have a new state exam again anymore, then they would have to take the registry exam.

MR. WASHKO: Yeah. So --

DR. BOMBARD: Which is arguably a better exam anyway. So --

MR. WASHKO: I don't -- I don't disagree. I'm in full support. I just want to make sure there's all the unintended consequences. Like I said, I'm asking our educators in the room to help me understand what the pros and the cons are because there was questions have asked about that. So, I'm just bringing those up just to make sure everybody fully appreciate some of the work that has to be done as we move forward with this, so.

CHAIR DOYNOW: So we've been asked to call recess for the next five minutes for a discussion. So good five -- everybody five minutes stand up and think about this.

(Off the record at 12:59 p.m.)

(On the record at 1:10 p.m.)

CHAIR DOYNOW: Everyone, we would like to restart the meeting, please. If we could have everyone please proceed so we can restart the meeting. We actually are running out of time. Okay.

Thank you everyone. We're returning. So it's come to the attention of -- of the Chair that -- and the Department that there may be some people who have a conflict of interest in this vote. And we're asking those people at this time to recuse themselves. I guess that would be both is what they've been asking.

DR. EGIN: So, what we're asking is if any voting members feel if they a conflict, they have to recuse themselves and leave the room.

DR. MCEVOY: I am not a voting member, but I am the immediate past chair of the National Registry Board of Directors. So, I will also leave the room.

CHAIR DOYNOW: Okay. Does anybody else feel they may have a conflict of interest? Okay. The next request is that -- we've amended this motion so many times, if it can be restated and have a re-second so we know that there's no confusion.

DR. BOMBARD: The motion is to sunset all levels of the New York State Initial Certification E.M.S. exams with a sunset date of January 1st, 2029 with the adoption of the National Registry Exams for Initial Certification.

CHAIR DOYNOW: Can we have a second

for that? Dr. Black is seconding the motion. Can we put the motion up on the screen? Hang on, Dr. Cooper. Okay. Now, could we have any more discussion? Dr. Cooper.

DR. COOPER: Mr. Chair, I -- I respectfully report that until about 2006, I was the chair of the Committee on Accreditation of Paramedic Programs. I leave it to the group to determine whether that would constitute a conflict. If it -- if it does, I'm happy to step aside.

UNIDENTIFIED SPEAKER: It's you that decides, not us.

DR. COOPER: I don't -- I don't see a conflict, but --

UNIDENTIFIED SPEAKER: That's why —-

UNIDENTIFIED SPEAKER: I agree with you.

CHAIR DOYNOW: Any discussion before we vote?

DR. WALTERS: So, the only thing I would say just in discussion, I -- and I think this is something we've talked about for a long time, I hear a lot of people agreeing with -- with the premise of this motion. I'm just -- I'm a little

hesitant maybe -- maybe Don, maybe you can weigh in.

It just seems like we're kind of rushing to put a date out there rather than having a kind of more concrete plan and time frame from T and E and what that would look like or pros and cons and things like that. And I just don't know if that's worthwhile. Although I understand the point of wanting to push this forward and not keep kicking it down the road, but I just -- I'm not sure, Don, if there's -- if there would be benefits of coming back in December with an actual plan of what that implementation would look like timeframe wise and -- and things, and if that would be better serving the interest of our -- our educators, number one.

Number two, I think the question was asked, and I still don't know that we have an answer. It's been asked several times about why are we so reluctant to move away from a state -- state certification, right? And I mean, we had a bunch of people leave the room, and all we do is come back and ask people to disclose conflicts, and I don't know that we still have an answer. And -- and I think that before we vote, we've asked for some discussion on that, and maybe someone could opine in that

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direction.

DR. HUDSON: So, I appreciate the question -- I'm not even on this committee, so thank you for sucking me in, but that being said, so training is going to do the work, and we'll produce something in December anyway. I don't know the intent behind the deadline, but may I suggest my interpretation is that, not to speak for anyone else, I am frustrated and fully acknowledge that without a deadline, government is not good at doing anything. So we can always move a deadline, but without a deadline, we just know things go on forever.

So I'm not opposed to a deadline, artificial or not, we can -- we can always move it. And it's also New York. If you don't make a deadline, pay a fee or whatever, I don't know. It's also the culmination of decades of a scab that really has never healed that it's time to -- it's time to address. So, on what time frame, I leave that to your good -- your good committee, but I think we need to produce some data, have a discussion with -- without a time frame.

CHAIR DOYNOW: Brian? Dr. Winslow?

DR. WINSLOW: To put on my medical

director hat, which I rarely do, I -- I just think it's the right time to make this move. The National Registry exam is vetted. It is a good exam, and I've taken both the National Registry and the state exams, and I got to tell you, I think the National Registry is a better exam, period.

DR. BLACK: I move to split the question into two parts. I move to split at the word exams, and then I move to table the second half to December, and I move to vote on the first half.

CHAIR DOYNOW: Well, I don't think we can actually do that. We can vote on the -- on the motion, and then we can have another --

DR. BLACK: I mean, you can -- you can vote on my request to split the question.

CHAIR DOYNOW: We can after we vote on the initial, or Dr. Bombard can amend her motion.

DR. BLACK: We -- we don't -- we're not currently in a vote, are we?

CHAIR DOYNOW: We're in discussion at the moment.

DR. BLACK: Okay.

CHAIR DOYNOW: Is there any other discussion before we vote on this?

DR. BOMBARD: No.

DIRECTOR GREENBERG: Microphone. And state your name.

DR. DUVALL: Don Duvall. This is a question of clarification. The way I understand Article 30, decisions about examination processes are the purview of the Commissioner, so the most that SEMAC and SEMSCO could do is make a recommendation to the Commissioner for a-- an abolition of exam processes and any kind of a sunset date.

We know how the issue with critical care has turned out when we set a sunset date, and the -- the Commissioner's subsequent pushback on that. That -- that lesson still stings a little bit. I think more properly, the order would be -- we can make recommendations, but it's ultimately going to be up to the Commissioner of Health.

CHAIR DOYNOW: Thanks, Don. And -- and I believe it's true. Is there any other discussion before we vote on this motion? And Dr. Black, after we do that, if you want to --

DR. BLACK: I withdraw.

CHAIR DOYNOW: Okay. All right. Well, Theresa, if we can have a roll call vote.

MS. ALLEN: Dr. Afienko?

DR. AFIENKO: Afienko, yes.

MS. ALLEN: Dr. Berkowitz?

DR. BERKOWITZ: Berkowitz, yes.

MS. ALLEN: Dr. Black?

DR. BLACK: Black, yes.

MS. ALLEN: Dr. Bombard?

DR. BOMBARD: Bombard, yes.

MS. ALLEN: Dr. Clemency?

DR. CLEMENCY: Clemency, yes.

MS. ALLEN: Dr. Cooper?

DR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Dailey?

DR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Dorsett? Dr. Doynow?

DR. DOYNOW: Yes.

MS. ALLEN: Dr. Goldman?

DR. GOLDMAN: Goldman, yes.

MS. ALLEN: Dr. Hallinan?

DR. HALLINAN: Hallinan, yes.

MS. ALLEN: Dr. Isaacs?

DR. ISAACS: Isaacs, yes.

MS. ALLEN: Dr. Kugler?

DR. KUGLER: Kugler, yes.

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MS. ALLEN: Dr. Olsson?

DR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Papish?

DR. PAPISH: Papish, yes.

MS. ALLEN: Dr. Rubano?

DR. RUBANO: Rubano, yes.

MS. ALLEN: Dr. Seth?

DR. SETH: Seth, yes.

MS. ALLEN: Dr. Shih?

DR. SHIH: Shih, yes.

MS. ALLEN: Dr. Walters?

DR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow?

DR. WINSLOW: Winslow, yes.

MS. ALLEN: Motion passes.

CHAIR DOYNOW: Okay. Thank you. If someone can have Dr. Dorsett come back in, please. All right. Moving all along, E.M.S. in children was going to be Dr. Cooper, but Dr. Cooper has exited. So Amy, can you give us an update on E.M.S. for children? Oh, Dr. Cooper, if you can give us an update on E.M.S. for children.

DR. COOPER: Thank you, Dr. Doynow. The Emergency Medical Services for Children Advisory

Committee to the Department met earlier this week, December 14th. We had a very, very busy meeting. I'll hit just a few highlights of that meeting.

Before doing so, however, I want to express on behalf of the committee our, you know, congratulations to Dr. Harris for winning the -- the Physician of the Year Award. That's a huge honor for him, and he certainly has done way more than enough to deserve that honor. Matt, if you happen to be listening today, congratulations from us all.

The -- perhaps the most pressing work problem or work project we've been dealing with is the procedural sedation work group, which more properly is a procedural comfort work group focusing on how to keep children comfortable during procedures, both in the E.D. and in the pre-hospital environment.

A lot of work has gone into this over the summer. There's a -- a survey that has been developed and is undergoing its very final stages of -- of technical review and -- and commitment to an electronic format for distribution and so on. At this point, the plan is for it to go to all fifty-six hospitals that are participating in the Always Ready

for Children Program. We anticipate that the survey will be ready at some point in the next month or so, or perhaps two. We hope to have some initial review at our December meeting, but that survey is moving ahead.

We did hear from George Stathidis about the pediatric equipment and supplies advisories. Thank you, George. We finalized the -- the wording for a letter that's going to go out to all ambulance agencies, E -- E.M.S. agencies in New York State regarding length-based resuscitation tapes. The recent -- recently promulgated regulations require that all ambulances carry a length-based resuscitation tape. There -- there was some concern on the part of some basic life support agencies that this was really not necessary for them because, you know, they did not administer drugs according to a weight-based algorithm.

But you know, the -- the tapes, as you all know, include, you know, appropriate vital signs for length and so on, on the reverse side of the tape. And so, a letter has been created. And with wording initially provided by Dr. Dorsett, thank you, Maia, and reviewed by the committee, which will, with

the Department's approval, go out, as I said, to all ambulance agencies, E.M.S. agencies in New York State.

Ben Kasper and Tiffany Fabiano from the Golisano Children's Hospital in Buffalo have been working on a -- a development of a potential educational tool. It could be a reference card, could be included in protocol. We haven't gotten quite that far yet outlining red flags, if you will, for abuse of injury in -- in children. And that -- that will be presumably finalized at our -- at our next meeting.

And finally, the two major issues -- not finally, but two major issues that also Dr. Dorsett was gracious enough to take on, focused on pain assessment and management in children. And the -- the, you know, the -- the disposition of children who did not undergo E.M.S. transport despite having a nine-one-one call being made. Dr. Dorsett said gave two lovely presentations on the data that was provided by the Department. And again, thanks to those from the Department staff who helped put that together. More to come on both of those issues.

And then at last, Dr. Redwiner

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(phonetic spelling) reported on the mental health crisis center issues, which I believe he reported on earlier this morning, may report on here this afternoon, I'm not sure. And then -- those are the major points.

Dr. Ed Conway, who has played a major role at a national and international level in terms of pediatric sepsis guidelines, updated us on progress on that front. The pediatric sepsis guidelines have recently been updated, published in -- - in pediatric surgical critical, sorry, pedia -- pediatric critical care medicine in April of this year. And -- and we will -- we will ensure that a copy of those guidelines is provided to all of you on this -- on this body, so that you have them for review.

That concludes my report, brief as it is, and I'll be happy to answer any questions that anyone may have.

CHAIR DOYNOW: Does anybody have any questions for Dr. Cooper? Okay. Moving along.

DR. COOPER: Thank you, Dr. Doynow.

CHAIR DOYNOW: Thank you, Dr. Cooper. Old business, Dave Violante, bylaws. Did you want to

bring those up? Dave's here.

MR. VIOLANTE: Not really. But I will. We have a bylaws TAG that we have modified the section three of the bylaws as posted and sent out in boardable previously. What we did was clean up the language to refer to and conform to New York Public Health Law Article 30, especially Section 3002-A, related to membership, terms and purposes, attendance, voting and quorum, and chairperson responsibilities. That's been out for everybody to review.

We had a pretty good discussion about this at the last meeting and the meeting prior to that. And so, these have been posted or out, and we will vote on these at SEMSCO today. If there's any questions or discussion about these, I'm happy to entertain those.

CHAIR DOYNOW: Does anybody have any questions on those bylaws? Just so the members know, you still have a two-year term, but you can be on the committee forever if you so desire, as long as your region reappoints you every two years. There's no term limit from not being able to be reappointed.

All right. Let's move along then.

Ryan, a state medical advisor, any update? Anybody been interviewed? And do you have any knowledge of what's going on there?

DIRECTOR GREENBERG: Going well, moving through the state hiring process. And so hopefully we'll have an update in December.

CHAIR DOYNOW: Okay. Great. So, for the spinal suspected injuries, just an update on that. SEMAC did vote on that. It then went to STAC. STAC changed the language, and the Department has requested that the protocol go back to the collaborative committee to clean up the language and bring it to the December meeting for voting on. Moving along, Keppra Pilot Project.

DR. DAILEY: Excuse me, I thought that was going to be an agenda item here today for Med Standards, that didn't need to go back to the collaborative, that needed to go back to Med Standards to then come here today, and that was what I had been told the pathway was going to be. So I was a little bit surprised not to see it on the agenda.

CHAIR DOYNOW: Well, that has been what has been requested by the Department.

DIRECTOR GREENBERG: You -- you can speak on the wording or anything else in it. It does -- it -- it did not come up in Med Standards, but there's -- there's the wording in it that the Department wanted to look at, not the Department, this group, in the one section, in the one box. So you brought one thing forward, STAC brought it to another, and then the -- the one part was to this group, and they brought it to this group at a collaborative to work on the component of that, and Dr. Doynow was on those conversations. So we -- we can pull it up. It is just the one component of it. Do you want to pull it up?

CHAIR DOYNOW: We can pull it up if you'd like.

DR. DAILEY: So, when I was notified that the Department had made the decision that this would not move forward after the STAC review and our exchange of the conversations, Dr. Doynow, you had told me that it was coming back to Med Standards for discussion today.

I apologize for not making it this morning to the meeting. I'm still a little bit confused as to how that pathway went. This does not

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go back to the collaborative again, this is already at this level with very clear intentions as to how this is to progress forward. I think it does require a robust discussion that should be at Med Standards based on the concerns of the Department. I'm incredibly disappointed that the process did not follow the way it should have and was not there this morning.

This is something, quite frankly, that we've had an awful lot of discussion about. Snow-mageddon threw off the time frame in the first place, or we would already have all of this stuff done. But, you know, moving items around so they end up getting delayed like this is just a -- is a darn shame.

So let's make sure that indeed it is out to everybody, that it is cleared through the executive approval process so it can be on the agenda and then can be discussed appropriately, and that we do this in -- in December so we can actually move the medicine forward in 2027 the way we need to.

CHAIR DOYNOW: Dr. Rubano, anything to add on that?

DR. RUBANO: No, I'm good. Thanks.

DR. DAILEY: Sorry, I have my resident surgeon next to me, who is not a resident, but -- yeah.

DIRECTOR GREENBERG: I think past residency now, attending in multiple places. It is past the executive process. Like I said, you can pull it up here for discussion, and I think Dr. Doynow, if you want, can, you know, have those discussions on some of the wording for this group to clarify on what that is.

There was also an excellent point on that -- that was discussed that I didn't even think of, about how this is going to be rolled out to hospitals so that they're aware of the change as well and that, you know, when someone comes in and so they have the education on that front. That was brought up by some of the physicians. I don't know what that plan is on that. So does anyone have any ideas?

CHAIR DOYNOW: We can put it up and we can certainly discuss it.

DR. DAILEY: I think particularly after a lengthy discussion on the registry and how that process went around and around, I would suggest that this go back to Med Standards for that long

discussion in Med Standards and be brought here as something where concerns of the Department have been well discussed, any additional concerns that have popped up along the way, so we continue to move forward as smoothly as possible and keep this meeting efficient.

CHAIR DOYNOW: So, I'll bring it up to the group. Does the group want to bring this up, or do they want to stick with what Dr. Dailey asked?

DR. WALTERS: So I --

DIRECTOR GREENBERG: To -- to be clear, and you weren't at Med Standards, the Department's concern on it is not long. It's actually short. It's one box. It is several words, words that the STAC felt should be changed in such a way, things that could be beneficial to talk here because there is a STAC meeting in three weeks. Should you decide to want to bring it to the STAC again, but also knowing kind of from that front what the rollout is after that component when it comes out, so that both the E.R.s and the trauma surgeons and everyone else are aware and on the same page as well.

DR. CLEMENCY: I think it'd be helpful

if we put it up, knew what the changes were, and then we could triage whether it's something that we can deal with today or needs to go to December.

CHAIR DOYNOW: All right. Theresa, why don't you put it on?

COURT REPORTER: I'm sorry, who said that last comment?

DR. CLEMENCY: Clemency.

COURT REPORTER: Thank you.

DR. COOPER: Excuse me, can you make that a little larger for us all?

DR. DAILEY: That's the right one.

CHAIR DOYNOW: Not quite that large.

DR. DAILEY: The biggest change that the STAC added here was age greater than sixty-five in terms of an area of concern.

CHAIR DOYNOW: And so --

DR. DAILEY: That was --

CHAIR DOYNOW: -- I believe the -- the concern was the may, believe it or not.

DR. DAILEY: No. And I'm -- I'm sure the may was a concern. So the idea, right, is that what we're doing is taking care of the patient, and you may consider the use of a collar if you think it

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is going to be the right intervention for your patient.

The patients on the -- on the left-hand side, the patients with the significant blunt trauma, right, in all of these is there a concern for an injury? If there is a concern for an injury, the clinician may consider the use of a collar because the collar may not be the best way to assure that that patient remains safe. I spent the morning with my mother, who is ninety years old. She is shaped like the letter C. A cervical collar would be horrible care for her.

However, if she were to fall and strike her head, she would indeed be at risk of a cervical fracture. So careful movement, careful padding, and appropriate care is the best way to keep my mother safe. Frankly, it's the best way to keep my mother safe anyway, which I would appreciate all of you to do.

So, goal here is good medical care, allowing clinicians a significant amount of judgment, and assuring that indeed we are keeping up with what is developing as a national standard. Dr. Rubano, anything to add from a trauma perspective?

DR. RUBANO: No, I'm in this part, I would guess I'll comment. And the -- the concern I think as you mentioned was adding on the age. There's a fair amount of literature, and there was a concern from some of the research also being done at Rochester that you're going to miss spine injuries in that age group. So it was just, to your point, a word of caution to include that in the high-risk group, but not necessarily to immobilize them.

CHAIR DOYNOW: Ryan, did you want to add anything about the wording that -- that was in question?

DIRECTOR GREENBERG: I can just express from the Commissioner's Office side of things that the -- the may consider with some of the wording of, is it a little bit too gray in the description of it? I am belaying -- you know -- and is that the best wording for that sentence for providers to clearly understand that and make that clinical judgment?

DR. DORSETT: I was going to say, I think there's going to be a very large educational lift as we saw when we removed, right, the -- the use of backboards through standard practice. But I think

it's a -- is it gray? Yeah, because medicine is gray, and we know patients are shaped differently, and there's different circumstances. And so I think a lot of the education is going to have to center on this clinical judgment and how do you achieve spinal motion restriction, rather than how do you apply a particular device to achieve that. And so I think it's quite reasonable. Is it going to be hard to educate on? Probably. Is it worth it because we're causing harm? Yes.

DIRECTOR GREENBERG: And I think the concept behind it is very much in support from the Commissioner's Office to move -- to move forward on that. That -- that was not the resistance on it. It was just the terminology and the words being used in that component.

CHAIR DOYNOW: So what could be changed in that wording that would pass through the Commissioner's Office?

DIRECTOR GREENBERG: Unfortunately, Dr. Fish is not here today, who had the express concerns. And so I know that, you know, we met with him before, and that was expressed. I -- I think it's a fact that says may consider versus just -- and

I think in the original version, Dr. Dailey, it just said consider. It didn't say may consider. I think if we took out the word may, that would probably resolve it. But this is the part of, in terms of -- I -- I don't -- I apologize. I had a family thing, I was not at the STAC meeting to know why the word may was put in there. I don't think it was there in the original version, which is, again, was flagged by Dr. Fish, who I think was at the STAC meeting.

DR. DAILEY: So that -- that was indeed, it was the may versus consider is -- is the big question. Honestly, I can see both sides. Frankly, I think the more prescriptive consider is more potentially problematic as we move forward, because it will lead to additional collar applications and patients who would be much better off without them. I will add in that I think all patients are better off without them. So, I guess I have a horse in that race.

You know, if we had a device that really we knew was going to work and was safe and didn't potentially hurt people and had a good demonstration of success in its use at keeping people safe, then I think it would be a reasonable thing to

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do to take the may out and just make it consider. But, we put on collars not for patients. We put on collars for us. The number of patients that I see come into the hospital where clinicians have made the right decision, and then a doctor makes the wrong decision and puts that collar on is huge. If in order to move New York forward, we remove the may, I think what we should do is remove the may. And then we can continue to teach to the right thing and advance care over time. But what we're doing with putting everybody in a rigid extrication collar is not good medicine.

DR. WALTERS: So personally, I think we're focusing a little too much on the word may, right? The -- the intent here is if they meet these criteria, right, we should limit spinal motion, right? We -- we agree it's -- we should -- spinal motion should be minimized. I think the intent of the word may or consider or may consider, however it's phrased, is that a properly sized and applied cervical collar may be one of the options for limiting that spinal motion, right? I think that that was a conversation here last time and that the STAC had.

Now, I understand, and I don't want to get into the debate of whether we should or should never use cervical collars, right? But I understand what Dr. Dailey is saying. But I think that since we're saying that spinal motion should be minimized, I think that that beginning of the sentence is the more important piece. I think may consider becomes almost irrelevant at that point if we're saying we're minimizing spinal motion.

DR. RUBANO: So sorry, just to jump in there. So it's actually kind of funny because at each co -- each meeting we go to, the opposite opinion is sort of had. It was that consider was too strong because we were implying that you should put the collar on, and now may consider is too weak because we're implying that you shouldn't. So I think it's -- to everybody's point and to go back to the education. Like, it's the spinal motion. Don't move them around. You know, Dr. Dailey's mom hits her head, don't twerk her neck to put the collar on. But because she's older, you should consider putting a collar on if she didn't have some weird kyphosis or whatever. So I -- I think we're just getting stuck on this a little bit, and it'll just go in circles

for a while.

DR. DAILEY: Yeah, I think also if we focus on the times we truly put these patients at risk, right? When we've got that patient and we have carefully moved them out of whatever environment they're in, we've got them on a stretcher, right? If we've left them on a backboard, which I still see patients on, and they're sliding all over creation while we're careening down the streets, that's one of those times the patient is at risk.

If we're moving that patient from the E.M.S. stretcher onto a hospital stretcher and we're yanking them over using a sheet lift and not using a slider, that's where we're putting that patient at risk. And ultimately, either pre-hospitally or in the hospital, when we're pushing medications inducing -- inducing paralysis and intubating that patient, that's one of those times we're really putting patients at risk.

But when patients are just sitting on a stretcher, comfortable at thirty degrees, not moving their head around, guess what? Their head is -- if their neck is broken, they're not going to move their neck around because it hurts. So, we're doing

the right thing here. Whether it's may or no may, honestly, I think we're heading in the right direction.

DR. DORSETT: So, I -- sorry.

DR. WALTERS: Just to clarify then, with the discussion at STAC, their recommendation was to put may in the phrasing because it was felt to be less forceful, more permissive. Is that -- if that's the STAC's recommendation, right, then I think that we should consider a strong --

DR. RUBANO: Yeah, I mean -- I think the -- the more STAC was being concerned about the age and everything, and then just, you know, the -- the -- the -- maybe I just didn't think may was such a big deal, but the may didn't seem to be the -- the crux of the matter there. It was more the -- the mechanism and the age. And then the may was to make it more gentle, that you're not being forced, yes.

DR. DORSETT: So, clearly this is not a short discussion, but we don't say you may use blankets, you may use a booster, you may use this. So why can't it just say -- I can't read anything, but spinal motion should be minimized, period. The end. And then by -- and then the implication is you

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provide education about what are the mechanisms and how do you decide on how to do spinal motion restriction, you know.

CHAIR DOYNOW: That sounds actually very reasonable, and may resolve the issue.

DR. CLEMENCY: If we change (overspeaking) —

CHAIR DOYNOW: -- put that in purposely.

DIRECTOR GREENBERG: The only thing I would say to that is this is a pretty significant change in medicine that's being delivered. Not a bad one, just a pretty considerable one. And I think something in the protocol or the -- the -- the pathway to it that says to consider the use of appropriate applied cervical collar also lets E.M.S. providers know, like, that maybe not having it there is, you know, that option as well. So that's just my personal opinion on that one. But I think, you know, Dr. Dorsett's point of the appropriate education and kind of framework that goes along with it is significant to this as well.

CHAIR DOYNOW: Dr. Clemency?

DR. CLEMENCY: If -- if we make

changes, does it have to go back to STAC or are we the last step before this moves?

CHAIR DOYNOW: It actually never had to go to STAC, except out of consideration for our trauma.

DR. DAILEY: So --

CHAIR DOYNOW: So --

DR. DAILEY: -- just as a reminder, the reason it went to STAC, right, was my fault. But -- but the -- but the reason it was my fault is because I don't believe that E.M.S. or, frankly, emergency medicine exists in a silo all by ourselves. We -- we are part of the House of Medicine, and if we're going to make a change within the House of Medicine that's going to impact other departments within the hospital, I think we need to have a discussion with them so they know where our medicine is coming from. So, that's why I hang out with surgeons sometimes.

DR. CLEMENCY: So, you called the trauma consult is what you're saying?

DR. DAILEY: Exactly.

DR. CLEMENCY: Way to go, Mike.

DR. DAILEY: I called the trauma

consult, and Brian, in keeping that -- that analogy, my initial goal was to call the trauma consult and then call the -- it to question in E.M.S. forum. And unfortunately it got reversed because of Snow-mageddon.

DR. CLEMENCY: You're aware the trauma consult always slows down disposition, though?

DR. DAILEY: That's true.

DR. CLEMENCY: Okay. Trauma is happy to sign off. Okay. Disposition per E.R. Turf to medicine, it'll be fine. So I -- I think we're very close. I -- I -- I think Director Greenberg's point about we need some mention of collar to -- to show that the intention of this is to change that mindset. So, I'd make a motion that we approve this as written with the word may removed.

DR. COOPER: Second.

DR. HUDSON: Just on that discussion since you mentioned education three times, I know how this is going to play out. Regardless of what it says, the messaging of what it means is more important, and that's the di -- the change from practice, decades long practice, which we know is probably not the best now, like we've done with many

other things, to say that, forget it's a neck. If this was an arm and it hurts when it moves, don't move it. If they can do that on their own, you may use a splint. You don't have to. You may use a saline swath. You don't have to.

The objective is, if it hurts, don't move it. How you do that is the art of E.M.S., right? So, that's the educational message, the -- the -- the teaching point, if you will, that I think we need to just promulgate in explaining what the intent is, not necessarily argue over commas or semicolons again.

CHAIR DOYNOW: Okay. So, there's a motion on the floor. Dr. Clemency, could you repeat that, please?

DR. CLEMENCY: I make a motion we approve this as it currently exists with the word may removed.

CHAIR DOYNOW: Okay. That was seconded by Dr. Cooper?

DR. COOPER: Yes. And it remains seconded by Dr. Cooper.

CHAIR DOYNOW: Okay. So, can we pull the may out of there? May we remove the may?

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DIRECTOR GREENBERG: You may because she has it in the Word document.

CHAIR DOYNOW: Dr. Dailey, while we're doing that, when would you like this to be implemented? That means we do have a significant education component for pre-hospital as well as maybe more so hospital.

DR. DAILEY: Honestly -- honestly, Dr. Doynow, I'm a lot less concerned about whether or not we can teach E.M.S. clinicians to do a good job for our patients than I am whether or not we can teach the people who will be receiving those patients, what the appropriate medicine is, so those poor clinicians don't get beat up when they walk into the trauma bay.

So I think the -- the group needs to come to a conclusion on what the -- what the date is. You know, any -- any major change like this thrown out of cycle from the rest of the protocols, which is what we did with this when we pulled it out, means that we're, you know, frankly, off cycle. So we're making a major change outside of our usual changes.

I just had yearly educational meetings with my -- with some of my agencies because we just had a protocol change. So, I'm really -- I am

challenged by coming up with a date that this should be formally implemented.

DIRECTOR GREENBERG: Dr. Dailey, can I make a recommendation? Would you be open to it?

DR. DAILEY: Sure.

DIRECTOR GREENBERG: You're so kind. And I didn't think of it until literally the conversation we had with Dr. Fullagar and some others related to the hospital component, right, and not having the paramedics and the E.M.T.s take the abuse of perception. Why didn't you do this if you're coming in with this?

My recommendation would be to approve this. So, it may. No. Approve this, we can then either get it up on the protocol page or another page. I would probably recommend a letter from either the -- the SEMAC chair or others or cosigned about why this change is there, what it means, and get that up on the protocol pages, you know, protocol change forthcoming July 1st or whatever it might be, to allow for the education, the communication, and the other things to the hospitals.

The protocol change itself would happen with the -- with the updated collaborative

protocol group. But that gives time for education. It gives time for communication to the hospitals. It gives -- and I wouldn't wait for the, you know, December meeting and things like that. We would get up sooner than later so that those conversations can start now. This is coming in nine or ten months from now. Hopefully it's not a surprise to anybody. And then I think from the Department's side, we can also help in possibly communicating that letter to the hospitals and to the E.R. directors, medical directors, so that it doesn't come as a surprise or at least a little bit less of a surprise.

DR. DAILEY: Excellent idea.

CHAIR DOYNOW: Okay. So we can vote on this. My suggestion, actually, that letter can come from myself, but also Dr. Banks from STAC. Therefore, we have the buy-in of also the trauma surgeons. Dr. Cooper.

DR. COOPER: How about emergency medical services for children as well?

CHAIR DOYNOW: And Dr. Cooper as well. I'd love to have you on that letter. Any discussion of this before we vote on it?

DR. BOMBARD: So the plan is for

implementation in July, correct?

CHAIR DOYNOW: In July, and that will give enough time hopefully for education of everyone that's going to be involved.

DR. BOMBARD: Sounds great.

CHAIR DOYNOW: Okay. We can have a roll call vote.

MS. ALLEN: Dr. Afienko?

DR. AFIENKO: Afienko, yes.

MS. ALLEN: Dr. Berkowitz?

DR. BERKOWITZ: Berkowitz, yes.

MS. ALLEN: Dr. Black? Dr. Bombard?

DR. BOMBARD: Bombard, yes.

MS. ALLEN: Dr. Clemency?

DR. CLEMENCY: Clemency, yes.

MS. ALLEN: Dr. Cooper?

DR. COOPER: Cooper, yes.

MS. ALLEN: Dr. Dailey?

DR. DAILEY: Dailey, yes.

MS. ALLEN: Dr. Dorsett?

DR. DORSETT: Dorsett, yes.

MS. ALLEN: Dr. Doynow?

CHAIR DOYNOW: Yes.

MS. ALLEN: Dr. Goldman?

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DR. GOLDMAN: Goldman, yes.
MS. ALLEN: Dr. Hallinan?
DR. HALLINAN: Hallinan, yes.
MS. ALLEN: Dr. Isaacs?
DR. ISAACS: Isaacs, yes.
MS. ALLEN: Dr. Kugler?
DR. KUGLER: Kugler, yes.
MS. ALLEN: Dr. Olsson?
DR. OLSSON: Olsson, yes.
MS. ALLEN: Dr. Papish?
DR. PAPISH: Papish, yes.
MS. ALLEN: Dr. Rubano?
DR. RUBANO: Rubano, yes.
MS. ALLEN: Dr. Seth?
DR. SETH: Seth, yes.
MS. ALLEN: Dr. Shih?
DR. SHIH: Shih, yes.
MS. ALLEN: Dr. Walters?
DR. WALTERS: Walters, yes.
MS. ALLEN: And Dr. Winslow?
DR. WINSLOW: Winslow, yes.
MS. ALLEN: The motion passes.
CHAIR DOYNOW: Excellent. I'm sorry we are running over. So just one other vote that we

need. Dr. Winslow's Keppra Project that we never actually voted on, so.

DR. WINSLOW: Thank you. I'll keep it brief because I know we are way over. We already discussed the Keppra implement -- the Keppra Project in terms of treating -- treating resistant seizures, status epilepticus with Keppra. After the May meeting when I showed the protocol and we discussed it, the group decided a -- a universal dose of three thousand milligrams was the correct dose as opposed to weight-based.

I will also say that we then partnered with the University of Buffalo and Dr. Clemency and his I.T. division and staff to assist with data mapping for making the project more readable as well from a data standpoint. And we have a proposed timeline for implementation on January 1st of 2027 to begin the pilot program for one year with the idea being after January 2028 we would do the data query and management and present it at the first meeting of the SEMAC and in 2029 -- I'm sorry, in 2028. That would probably be February or March, with the idea being that if that showed success over the one-year project that we could put it in for the July 2028

protocol rollout.

So, that was our proposed timeline. What I can tell you is it's supported by the REMACs of Nassau, Suffolk County, and the Buffalo region. If any other regional REMAC wanted to participate as in other statewide pilot programs, they could reach out to me. I'd be happy to assist. But I do just -- do just need final approval from this body so that I can then have not only the Commissioner of Health opine and give his final approval through the division, but then Dr. Clemency could take it to the I.R.B. of the University of Buffalo to have it I.R.B. approved as well.

CHAIR DOYNOW: Any discussion on this before we vote? We need a second, actually. Dr. Cooper. Any discussion?

DIRECTOR GREENBERG: The only thing on discussion I would say is with a recommended start date of January 1st, 2027, this is a -- any pilot program is a pilot program under the direction of the Commissioner of Health, and even I do not dictate what that timeline looks like.

CHAIR DOYNOW: I agree - I agree with that edit -- edit, if that's okay with the group.

Okay. And there's no discussion. There will be a roll call vote again.

MS. ALLEN: Dr. Afienko?
DR. AFIENKO: Afienko, yes.
MS. ALLEN: Dr. Berkowitz?
DR. BERWOWITZ: Berkowitz, yes.
MS. ALLEN: Dr. Black? Dr. Bombard?
DR. BOMBARD: Bombard, yes.
MS. ALLEN: Dr. Clemency?
DR. CLEMENCY: Clemency, yes.
MS. ALLEN: Dr. Cooper?
DR. COOPER: Cooper, yes.
MS. ALLEN: Dr. Dailey?
DR. DAILEY: Dailey, yes.
MS. ALLEN: Dr. Dorsett?
DR. DORSETT: Dorsett, yes.
MS. ALLEN: Dr. Doynow?
DR. DOYNOW: Yes.
MS. ALLEN: Dr. Goldman?
DR. GOLDMAN: Goldman, yes.
MS. ALLEN: Dr. Hallinan.
DR. HALLINAN: Yes.
MS. ALLEN: Dr. Isaacs?
DR. ISAACS: Isaacs, yes.

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MS. ALLEN: Dr. Kugler?

DR. KUGLER: Kugler, yes.

MS. ALLEN: Dr. Olsson?

DR. OLSSON: Olsson, yes.

MS. ALLEN: Dr. Papish?

DR. PAPISH: Papish, yes.

MS. ALLEN: Dr. Rubano?

DR. RUBANO: Rubano, yes.

MS. ALLEN: Dr. Seth?

DR. SETH: Seth, yes.

MS. ALLEN: Dr. Shih?

DR. SHIH: Shih, yes.

MS. ALLEN: Dr. Walters?

DR. WALTERS: Walters, yes.

MS. ALLEN: And Dr. Winslow?

DR. WINSLOW: Winslow, yes.

MS. ALLEN: Motion passes.

CHAIR DOYNOW: Excellent. Thank you. Some other business Dr. Bombard wanted to bring up.

DR. BOMBARD: Briefly, I know it's late. Could we just review the two -- I think it's just two changes in the SEMSCO bylaws that regard the SEMAC. There were just two changes between 2025 and now. Could we put those up and just review them

before we close?

CHAIR DOYNOW: We can try. Okay. We'll put that up. While we're waiting to do that, Dr. Winslow, you also had something else you needed to bring up. You did. Something about payments -- payment -- payment protocol. Reimbursement, anything like that?

DR. WINSLOW: No.

CHAIR DOYNOW: Okay.

DR. BOMBARD: So this is the first one about the Commissioner shall appoint a physician chairperson to the SEMAC is my understanding. And we will no longer be able to appoint our own chairperson.

CHAIR DOYNOW: Yes, that is correct. As we -- we were made aware that the com -- the SEMAC is the Commissioner's commission, and he -- he makes a decision, and we don't have the ability to elect someone.

DR. BOMBARD: This was just to me, like -- I -- I confess that I had not read this thoroughly, and I was unaware of this, and I wanted to make sure everybody else was aware of this, that this was a change being upon -- imposed upon us.

CHAIR DOYNOW: Well, actually, it's not a change. The initial bylaws were not approved by the Department of Legal Affairs because the committee actually is -- is bound by statute, and we can't change -- we can't make bylaws that conflict with the statute, apparently. And D.L.A. is here, they can certainly explain that.

DIRECTOR GREENBERG: So it's -- so in this particular case, it is the seat of the commission -- of the -- the chair of the SEMAC is appointed by the Commissioner of Health. And so that's why it is that way. And I think we talked about some of the things and the opportunities for the future, should that seat come open to make it aware of this coming open, anybody who would like to possibly put in for it, to put in a resume to the Commissioner and things like that, to put together a process like that.

The last time it was changed was prior to me being here, my tenure. But I think the future and how, if that was to change or things like that, again it is at the discretion of the Commissioner, but that there would be information and -- you know, a process in place to allow for, you know, people who

might be interested in it to show their interest and submit their interest to the Commissioner.

DR. BOMBARD: Does that mean our chair human could be a non-emergency physician or not a part of the committee to begin with?

DIRECTOR GREENBERG: I think it's at the discretion of the Commissioner as per statute.

DR. BOMBARD: So the Commissioner could appoint someone from another specialty to lead us, but it doesn't have anything to do with E.M.S.?

DIRECTOR GREENBERG: I think --

DR. BOMBARD: Yeah.

DIRECTOR GREENBERG: -- that is --

DR. BOMBARD: That is what it says.

DIRECTOR GREENBERG: --- as per the statute, not the bylaws.

DR. BOMBARD: I think we should just all be aware of that.

DIRECTOR GREENBERG: Right. As per the statute, not the bylaws.

DR. BOMBARD: Okay.

DIRECTOR GREENBERG: Right. So -- and -- and I think if you look, I mean, look, I think this group has always been led by someone who is a

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subject matter expert to chair to it. I think the Commissioner recognizes the importance of having, you know, a person who has the subject matter expertise in that and then to allow for that to occur. Could hypothetically, there's a lot of things that hypothetically could happen. But that is, you know, I think, part of what comes with it.

DR. BOMBARD: Understood.

MR. BRANDT: The Chairman has asked me or invited me to the table. It's clear in the statute that all members of the SEMAC are appointed by the Commissioner, so are all members of the SEMSCO. Why is the SEMSCO allowed to elect its own chair?

DIRECTOR GREENBERG: It is not a separate seat in the SEMSCO. It is a separate seat in the SEMAC as dictated by the statute.

MR. BRANDT: I don't follow your answer, Mr. Greenberg. I'm sorry.

DIRECTOR GREENBERG: Sure. So the -- the seat of the chair is a separate seat. So in other words, there's not a vacancy that occurs or anything of that nature when there's in -- where in the SEMSCO, it is amongst the body and there's not a

chair. So the current sitting chair for today is represented by a region. It's not a separate seat. And so that's why that is different in one versus the other.

MR. VIOLANTE: So these are in 3002 Section A, and it clearly states for the SEMAC as to the position of the chairperson as being appointed by the Commissioner is not so for the SEMSCO.

MR. BRANDT: That's in 3002-A?

MR. VIOLANTE: Correct. I'm looking at paragraph one. Yeah, I'm looking at it right now and it's one from each region, right? So it's eighteen people and then it lists five others, an additional physician from the City of New York, one pediatrician, one trauma surgeon, one psychiatrist and the chairman. But Dr. Bombard, to your point, the next sentence reads, each of the physicians shall have demonstrated knowledge and experience in emergency medical services, which I think covers what you're looking for.

DR. MCEVOY: And it's also important to note that SEMAC is a subcommittee of SEMSCO.

MR. BRANDT: That's clear in the statute.

DR. MCEVOY: Yeah.

CHAIR DOYNOW: And I would say at this point, if anybody is interested in this position, particularly after today's meeting, please forward your interest to -- to Director Greenberg.

DIRECTOR GREENBERG: And in the essence of time, I'm happy to talk to anybody offline after who has additional questions related to this or interest, I guess, in that case. But no, in order to, you know, kind of just in the essence of time, I'm going to say because it's after two o'clock at this point. Rich, can you just come to the microphone and give your name, first and last?

MR. BRANDT: Oh, I'm so sorry. My first name is Richard, common spelling. My last name is Brant, B Baker, R Robert, A Adam, N Nancy, D Delta, T Tango. I'm an observer of public process today.

CHAIR DOYNOW: All right. I would just say the next meeting is going to be December 15th and 16th at Saratoga. And let's close the meeting. Hopefully we can have a motion to close. Dr. Dailey.

DR. DAILEY: This is my last thing in

-- all right. Just a request. And I don't think it needs to be a motion. It certainly doesn't need to be a roll call motion. But when the letter goes out from the M.S.C., the chair of this committee, as well as the STAC, would you please include in that that hospitals please re -- reevaluate their own internal applications of collars to match the new E.M.S. protocols.

CHAIR DOYNOW: Absolutely.

DR. DAILEY: Thank you.

CHAIR DOYNOW: Okay. Can we have a motion to close? Second. Anybody?

DR. DORSETT: Second.

CHAIR DOYNOW: Okay. Okay. All in favor? Yes. All right. See you folks in December.

(The meeting adjourned at 2:08 p.m.)

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9/16/2026 – SEMAC Meeting – Troy, N.Y.

STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 128, inclusive, is a true record prepared by Associated Reporters Int'l., Inc. from materials provided by me.

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DANIELLE CHRISTIAN, Reporter

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