

12/10/2025 - SEMAC - Troy, New York
NEW YORK STATE
DEPARTMENT OF HEALTH
STATE EMERGENCY MEDICAL ADVISORY COMMITTEE MEETING

DATE: DECEMBER 10, 2025

TIME: 11:33 a.m. to 12:43 p.m.

CHAIR: DONALD DOYNOW

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

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2 (The meeting commenced at 11:33 a.m.)
3 **CHAIR DOYNOW:** Welcome, everybody
4 back. If I can have everybody stand for the Pledge
5 of Allegiance. I pledge of Allegiance to the flag of
6 the United States of America and to the republic for
7 which it stands, one nation, under God, indivisible,
8 with liberty and justice for all. Okay. Thank you
9 all. Theresa, if we can have a roll call.
10 **SECRETARY ALLEN:** Dr. Afienko.
11 **MR. AFIENKO:** Afienko here.
12 **SECRETARY ALLEN:** Dr. Berkowitz. Dr.
13 Black.
14 **MR. BLACK:** Black here.
15 **SECRETARY ALLEN:** Dr. Bombard. Dr.
16 Clemency.
17 **MR. CLEMENCY:** Clemency here.
18 **SECRETARY ALLEN:** Dr. Coates. Dr.
19 Cooper.
20 **MR. COOPER:** Here.
21 **SECRETARY ALLEN:** Dr. Dailey.
22 **MR. DAILEY:** Dailey here.
23 **SECRETARY ALLEN:** Dr. Dorsett.
24 **MS. DORSETT:** Dorsett here.
25 **SECRETARY ALLEN:** Dr. Doynow.

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2 **APPEARANCES:**
3 AIDAN O CONNOR
4 ARTHUR COOPER
5 BRIAN CLEMENCY
6 BRIAN WALTERS
7 DANIEL OLSSON
8 DAVID AFIENKO
9 DAVID KUGLER
10 DAVID VIOLANTE
11 DON DUVAL
12 DONALD HUDSON
13 DOUGLAS ISAACS
14 EUGENE HESLIN
15 JASON WINSLOW
16 JENNIFER GOLDMAN
17 JON WASHKO
18 KATHLEEN HALLINAN
19 KIRBY BLACK
20 MAIA DORSETT
21 MARYANNE PROTORO
22 MERRY RUDRINGER
23 MICHAEL DAILEY
24 MIKE MCEVOY
25 OREN BARZILAY
PAMELA MURPHY
RYAN GREENBERG
STEVEN KROLL
THERESA ALLEN

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2 **CHAIR DOYNOW:** Doynow here.
3 **SECRETARY ALLEN:** Dr. Goldman.
4 **MS. GOLDMAN:** Goldman here.
5 **SECRETARY ALLEN:** Dr. Gomez. Dr.
6 Hallinan.
7 **MR. HALLINAN:** Here.
8 **SECRETARY ALLEN:** Dr. Isaacs.
9 **MR. ISAACS:** Isaacs here.
10 **SECRETARY ALLEN:** Dr. Kugler.
11 **MR. KUGLER:** Present.
12 **SECRETARY ALLEN:** Dr. Murphy.
13 **MS. MURPHY:** Murphy here.
14 **SECRETARY ALLEN:** Dr. Olson.
15 **MR. OLSON:** Olson here.
16 **SECRETARY ALLEN:** Dr. Rabrich. Dr.
17 Seth. Dr. Shi. Dr. Walters.
18 **MR. WALTERS:** Walters here.
19 **SECRETARY ALLEN:** Dr. Winslow.
20 **MR. WINSLOW:** Winslow here.
21 **SECRETARY ALLEN:** Oren Barzilay.
22 **MR. BARZILAY:** Here.
23 **SECRETARY ALLEN:** Aidan O'Connor.
24 **MR. O'CONNOR:** Good morning. Here.
25 **SECRETARY ALLEN:** Maryanne Portoro.

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 2 **MS. PORTORO:** Maryanne Portoro here.
 3 **SECRETARY ALLEN:** Mike McEvoy.
 4 **MR. MCEVOY:** McEvoy here.
 5 **SECRETARY ALLEN:** Steve Kroll.
 6 **MR. KROLL:** Kroll, present.
 7 **SECRETARY ALLEN:** And Jon Washko.
 8 **MR. WASHKO:** Washko, present.
 9 **SECRETARY ALLEN:** We have a quorum.
 10 **CHAIR DOYNOW:** Excellent. Thank you,
 11 Theresa. Can we have approval of the September
 12 minutes. Anybody want to make that motion? Dr.
 13 Cooper. Second? Dr. Olson. All in favor, just raise
 14 your hands. Anybody against? Any
 15 abstentions? Okay. The minutes pass. Okay. Ryan,
 16 up to you.
 17 **MR. GREENBERG:** Good morning. I'm
 18 going to try and breeze through this one
 19 today. Related to operations, there is a number of
 20 new staff who you've probably met over the past
 21 couple of months, and there is a number of new
 22 positions that are posted on our website. So if --
 23 for those who might be interested in joining the
 24 State E.M.S. office, there's a variety of
 25 positions. Some of them are Civil Service list

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 2 appointees. So if you're in a Civil Service position
 3 already and possibly have some lists, take a look at
 4 our website. On our website, on the left-hand side,
 5 under Current Jobs. I am also excited, as many of
 6 you know, we've moved from a bureau to a division
 7 with three bureaus. And we have just last week
 8 finished filling all three Bureau Chief
 9 positions. So we have the Lynn Farrugia, who you've
 10 known for many -- for a while now. She's been with
 11 us. She is the Bureau Chief over our Bureau of
 12 E.M.S. Administration. We have -- also been with us
 13 for a while, Stephen Brucato, who is actually at
 14 another meeting today and couldn't be at this
 15 meeting, who is our Bureau Chief of E.M.S. Emergency
 16 Management.
 17 And last, our Bureau Chief of E.M.S.
 18 Standards and Licensure, who was just hired and
 19 started. This is day five for her, is Barbara Lee
 20 Steigerwald. I got to get used to saying that last
 21 name. Forgive me for that one. And she's
 22 here. Where is she? I think she was over -- oh,
 23 she's outside for the moment. But -- so please, if
 24 you get a chance, say hello to her as well. We're
 25 really excited to, you know, have all these positions

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 2 filled and be able to move on to the next things.
 3 Surge Operations Center continues to,
 4 you know, be increasing both in the staff to do
 5 different roles as well as the functions that they're
 6 doing. New York Diverts continues to add, you know,
 7 any diverts that are on that -- that -- that the
 8 State Operations -- the Surge Operations Center or
 9 the SMOCC, which is now the State Medical Operations
 10 Coordination Center, you know, is notified of,
 11 so we're working with a lot of different hospitals
 12 and things like that. It is also a giant
 13 resource. So I had an entire conversation yesterday
 14 about the things that it can do.
 15 If you are in a facility or hospital
 16 and you're running into an issue, whether that be
 17 transporting a patient or finding a bed for a patient
 18 that the patient needs to be transferred to, please
 19 feel free to call the SMOCC. They will help in
 20 coordinating that. They have visibility, you know,
 21 with a lot of the hospitals and particularly outside
 22 of your region. And so we're happy to be moving
 23 forward on that front. Administration-wise, we have
 24 about half of the REMSCOs in contract, and we have a
 25 little over half of our Program Agencies in

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 2 contract. If your REMSCO, your Program Agency is not
 3 in contract and you are a member of that REMSCO
 4 service -- or Program Agency, please talk to them and
 5 see if there's anything you -- you can do to
 6 help. We would love for everybody to be in
 7 contract. This has a lot of things that go along
 8 with it.
 9 Our Aid to Locality can't be
 10 distributed until they're in contract. And in
 11 addition to that, we have two, you know, really
 12 positive grants both for the paying for two
 13 paramedics educations each year, as well as fifteen
 14 thousand dollars for recruitment and retention. But
 15 if the Program Agency is not in contract, the region
 16 is not eligible for those funds, so please keep that
 17 one in mind. Related to education, a lot going on
 18 that one, you know, in -- in new pathways and working
 19 on some manuals. If you were part of the Education
 20 Committee yesterday, and I think it will put out
 21 later, we do have some updates coming to some of our
 22 manuals.
 23 The big one though is, you know, at
 24 the last meeting I did report that National Registry
 25 was taking about six to eight weeks for us to process

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 2 people who came in using the alternative
 3 pathway. The software that we validate things with
 4 National Registry was updated. It had a -- you know,
 5 a -- a transition period that was -- did not go as
 6 smoothly as I think they wanted it to. However,
 7 happy to report that now it is much -- much
 8 better. So we are back down to about two weeks for
 9 anybody who uses that alternative pathway. So if you
 10 do go that pathway, you know, please keep that one in
 11 mind. And just a reminder too, if you took a state
 12 class and then you take your registry exam, you are
 13 not getting reciprocity. You're just using
 14 alternative exam that we've approved to use, so that
 15 is one of the biggest things that we hear, oh, I have
 16 to go for reciprocity. It's not -- you're just
 17 submitting the paperwork so that we can issue your
 18 State card.
 19 Trauma meeting, our next trauma
 20 meeting is in January. For anybody who wants to join
 21 us, E.M.S. for Children just had a really wonderful
 22 meeting last week that I think Dr. Cooper will be
 23 reporting out on later. Vital Signs, Amy just let me
 24 know that a call for speakers is open, so do many of
 25 our docs. I know many of you have spoken in the

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 2 past. We'd love to see many of you -- many -- many
 3 additional ones come and join us again. We had just
 4 over about twelve thou -- twelve hundred attendees at
 5 the conference this year, so really excited about
 6 that. Next year, we're at Niagara Falls and November
 7 10th to the 14th. The Memorial is in May. Please
 8 come join us.
 9 And just a quick update on the
 10 regulatory side. So equipment standards go into
 11 place on April 26 -- April 2026. Ambulance build
 12 standards will be out for public comment period most
 13 likely in the -- one of the first two quarters of
 14 2026. Blood administration as well as Community
 15 Paramedicine, we're hoping to see come out for those
 16 public comments in 2026 as well. Our System, Agency,
 17 and Performance Standards, we're working on both the
 18 system side and the quality sides. That one is a
 19 little bit delayed right now just because Community
 20 Paramedicine and Blood Administration regs took
 21 priority over those due to other requirements that
 22 were going on. So, you know, keep those in
 23 mind. For our medical directors, the i-gel policy
 24 statement was released, that's up on our
 25 website. The independent provider C.M.E. renewal is

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 2 up on our website, and the updated educational
 3 funding pilot program is up on our website.

4 The last meeting I also gave you a
 5 little bit of a -- you know, a notification on our
 6 Mental Health and Wellness Program. Our next
 7 symposium is being planned for June. Really excited
 8 about that one. And our fellowship program just had
 9 their second in-person meeting. That went really,
 10 really well. They went through additional training
 11 for three days that they can bring back to their
 12 regions.

13 We are working on two one-day
 14 Recruitment and Retention Symposiums. One will be
 15 Downstate on Long Island, one will be Upstate. And
 16 it looks like we're aiming for February and
 17 March. It looks like more likely we're going to be
 18 March and June. At the February meeting, I should
 19 have more of an update for you on that one. And then
 20 last but not least, I'll leave you with, you know,
 21 what you heard a little bit in the beginning. We
 22 have a number of positions that are open in a number
 23 of different areas of the State E.M.S. office. We
 24 would, you know, love to see people applying, and you
 25 can find many of those jobs along with jobs

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 2 descriptions and things like that on our State
 3 website on the left-hand side under Current Open
 4 Jobs. That's all I got unless anybody has any
 5 questions.

6 **CHAIR DOYNOW:** Any questions for
 7 Ryan? Go ahead, Mike.

8 **MR. DAILEY:** Dr. Dailey. Is that
 9 better? One question that had come up earlier that -
 10 - that I just want to make sure we address here is
 11 B.L.S.F.R. and the supraglottic project, as well as
 12 the other component of this that is a real seminal
 13 change in terms of how the Department of Health is
 14 going to work with the regions in terms of approving
 15 su -- B.L.S. agencies for supraglottic airway use
 16 centrally rather than allowing it to happen at the
 17 regional level like we've done in the past with
 18 interventions like these. So just if you'd speak to
 19 those.

20 **MR. GREENBERG:** Yeah. So I think if
 21 you look at the policy statement, it still has an
 22 involvement of the regional side on the educational
 23 front and the things that are happening as well as if
 24 it's going to happen in the region or not. The State
 25 approval process and kind of the step in there where

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 2 the final packet comes to us is making sure that
 3 everything is there from a regulatory and compliance
 4 point of view because it does have a lot of
 5 additional things that come along with it that aren't
 6 seen, you know, in -- in many of the other
 7 things. And then to start to work towards
 8 streamlining the same way our licenses are kind of
 9 look and appear and -- and outlined as other things
 10 are in the Department of Health.

11 And so in the future and what we're
 12 working towards, and this is one of those first steps
 13 there is your license will list on it, you know, hey,
 14 this is -- this is the license, here's your service
 15 area and here's the -- the components of what you do
 16 in addition, above and beyond of the -- of the
 17 agency. So it -- this is -- what you're seeing is
 18 the first step of things in order to, you know, kind
 19 of move along and have that in the -- in the
 20 front. Sorry.

21 I think one other important part too,
 22 you know, in that front is we will make sure to say
 23 in that way that we have with a lot of the different
 24 things that have come in and started to automate
 25 through Drupal and stuff like that. So everything

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 2 also circles back to the region, so the region is
 3 always aware of what's been approved and what's being
 4 used. So that when the region is doing the quality
 5 assurance and things like that, they know what
 6 they're looking at for -- you know, for those
 7 standards.

8 **MR. WALTERS:** Can I ask a follow-up
 9 question too, and I think Gina spoke to this during
 10 Med Standards and the question was raised. And if --
 11 if I understand correctly, and correct me if I'm
 12 wrong, in applying for that B.L.S. Supraglottic
 13 approval, you have to submit a Medical Director
 14 Verification Form during the application
 15 process. And then once you're approved, you have to
 16 refill another Medical Director Verification
 17 Form. Why the redundancy? Am I understanding that
 18 correctly?

19 **MR. GREENBERG:** If the wording needs
 20 to be updated on the policy, it's the same
 21 form. It's just making sure that it's handed in to
 22 both places. We just want to make sure that the
 23 physician, the Medical Director of the organization
 24 is aware that it's occurring.

25 **MR. WALTERS:** But I guess if I have to

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 2 sign the form for my agency when they are applying,
 3 attesting that I approve this, we're doing the
 4 training, I will Q.A. every -- every instance of use,
 5 right? As outlined in the policy. Why do I need to
 6 fill out another one of those at the end?

7 **MR. GREENBERG:** I will go back and
 8 check the policy. I think it's the same form. I
 9 think it's just making sure that it's submitted in
 10 both places. So if the -- like I said, if I need to
 11 go back, happy to take a look at that and -- so thank
 12 you. You should not have to fill out the form once,
 13 more than once. I'm sorry.

14 **MR. WALTERS:** Thank you. That's all I
 15 want. And -- and I do have -- I have a follow-up
 16 question, Ryan, for one other question unrelated to
 17 the supraglottic policy. But you talked about half
 18 the Program Agencies are in contract and we had our
 19 REMSCO meeting last week and -- and we do have a
 20 contract for our Program Agency, but it's my
 21 understanding they still haven't been paid in a
 22 while. Can you speak to that and when we can expect
 23 those funds?

24 **MR. GREENBERG:** Yeah, absolutely. So
 25 we have distributed just under a million dollars in

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 2 Program Agency funding, Program Agency and REMSCO
 3 funding. So we absolutely have REMSCOs and Program
 4 Agencies that have submitted invoices. The invoices
 5 have met all the requirements and have been paid. It
 6 is -- you know, it's a normal timeline for
 7 submission, review and things of that nature. Some
 8 invoices are kicked back because they don't meet
 9 compliance or they're missing something of that
 10 nature, and then they have to resubmit it.

11 We did have a -- you know, a really
 12 good productive, I think Program Agency meeting on
 13 Monday and some things that we might be looking at to
 14 adjust in that process, particularly if something
 15 gets kicked back because it's missing the piece. It
 16 was a first-come first-serve situation. And then if
 17 you got kicked back, circle back again, and we think
 18 we're going to make it on two pathways. But we've
 19 given out about a million dollars in funding and if
 20 your particular region or if you have specific
 21 questions on a region, not even yours, we're happy
 22 to, you know, address it on an individual basis.

23 **MS. DORSETT:** I -- I heard Mike Dailey
 24 ask a question about why B.L.S.F.R.s can't do it, but
 25 I didn't hear an answer.

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 2 **MR. GREENBERG:** So B.L.S.F.R.s are
 3 unregulated or -- or do not fall into the licensed
 4 category that we see some of the other things fall
 5 into. It's a voluntary participation in that
 6 one. And so we are working towards having
 7 B.L.S.F.R.s be able to do it as well as there's been
 8 other desires to bring B.L.S.F.R.s into the regulated
 9 space.
 10 **MS. DORSETT:** So when we vote on
 11 what's in the B.L.S. protocol, that also defines what
 12 a B.L.S.F.R. can do, right? Am I misunderstanding
 13 that B.L.S.F.R.s have to abide by B.L.S. protocols?
 14 **MR. GREENBERG:** They have to abide by
 15 B.L.S. protocols, but if there are additional things
 16 within it, then there can be additional requirements
 17 that go along with it for regulated agencies.
 18 **MS. DORSETT:** But like -- I mean -- I
 19 think the -- the confusion is if we have -- they have
 20 to follow protocols that are defined, right? The
 21 B.L.S. protocols, then we are saying what they can
 22 do. And at a regional level, they're controlling
 23 what the b -- like, they oversee what the B.L.S.F.R.s
 24 can do. And there's a regional component to
 25 verification of the educational process for B.L.S. i-

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 2 gel. And I think the -- the consternation about this
 3 is when we thought about what is the value of B.L.S.
 4 i-gel.
 5 I can say as a Medical Director, what
 6 I envisioned was the cognitive offload of being able
 7 to turn that over to the B.L.S.F.R. colleagues in
 8 cases and also allow them to, like, initiate airway
 9 management, have capnography, make sure that
 10 ventilations are optimized even before the ambulance
 11 gets on scene. And then a policy came out that said
 12 that the number one group that I actually want to
 13 have access to i-gel and capnography, is the group
 14 that's excluded from the policy.
 15 So I -- I think when we say, like, we
 16 can't regulate, like, we have a process, the
 17 regions. It's not like they're totally -- nobody's
 18 telling them what to do and we write protocols that
 19 say what you're allowed to do, but then we exclude
 20 them from the policy that it's in the B.L.S.
 21 protocols that they can do it. So that doesn't make
 22 sense to me.
 23 **MR. GREENBERG:** I think what you see
 24 is the evolution of medicine in a lot of ways. And
 25 so when a B.L.S.F.R. first was established and the

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 2 role that it played, that the advancement of what it
 3 did and the requirements of what it needed to have
 4 were not as advanced as where we are today and I
 5 think where we're going into the future. I think
 6 really what the conversation comes down to is that
 7 subset, which I think for a long time did not live in
 8 an area where they had to follow a lot of things or
 9 weren't required to or didn't have the same set of
 10 rules and regulations is at a period of time where
 11 they should be.
 12 And so I agree that they -- you know,
 13 there's opportunity here to advance the system and
 14 advance the B.L.S.F.R.s in the future, and that we
 15 should look at that pathway and putting it into not
 16 just related to an i-gel, but many of the things that
 17 we would want from individuals who are responding on
 18 an emergency vehicle and providing emergency care.
 19 **MS. DORSETT:** Yeah. I mean, I guess
 20 the fundamental thing I understand is what is so
 21 special about an i-gel? We did a pilot, we
 22 demonstrated it was safe. We came up with a -- a
 23 mode that says if you're trained and equipped,
 24 right? Like what's so special about it that it falls
 25 in some -- that we like specifically excluding

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 2 B.L.S.F.R., right? So like they can check a blood
 3 sugar if trained and equipped, and their B.L.S.F.R.
 4 is not excluded from doing that because their
 5 B.L.S.F.R. and unregulated even though there's
 6 equipment that you have to have, that there's quality
 7 checks that you have to do, and training that needs
 8 to be done.
 9 **MR. WALTERS:** And -- and a B.L.S.F.R.
 10 can do check and inject, right? And CPAP?
 11 **MS. DORSETT:** I think that's what Dr.
 12 Dailey was getting to is like, why is this different
 13 than all the other things?
 14 **MR. GREENBERG:** So I think it's -- it
 15 -- especially concerning, I think the -- you know,
 16 from the conversation before, the protocols are also
 17 -- you know, there's a number of things that are
 18 going to come up in the February meeting. Give me a
 19 meeting to come back and let me see if I can come to
 20 bring back some specific additional
 21 information. We've spoken to Legal about it and kind
 22 of some of the barriers and obstacles that they think
 23 there is but let me bring that directly back
 24 here. It's not something that I have right off the
 25 bat. Does that work?

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 2 **CHAIR DOYNOW:** Any other questions for
 3 Ryan? Okay. Moving on. Don Hudson, if you'd like
 4 to talk about education.
 5 **MR. HUDSON:** I was thinking Donnie
 6 Duval had raised his hand.
 7 **MR. DUVAL:** I apologize for conferring
 8 with our Regional Medical Director, but the thing
 9 that nobody's mentioned is quite a number of years
 10 ago, the C.F.R. level education in New York State was
 11 limited by legislation to a maximum of fifty-one
 12 hours, which is barely enough to teach the existing
 13 skill set at the time. So the idea of adding extra
 14 skills and extra skill sets to the current C.F.R.
 15 curriculum is troublesome without running afoul of
 16 the legislation that was passed with a fifty-one-hour
 17 limit.
 18 **MR. GREENBERG:** And for this --
 19 no. Fi -- can you just list your first and last
 20 name, please?
 21 **MR. DUVAL:** Sure. I'm Don Duval.
 22 **MR. GREENBERG:** Thank you.
 23 **CHAIR DOYNOW:** Any other comments?
 24 **MR. DAILEY:** If -- if I can just
 25 respectfully tell Mr. Duval that -- that actually

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 2 Course Funding Technical Advisory
 3 Group in conjunction with our compatriots at the
 4 Finance Committee. So as was stated, look at New
 5 York State Policy twenty-five dash O eight, which was
 6 released, which has some updated course reimbursement
 7 information in there. And thank you to everybody
 8 that worked on continuing our momentum to not only
 9 reorient the course funding, but also to increase
 10 course funding moving forward. And my hope and the
 11 hope of many others is that momentum can continue.
 12 So a few other things. We have some
 13 information potentially coming from our exam vendor
 14 for State certification at P.S.I. specific to exam
 15 results. So as more information is available there,
 16 we'll get it out to course sponsorships. The hope is
 17 that will aid in vouchering not only to make our
 18 course sponsorships whole, but to continue to move
 19 money out the door as allotted within our budget. We
 20 have an ongoing open conversation with our
 21 compatriots at the mental health alternative,
 22 potential alternative transport destinations known as
 23 Crisis Centers. Beginnings of those conversations,
 24 but we're in the door with them, thankfully a -- as
 25 intended on both sides of that conversation right

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 2 this is for E.M.T.s., not for C.F.R.s at that
 3 level. So we're not expanding it to Certified First
 4 Responders. Just -- just making sure that we're
 5 remaining talking about apples and apples.
 6 **CHAIR DOYNOW:** Okay. Let's move
 7 on. Don?
 8 **MR. HUDSON:** Good morning to everybody
 9 still and Happy Holidays. So Don Hudson from
 10 Training and Education. So short report. Just an
 11 update on some of our Technical Advisory Groups. So
 12 the Practical Skills Exam Technical Advisory Group,
 13 we anticipate a -- a pilot program for E.M.T.
 14 originals sometime in 2026. So we'll provide more
 15 update on a subsequent policy and what that would
 16 look like. It will begin initially with a small
 17 group of select course sponsors around the State as a
 18 pilot program. Field Training Officer, so where that
 19 stands is at the Vital Signs Conference, we had forty
 20 or so students partake in the Field Training Officer
 21 or FTEP program. We re waiting on student feedback
 22 from that to see if that is indeed the platform and
 23 the program that we're looking to for the future, and
 24 what that implication and funding might look like for
 25 Statewide rollout.

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 2 away about where those might be, what that might look
 3 like, what the regional training and procedures for
 4 potential patient transport to them might look
 5 like. So again, more information to follow on
 6 that. And then lastly, I assume for Med Standards
 7 will -- the protocols will come up. We'll talk about
 8 E.M.S. Education's role in that process moving
 9 forward. Happy to take questions. Have a happy
 10 holiday.
 11 **CHAIR DOYNOW:** Anybody have any
 12 questions for Don? Okay. Moving along. Dr.
 13 Walters, who's substituting for Dr. Rabrich today and
 14 has done an excellent job.
 15 **DR. WALTERS:** Thank you. Just a
 16 couple of updates. There's no seconded motions
 17 coming forward, but we did have some discussions on
 18 the S.G.A. policy that we've just discussed. Gina
 19 gave us an update on the blood implementation
 20 regulations and where those stand, and those proposed
 21 regulations should hopefully come out for public
 22 comment in the next few months in early 2026. So
 23 we'll look forward to those. Dr. Dorsett gave an
 24 update on the Clinical Data Integrity TAG, and I'm
 25 sure we'll be reporting out at SEMSCO as well, but

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 2 what -- what they're doing to standardize mapping of
 3 procedures and medications and that.
 4 Erin Reese gave us an update also on
 5 the Specialty Care Transport TAG and there are three
 6 working groups, and I know she'll report out at
 7 SEMSCO as well. And as we go through those updates
 8 that were presented, there was also one on R.S.I.,
 9 Rapid Sequence Intubation. And Dr. Winslow has
 10 updated us about the five regions that have --
 11 looking at their policies, looking at minimum
 12 standards and trying to come up with some best
 13 practices, and they'll be reporting back to us at the
 14 February meeting.
 15 The -- I think largest part of our --
 16 our meeting and conversation centered around the
 17 proposed Collaborative Protocol updates. And those
 18 were discussed, and Don Hudson presented some
 19 concerns and questions from Training and Education
 20 on, as we look at the national scope of practice and
 21 education documents, and I think we had some good
 22 educational discussions at that meeting for those of
 23 you that were there. At the end of all that, there
 24 aren't -- weren't any substantive changes or
 25 recommendations to the proposed protocol

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 2 updates. Those will come up for -- for a vote to
 3 move forward at the February meeting and then won't
 4 take effect until July. But those change logs and
 5 protocols are out there and circulated, so please
 6 take a look at those.
 7 The one thing that came up is that
 8 there was discussion and -- about including an
 9 appendix on the proto -- in the protocol regarding
 10 the protocol change process and time frames, and
 11 maybe a link to -- for providers who have suggestions
 12 on protocol updates in the future. So we'll look to
 13 include that when it comes back in February, but the
 14 decision was to keep the change log itself out of the
 15 protocol just because it gets to be too big of a
 16 document in that.
 17 And then I think there was a lot of
 18 discussion on the -- on education, the national
 19 education standards and -- and how we try to align
 20 things and be nimble and efficient moving forward
 21 because sometimes those documents take time
 22 nationally to be updated. And I know I want to thank
 23 Drew Chesney for reaching out afterwards to several
 24 of us and -- and being involved in that conversation
 25 and maybe getting a group together to try to look at

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 2 how we -- we all agree on what we want to do and --
 3 and trying to align those practices moving forward,
 4 so I thank him for that.
 5 And then I think the only other thing
 6 that I'll -- I'll bring up, there was a couple of
 7 protocols, the New York City protocols, which were
 8 not in in time to be presented and voted on, and the
 9 LifeNet Air Medical protocols that weren't approved
 10 regionally yet. Those will come up at the February
 11 meeting. And last is Dr. Winslow and Dr. Kugler both
 12 spoke about a joint Nassau-Suffolk proposed pilot
 13 program regarding I.V. Keppra for refractory --
 14 refractory seizures that they have approved in both
 15 regions and will be presenting to us at the February
 16 meeting. And I think with that, I will take any
 17 questions or comments starting with Dr. Dailey.
 18 **MR. DAILEY:** So just to clarify, the
 19 LifeNet protocols and LifeNet finger thoracostomy
 20 procedures were both approved regionally just not in
 21 time for the meeting.
 22 **MR. WALTERS:** Thank you for the
 23 clarification.
 24 **CHAIR DOYNOW:** All right. Any other
 25 questions for Dr. Walters? Okay. None -- none being

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 2 seen. Dr. Cooper, do you want -- the E.M.S.C.
 3 report?
 4 **MR. COOPER:** Thank you, Dr.
 5 Doynow. E.M.S.C. met remotely early last week. And
 6 we really had a very -- very full meeting, a --
 7 a good discussion. I'll just begin by hats off to
 8 Amy Eisenhower for her strong work on the Always
 9 Ready for Children program. There are now as many as
 10 fifty of our hospitals in New York State that are
 11 part of that program and -- and two more had joined
 12 just immediately prior to the meeting, so we're up to
 13 fifty-two. And if your hospital has yet to sign on
 14 to that program, please consider doing so.
 15 The second issue that I -- I'm just
 16 delighted to report on is that the -- the videos for
 17 the three scenarios dealing with pediatric agitation
 18 have been completed and we are figuring out at this
 19 moment exactly how to get them out and available to
 20 everyone so you can all take a look at them. It's
 21 our hope that these will, you know, not only help in
 22 serving our -- our prehospital providers here in New
 23 York State, but potentially even nationally as
 24 well. The videos show a -- or -- or emphasize very
 25 strongly non-pharmacological methods for -- for

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 2 sedation. Or not sedation, I should say, but for
 3 dealing with -- with agitation. And we hope very
 4 much that you'll find these useful.
 5 But perhaps the most exciting thing
 6 that we're dealing with right now is the Procedural
 7 Comfort Project. Now, I'm sure that everyone in this
 8 room is aware of the -- the fact that in many venues,
 9 particularly smaller hospitals and smaller E.M.S.
 10 services, procedural comfort has not been at the top
 11 of the list in terms of our, you know, management of
 12 children. Simple things like starting I.V.s or -- or
 13 you know -- or splinting -- splinting, you know, a
 14 deformed extremity and so on. You know, it has sadly
 15 kind of traditionally been done just by sort of
 16 holding the child down and doing what needs to be
 17 done causing in many cases, you know, great angst for
 18 the child and even greater angst for the -- for the
 19 family.
 20 After a very robust discussion, we --
 21 and thanks to Maia Dorsett for some poignant
 22 suggestions, we've come up with a -- a -- a list of
 23 questions that we -- that we are considering asking
 24 in a -- in a Statewide survey of all of our Always
 25 Ready for Children facilities. And these questions

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 2 will really be a -- a -- a way for us to get at
 3 the extent to which procedural comfort measures are
 4 utilized in emergency departments and, you know --
 5 and when -- and where, what kind of emergency
 6 departments, so on and so forth. As a first step
 7 toward developing potential, you know, guidance for -
 8 - for folks both -- anywhere but with an emphasis on
 9 smaller hospitals without -- without specific
 10 pediatric expertise and in the prehospital
 11 environment.
 12 We are planning a -- a follow-up
 13 meeting prior to the holidays to fi -- finalize that
 14 -- that -- that set of questions, and then a -- a --
 15 a follow-up meeting to that on January 5th to
 16 confirm, you know, the -- the list of questions that
 17 need to be -- need to be asked in -- in the -- in the
 18 survey. And that will allow us to meet the -- the
 19 deadline for review by the -- by the -- you know, the
 20 departmental staff to ensure that we are, you know,
 21 on -- there on board with our presenting this at our
 22 next -- at our next meeting.
 23 A -- a subsequent follow-up to that,
 24 the -- the -- the -- the next day and that, Ryan,
 25 thank you so much for participating in that and

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 2 helping -- helping out with that. You know, we -- we
 3 were concerned that -- that by not being able to
 4 approve the list of -- of questions until -- until
 5 our January 5th me -- meeting or January 5th deadline
 6 to get the -- you know, the questions run up the
 7 flagpole for our February meeting. We were able to
 8 determine that once we get the questions in that the
 9 next step which is actually designing the survey,
 10 will not necessarily need to go through such a robust
 11 review process. The questions of course are the most
 12 important part. We are looking to partner with an --
 13 an expert group that has long experience and
 14 expertise in designing rigorous sin -- surveys to
 15 help us get that -- that -- that survey done. We're
 16 looking po -- potentially to get that survey out as
 17 early as, you know, springtime. And maybe if we're
 18 really lucky, we might even have some results by our
 19 -- by our -- our s -- our May meeting. But that's
 20 been what we've been focusing on of late. I -- I'll
 21 be happy to answer any questions you might have. I
 22 think these are two really super exciting work
 23 products that are going to be coming forth to the --
 24 to the fore for utilization by -- by all of our folks
 25 across the state both in hospital -- in hospital

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 2 and pre hospitally. Thank you.
 3 **CHAIR DOYNOW:** Thank you, Dr.
 4 Cooper. Any questions for Dr. Cooper? Okay.
 5 **MR. COOPER:** Thank you, Dr. Doynow.
 6 **MR DOYNOW:** Thank you. Okay. Moving
 7 on to old business. First -- what -- what's that?
 8 Okay. Moving to old business. First
 9 of all, I want to mention that Ryan does have a
 10 surgeon who's being vetted for the committee and as
 11 you said, hopefully will be on the committee by
 12 February, but no guarantee. Update on the State
 13 Medical Director. I know it's under New Business,
 14 but it's actually Old Business. Anything to say
 15 about that?
 16 **MR. GREENBERG:** Just that we're going
 17 through the processes.
 18 **CHAIR DOYNOW:** Okay. All right. And
 19 now let's move on to the subject that probably
 20 everybody's been waiting for the bylaws for SEMAC. I
 21 want to thank Dave Violante and the Bylaws Group and
 22 we've had a lot of discussions to hopefully resolve
 23 all the issues that this group raised in concern of
 24 what the previous bylaws stated. So let's do the
 25 easy part first. And Theresa, I don't know if you

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 2 want to throw them up there on the screen if you
 3 can. They have been available on Boardable to -- for
 4 folks to review.
 5 **MR. GREENBERG:** I don't think they can
 6 put it up because they didn't get through the
 7 process.
 8 **CHAIR DOYNOW:** Okay. I'm being told
 9 we can't put it up because it hasn't gone through the
 10 process, but it is available on Boardable. Let me
 11 give you -- let me give you the -- let me give you
 12 the highlights. Essentially, the highlights, first
 13 of all, there are no term limits anymore in the
 14 bylaws. That means that if you are on this committee
 15 and your region wants to reappoint you every two
 16 years, you can be on here for the next forty years,
 17 so -- should you so desire. And there have been some
 18 people that have done this committee over twenty
 19 years. You may want to think about maybe moving over
 20 for some of the younger folks. The more complicated
 21 is what to do with the Chair. In -- in the last
 22 thirty years, there have actually been three Chairs
 23 that I'm aware of. Mark Henry was a Chair for about
 24 twenty years. Then there was another physician whose
 25 name escapes me, who was a Chair for about two years,

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 2 I think. Okay -- okay. I'm glad you guys
 3 remember. And then as Ryan eloquently said to me
 4 last month, how much longer do you plan to be
 5 Chair? And I realized I'd been Chair for about ten
 6 years, and I did not realize how long it had
 7 been. It's probably because I enjoy seeing your
 8 smiling faces every few months, but it probably is
 9 time to be more democratic. So the new bylaws are
 10 going to have a provision to elect a Chair and a Vice
 11 Chair. And their terms will be every two years, but
 12 there's no term limit, which means if you find
 13 somebody that you like, you can vote them in for the
 14 next twenty years as well. That will start as of the
 15 first meeting after August 2026, so that would be
 16 September. We would have a -- a nominating
 17 committee. And then in December, we vote in the
 18 Chair and the Vice Chair. Yeah.
 19 And it would go to the Commissioner
 20 because technically, the way the statute states now,
 21 the Commissioner appoints the Chair. I cannot see a
 22 reason why the Commissioner would not appoint whoever
 23 we decided we want as Chair of this committee. But
 24 technically, it would have to go to the Commissioner
 25 to -- for the Chair to be actually appointed. The

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 2 only complicating factor with that is the current
 3 Chair position is separate from the regions, which
 4 means, at least initially, I would move into a post-
 5 Chair position so we don't lose a voting
 6 member. That was one issue that we -- we are trying
 7 to figure out. And then that position can either
 8 become a position at large or the following Chair can
 9 move into that position if somebody want to replace
 10 them on the committee for their region. That being
 11 said, does anybody have any questions? Go ahead,
 12 Ryan. Dave, you were part of this, go ahead.
 13 **MR. COOPER:** Yeah -- yeah. In terms
 14 of the physicians on the committee would stay in
 15 their roles. And so if -- if you have somebody from
 16 Nassau who you elect as a Chair to be recommended to
 17 the Commissioner, they could be Chair, but they would
 18 still be representing Nassau, so the current Chair,
 19 you know, would be that individual. So the other
 20 physician would be on the group still. So you
 21 wouldn't have people sort of ping-ponging around to -
 22 - to other positions, because those regions have
 23 represented those physicians in those positions.
 24 **CHAIR DOYNOW:** Right. You would stay
 25 with your region unless for some reason you decided

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 2 not to or your region decided that they want to
 3 appoint somebody else.
 4 **MR. GREENBERG:** So I think there's
 5 some things that might need to be flushed out here
 6 that we're happy to take offline and work
 7 through. We do have other councils that have similar
 8 variabilities, including our Trauma Council where the
 9 seat is a separate seat and the seat is vacated. So
 10 -- so let's say the nomination, which nomination
 11 doesn't have to be a person who's a vetted member of
 12 the council. It could be a -- that -- maybe you have
 13 a great committee member who's also a physician that
 14 you think would make the great next Chair that could
 15 be someone who you would nominate to the Commissioner
 16 and say, this is who we think. But let's say it did
 17 come from someone on the council, that council seat
 18 would -- the person would get vetted into the Chair
 19 seat, saying they were selected by the
 20 Commissioner. And then the backfill would happen for
 21 the seat that they used to sit in, but it would -- it
 22 would move to that other seat. And like I said, it
 23 sounds like there's a couple things that we can flush
 24 out. We're happy to flush those out with you to make
 25 it, you know, kind of the vision of what the -- the

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 2 group might be looking for -- for the bylaws as well.
 3 **CHAIR DOYNOW:** Dr. Cooper?
 4 **MR. COOPER:** Thank you. Not that I
 5 could necessarily see this happening, but the statute
 6 does say that the -- that the Commissioner appoints
 7 the Chair. Is there any -- would there be any
 8 barrier if the -- if the SEMAC were to recommend to
 9 the Commissioner a -- a -- a name or a pair of names
 10 for Chair and Vice Chair that were not members of
 11 SEMAC at the present time?
 12 **MR. GREENBERG:** So I don't think --
 13 no. I don't think there's any required -- the seat
 14 is independent of itself. It doesn't require to come
 15 from -- like I said, it wouldn't require IT to come
 16 from a member of this. It may be, right? Your
 17 nomination may be someone who you're like, they've
 18 served really well. They've been, you know,
 19 participating a lot. Fill in the blank, until you
 20 think about that. But it -- it wouldn't necessarily
 21 have to come here because the seat is independent.
 22 So where this would be different is
 23 our SEMSCO, right? So our SEMSCO, the Chair is
 24 elected by the body and remains in the seat that
 25 they're in. So there's not a separate seat for the

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 2 Chair of the SEMSCO, which is why that doesn't
 3 change. The SEMAC is different. It's -- it's --
 4 it's an independent seat of its own, which is the
 5 same reason why you can make a nomination, you know,
 6 as a Commissioner. A Commissioner can choose to
 7 accept that nomination. The Commissioner can choose
 8 to maybe send it back for a different
 9 nomination. The Commissioner can choose to make a
 10 nomination of their own, who -- someone who they feel
 11 would be a really good fit for the situation.
 12 **MR. MCEVOY:** A point of order. The
 13 SEMSCO bylaws currently require that person to be a
 14 member of the SEMSCO and D.L.A. had said that the
 15 SEMSCO was empowered to make those interpretations
 16 and those bylaws. So that would sort of disallow the
 17 Commissioner from arbitrarily choosing someone.
 18 **CHAIR DOYNOW:** That's for SEMSCO per
 19 se. Correct? What is it? For SEMAC? All
 20 right. No need to be in some offline
 21 discussion. The only problem I would see with that
 22 is it takes so long to vet a physician, that if you
 23 were to take someone who wasn't on SEMAC and
 24 essentially decide that they're going to be a Chair,
 25 it could be a year before they're actually becoming

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 2 Chair.
 3 **MR. GREENBERG:** One hundred percent an
 4 issue that we deal with in other councils as
 5 well. And in the same policies that we do with every
 6 vetted seat, the person would remain seated in that
 7 position until such time as the vetted member is to
 8 take the seat. So we -- we've had this issue in
 9 similar, and -- and again, un -- unfortunately, due
 10 to tragic instances on our trauma side, and, you
 11 know, it does. It -- it takes a period of time for
 12 people to get vetted. But if it is a situation where
 13 something changes or things of that nature, then they
 14 would remain in that seat until such time as the
 15 vetted member is appointed.
 16 **MR. COOPER:** Yeah. I'm not suggesting
 17 it would -- it would ever happen that we wouldn't
 18 pick from this body or recommend from this body, but
 19 I -- I just wanted to clarify that, you know, if for
 20 some, you know, unforeseeable reason, you know, an
 21 outstanding candidate emerged who was not a member of
 22 the body, that he or she would not be
 23 eligible. That's -- I was just seeking
 24 clarification.
 25 **MR. GREENBERG:** No. I -- I think

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 2 it's an excellent question and -- and I'm -- like --
 3 like I said, I think there's some things offline and
 4 I -- I won't automatically nominate you to the
 5 committee to help us discuss it further, but no. I
 6 think there's some things offline that we'll take and
 7 flush through some of those things, so thank you for
 8 -- for further bringing that up. And reality is is
 9 that, like I said, you may have a great physician
 10 who's only, you know, on a committee, right? They --
 11 they've been working on a committee for two
 12 years. They're not a vetted member of a council, but
 13 you think they'd be a really good fit. So I think if
 14 we take it offline, we can flush through many of
 15 those things and then bring it back at the February
 16 meeting, if that works for everyone.
 17 **MR. DAILEY:** Clearly, there's still a
 18 couple of things that need to be worked out. What I
 19 would really like to do is to thank both of you for
 20 working so hard on getting to some middle ground,
 21 because the amount of angst that came out of the
 22 wording that was inoffensive and quite frankly, was
 23 just trying to make -- make a reasonable pathway for
 24 both committees, you know, was way above what it
 25 needed to be. This needs to be a committee of people

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 2 that are ready to work, focused on work, focused on
 3 the healthcare of our clinicians and of our patients
 4 and we are looking at E.M.S. medicine. We got
 5 distracted there for a little while. So thanks for
 6 getting us past that so we can get back to the
 7 business at hand. I appreciate that a lot.
 8 **CHAIR DOYNOW:** Thank you, Doctor. Dr.
 9 Kugler?
 10 **MR. KUGLER:** Two things. First,
 11 Chairman Violante, I just want to say that it's not
 12 just Nassau, that -- that any member of the SEMAC if
 13 these bylaws passed could become a Chairman. But
 14 thank you for that acknowledgment. The -- the second
 15 thing is, I -- I believe that the committee met with
 16 the Bylaw TAG at a work committee, at work --
 17 whatever the nomenclature for the group is, met with
 18 good intention and work to resolve the discrepancies
 19 between what is -- what was originally stated at --
 20 or approved as bylaws, and then the problems that
 21 conflicted with what we perceived, at least our
 22 interpretations of the New York State Public Health
 23 Law.
 24 So the bylaws were fixed. There were
 25 multiple amenable fixes, and everybody on the group

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 2 was in agreement that this is the way it should
 3 work. The member, the Chairman should come from the
 4 committee that would already be a vetted
 5 member. They'll remain on a committee. And we
 6 removed the term limits, which was a -- a fantastic
 7 compromise which made it in compliance. So, you
 8 know, I don't know if this is an appropriate time to
 9 ask, but can we make a motion to approve these to
 10 send up to the SEM -- SEMSCO for their consideration
 11 and approval to bring to the Commissioner for his
 12 approval to make them our bylaws or is this too
 13 premature?
 14 **MR. VIOLANTE:** I -- I just do want to
 15 make one clarification about term limits. There are
 16 term limits. The language, however, is that
 17 physicians can succeed themselves. And so it -- it
 18 is in there and -- and regions do have the ability to
 19 say, hey, we want this doc. We don't want this
 20 doc. And it's up to the region to decide, do they
 21 still want to keep them or not keep them. So thank
 22 you for that. There -- there -- there definitely are
 23 limits, but physicians are able to succeed themselves
 24 in those positions.
 25 **CHAIR DOYNOW:** Essentially what's been

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 2 done in the past. So Ryan, I'll leave it up to you
 3 if you believe we can bring those forward as a
 4 motion.
 5 **MR. GREENBERG:** I would recommend that
 6 you hold off till February based on just the mere
 7 number of questions that came up related to procedure
 8 and -- and what you have in there. It doesn't sound
 9 like it aligns with what is in the statute and what
 10 would be allowed. Enter music now. For those of you
 11 online who couldn't hear it.
 12 **MR. KUGLER:** So then I have a question
 13 if -- to Director Greenberg. If we approve -- if
 14 this body did -- did approve it and then move it up
 15 to the SEMSCO and they approved it, then it would go
 16 to the Commissioner and the D -- D.L.A. for their
 17 vetting and approval. And if they did not approve
 18 it, then they -- they would send it back down for
 19 revision? This -- so we could sort of push it along
 20 instead of be passive partners in this, be more sort
 21 of substantial partners in the moving of this bylaw.
 22 **MR. HESLIN:** Sure. I heard a lot of
 23 confusion in the room. Maybe I just missed the
 24 conversations over the last month or two, but I
 25 couldn't hear that we had a complete or even clear

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 2 understanding of what was being said. So pushing
 3 along a document that I couldn't, in this room,
 4 listening to the conversation, understand that
 5 everybody clearly understood what they were voting on
 6 wouldn't make sense to me. I think that you need to
 7 have a clear understanding, especially when it comes
 8 to bylaws prior to moving that forward.
 9 And if you feel this group has clear
 10 understanding of what they're voting on because
 11 everybody has read it, understood it, and can
 12 articulate it, then I think you will vote. But I'm
 13 not sure that is true. So I would encourage people
 14 to clearly understand what the rules they're going to
 15 function under and be able to articulate them before
 16 they vote on them and then move it forward. So I
 17 would suggest you do it at your February meeting when
 18 everybody has that clear understanding. That will
 19 make it a lot faster moving through Legal and the
 20 Commissioner's office, because I would come back as
 21 the representative of the Commissioner and say, I
 22 don't think the group had clear understanding and
 23 they better go back.
 24 **MR. GREENBERG:** Thank you for
 25 clarifying. I would argue that we have a clear

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 2 understanding that these bylaws that are revised are
 3 better than the current bylaws.
 4 **CHAIR DOYNOW:** Dr. Isaacs?
 5 **MR. ISAACS:** Well, I appreciate the
 6 comments and thank you Dr. Kugler for bringing it
 7 up. I -- I thought we had a pretty extensive
 8 conversation previous meetings on this, and, you
 9 know, I feel this body of this agreement that we're
 10 pretty -- pretty clear to us on these bylaws and
 11 these changes and so on, and just to be able to move
 12 it along. But unless anyone on the committee feels
 13 differently.
 14 **CHAIR DOYNOW:** So I will say they --
 15 they are on Boardable and we actually do have them if
 16 we want to read through them and if -- if the
 17 Department's willing to put them up on the screen.
 18 **MR. HESLIN:** I'm okay with you moving
 19 it forward. I just didn't hear clear understanding
 20 and maybe I missed all the other meetings, but
 21 sitting here did not hear that. I heard a lot of
 22 questions and a lot of comments and confusion,
 23 frankly, on, you know, term limits, confusion on
 24 independent seat versus a dependency. The nomination
 25 could from -- be from SEMAC or not from SEMAC. And

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 2 so there are a variety of different conversations
 3 that I wrote down as it went along. Those
 4 conversations occurred in this room today. So if
 5 everybody understands all those things, I think it's
 6 great. Moving along is a wonderful thing, but I
 7 didn't hear that.
 8 **CHAIR DOYNOW:** I will say from a time
 9 standpoint that there's not a specific rush as these
 10 would not take effect essentially until August of
 11 2026. But I'll leave it up to the group as to what
 12 you folks want to do. So how about we have a show of
 13 hands. Does anybody not understand what is in the
 14 bylaws from this group? Doctor Cooper and Dr.
 15 Olsson.
 16 **MR. COOPER:** I think we do understand
 17 what's in them, but I -- I -- I happen to agree with
 18 Commissioner Hes -- Heslin that there were enough
 19 questions raised that perhaps some clarification is
 20 required before we actually bring it to a vote. And
 21 I personally see no downside since it won't affect
 22 the actual, you know, implementation date.
 23 **CHAIR DOYNOW:** Dr. Olsson, did you
 24 have anything? Okay. Well, since we have two
 25 members who have some questions, I think it is

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 2 reasonable to basically put off a vote until our next
 3 meeting. That gives everybody a chance to read them,
 4 it gives a chance for the Department to review them,
 5 and it's not going to change implement a -- when
 6 we're going to implement the -- the results. I don't
 7 think it's a problem. Is there any more discussion
 8 on that? No. Okay. So we'll bring those back to
 9 the next meeting and then hopefully, we'll be able to
 10 pass them.
 11 One other thing I wanted to say, when
 12 the State Medical Director job is posted, I sincerely
 13 hope it's going to be somebody from this group who's
 14 going to apply for it. You folks are the experts in
 15 E.M.S. in the State. You know what our providers
 16 need. I really don't want it to turn out to be
 17 someone who has no idea about E.M.S. So when it's
 18 posted, hopefully one of you guys will -- will apply
 19 for the position. Ryan tells me it has a great
 20 retirement.
 21 **MR. GREENBERG:** I can't see my
 22 retirement from here, but they tell me it does. You
 23 -- you know, and -- and I would also -- not only the
 24 people who are sitting around this table, but others
 25 who you know are subject matter experts in E.M.S.,

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 2 maybe it's a previous SEMAC member who, you know, is
 3 still very active in the field, but is no longer
 4 sitting in this particular seat. So lots of
 5 opportunity. We're excited to -- to have that one
 6 come to fruition.
 7 **CHAIR DOYNOW:** Exactly. Okay. Moving
 8 on. We're almost done here. A couple announcements
 9 -- before I move on, any old -- other Old
 10 Business? Dr. Winslow.
 11 **MR. WINSLOW:** Yeah. Jason
 12 Winslow. So at the last SEMAC meeting, we discussed
 13 the Medical Director Verification Form changes that
 14 were made in July. The forty-three sixty-two form,
 15 the language stating that Regional REMAC approval and
 16 notification was removed. I think that regional
 17 REMAC should be informed of who's serving as Agency
 18 Medical Directors in their regions as part of the
 19 regional quality improvement program. And I -- and I
 20 believe that the division stated that this might have
 21 been an oversight, so I -- I just ask if the old
 22 language could be put back. I -- I think it's
 23 specifically important with the new B.L.S.
 24 supraglottic airway policy where it states that
 25 REMACs have to approve on the education and on the

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 2 agency's policy for the implementation of the S.G.A.
 3 **MR. GREENBERG:** So I believe it is
 4 automated the -- so when they submit that new form
 5 now, it is also going to the regions. If it is not,
 6 please let me know and we're happy to -- to correct
 7 it, but I believe that has been corrected, so it is
 8 going to the regions at the same time that we're
 9 receiving those. The same way that, you know, with
 10 the supraglottic airway and things like that, the
 11 regions are getting the information at the same time
 12 that we are, if not before.
 13 **MR. WINSLOW:** With all due respect,
 14 who at the regions gets it?
 15 **MR. GREENBERG:** That is up to you, if
 16 the region is the Program Agency Director for your
 17 region. But if you let us know who, we're happy to
 18 make it happen and I think we can even make it go to
 19 multiple emails, but you would just need to tell us.
 20 **MR. WINSLOW:** Yeah -- yeah. My
 21 suggestion would be that the REMAC Chair of each
 22 REMAC get their region's Agency Medical Director
 23 forms. I also think the Director of the Program
 24 Agency should have that information because it may be
 25 two very different persons.

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 2 **MR. GREENBERG:** We're happy to
 3 accommodate. I think every region operates slightly
 4 differently, so I wouldn't want to make a blanket
 5 decision across the board. Some Program Agencies
 6 manage a lot of the paperwork and put into different
 7 places. Others may want it to go directly to that
 8 Chair. One of the things that we have recommended
 9 is, you know, we are pushing more and more
 10 information to the Program Agencies through these
 11 automatic pathways and that, you know, regions may
 12 not want it to go to a specific person's email. I'm
 13 not saying in this particular case, but you may want
 14 to have a general email box that you know, okay, all
 15 of our State communications are coming into this. So
 16 that if your Program Agency Director changes or
 17 something else that that mailbox is still available
 18 for them. But that is -- it's a backend fix. We are
 19 happy to change and adjust to whatever the region
 20 would like to see related to that and I do believe we
 21 can go to multiple ones, but happy to check on that
 22 one as well.
 23 **CHAIR DOYNOW:** Any other Old
 24 Business? New Business. Moving on to New Business.
 25 **MR. CLEMENCY:** Thank you. Public

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 2 access to A.E.D.s saves lives. Today there's a
 3 variety of automated and semi-automated F.D.A.
 4 approved devices in the -- throughout the country and
 5 actually deployed throughout New York State. It was
 6 recently brought to our attention that Article 30,
 7 Section 3000-B, the PAD law, although it does not
 8 include the word semi-automated anywhere in the
 9 document, has some ambiguity which could be
 10 interpreted to limit the section to only semi-
 11 automated defibrillators. I think national and
 12 international guidelines, best practices, and F.D.A.
 13 approval suggest that PAD access should include both
 14 automated and semi-automated models. And I would ask
 15 that the SEMAC recommend to the State that both
 16 A.E.D.s. and semi-automated A.E.D.s should be
 17 included in the way we operationalize this section
 18 and ask the Bureau -- sorry, the Division of E.M.S.
 19 to look for ways to clarify this to avoid any
 20 ambiguities in the future.
 21 **CHAIR DOYNOW:** Any discussion on
 22 that? Mike?
 23 **MR. MCEVOY:** I think this is
 24 incredibly important. I think more than anything
 25 else we have a significant number of the automated

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 2 defibrillators already distributed across New York
 3 State. We need to make sure that those remain in
 4 place. And we need to make sure that there is no
 5 enforcement based on a strict reading of the -- of
 6 3000-B. At the end of the day, it's about saving
 7 lives. These devices save lives. They're currently
 8 out there in a position where they can and what we
 9 need to do is continue to in -- enforce and support
 10 the use of these devices. So thank you, Brian. I
 11 think this is incredibly important for us to -- to
 12 address and give the -- the Department support from
 13 this body for that -- that change.
 14 **MR. GREENBERG:** So I am sitting next
 15 to the First Deputy Commissioner who is looking at
 16 some of the things. So I think give us from now to
 17 the February meeting. Let us, you know, go back,
 18 talk to Legal about it and just come back and kind of
 19 see where some of the things are and we can kind of
 20 go from there. Sound good?
 21 **MR. HESLIN:** I -- I might add to that
 22 that there's only sixteen or twenty states that
 23 require medical direction for an A.E.D. It's a Class
 24 three medical device, so you can't purchase it
 25 without a prescription, which means you have a

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 2 physician involved in it. We've made a big scene
 3 over having qualified people to use it. But when you
 4 call nine one one, they tell you where it is, how to
 5 get it, and then they tell you how to operate it, and
 6 then they tell you how to do C.P.R. So I wonder if
 7 our current requirements for A.E.D.s are a little
 8 over-prescriptive per se.
 9 **CHAIR DOYNOW:** Dr. Dailey, you looked
 10 like you wanted to say something.
 11 **MR. DAILEY:** Actually, the -- the one
 12 thing that I would echo Mike on here that's important
 13 is we do have a regulatory environment around
 14 A.E.D.s. It's clearly not working to keep things in
 15 compliance with the law. And since the law is wrong,
 16 it gives us an excellent opportunity to open the
 17 door. The one thing that I would suggest to the
 18 regions is that they look at a not-for-profit A.E.D.
 19 registry that's out there. That then opens the
 20 opportunity up for those A.E.D.s to then be accessed
 21 in terms of their location by nine one one call
 22 centers. So Public Safety Answering Points can
 23 develop a relationship with pro -- several different
 24 proprietary companies and access these A.E.D.
 25 registries. We regionally in REMO will begin using

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 2 that registry, because right now we get all these
 3 A.E.D. applications. We know we're probably only
 4 getting the applications for about half the A.E.D.s
 5 that are deployed in the region. But we get these
 6 applications and then they go into a file. And once
 7 they're in the file, they are good for nothing. So
 8 putting them into a registry that can then be
 9 accessed by Public Safety Answering Points gives us
 10 additional opportunities to save lives. So we'll be
 11 doing that shortly and I recommend you do the same.
 12 **CHAIR DOYNOW:** Dr. Cooper.
 13 **MR. COOPER:** I certainly support Dr.
 14 Dailey's suggestions, but I -- I -- I think it's
 15 worth remembering that when -- when this law was
 16 enacted, we were in a very -- very different
 17 environment. Public access defibrillation was brand
 18 new. And, you know, there was concern about
 19 potential mishaps and so on through the use, even
 20 though, you know, we all knew that the data was such
 21 that, you -- you know, mishaps would be, you know,
 22 essentially impossible to occur. But we're now ten,
 23 fifteen -- fifteen years, I think, if not
 24 more. Maybe twenty.
 25 **MR. GREENBERG:** 1998.

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 2 **MR. COOPER:** In their twenty.
 3 **MR. GREENBERG:** 1998.
 4 **MR. COOPER:** Huh?
 5 **MR. GREENBERG:** 1998.
 6 **MR. COOPER:** 1998. Yeah, so --
 7 **MR. GREENBERG:** I used to have a rock
 8 defibrillation below.
 9 **MR. COOPER:** Anyway -- anyway, the
 10 point is we haven't looked at that law in that period
 11 of time and we're living in a very different world,
 12 so it's high time we actually do take a look at
 13 it. It seems like a fairly simple technical fix, if
 14 -- if any fix is required at all. Commissioner
 15 Heslin is shaking his head, but --
 16 **MR. HESLIN:** The word simple in
 17 government and statute doesn't always align.
 18 **MR. COOPER:** Le -- let's put it this
 19 way. I think it's a lot simpler than many of the
 20 issues we discuss here but thank you.
 21 **MR. HESLIN:** So we could spend all
 22 afternoon doing this discussion, but just in review
 23 of this. The last time it was updated was in 2017
 24 for a 2018 start to add physician assistants into who
 25 could be able to provide A.E.D. service as a

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 2 emergency healthcare provider. Suffice to say that
 3 3000-B the way it's currently written, is completely
 4 out of date with what current practice is. And so it
 5 would require statutory change to update that and --
 6 and -- and -- because virtually every mall is out of
 7 compliance with this law at this point in time and
 8 there are A.E.D.s in every mall. And so the practice
 9 of medicine has outstripped the statutory -- statute
 10 of medicine. And so this needs to be taken back
 11 completely revised to meet the current standards and
 12 access. And so what we're talking about today with
 13 a, you know, change that puts people at risk is a
 14 legal law that is antiquated. That just has to
 15 change. And so I think that we'll take that
 16 back. It's great that it's been brought up here but
 17 changing a word or two to a -- allow it to just be
 18 automatic or whatever is -- all three pages doesn't
 19 fit, so let's just leave it at that. We're going to
 20 take it back. We're going to take a look at how we
 21 might be able to put that into a statutory package
 22 for change.
 23 **CHAIR DOYNOW:** Okay. Very good
 24 discussion, and hopefully that will be taken care
 25 of. Thanks for bringing that up. Looks great. Any

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 2 other New Business?
 3 **MR. HESLIN:** I would just add, you
 4 know, when we make these types of changes, it always
 5 helps then everybody in the entire State advocates to
 6 the legislature and your representatives that these
 7 are important changes. And, you know, these are
 8 difficult to do in budget because legislature, if
 9 it's not financial, doesn't like to address it in
 10 budget. But our tool is to bring it forward through
 11 budget, and they typically eliminate those things as
 12 they have in many years. So I would encourage you to
 13 encourage your legislators to think about what
 14 they're doing, particularly for important topics like
 15 this. That while it seems like a small change, it's
 16 a policy issue with how people function. And so we
 17 have to sometimes move beyond just policy, I'll say
 18 it that way, and move towards how we start to think
 19 about practice. And that's -- that's going to be
 20 important. So we need your advocacy to get this
 21 through.
 22 **CHAIR DOYNOW:** Thank you,
 23 Commissioner. Any other New Business? Okay, before
 24 we adjourn, just a few announcements. I'd like to
 25 congratulate Dr. Isaacs, Physician of the Year. And

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 2 also Dave Violante, who has the Pre-hospital Research
 3 Forum Award. Congratulations on the i-gel. That
 4 certainly was a lot of work and I'd also like to
 5 thank you. It's been a pleasure working with you for
 6 the last two years.
 7 **MR. GREENBERG:** Mr. Chair.
 8 **CHAIR DOYNOW:** Yes.
 9 **MR. GREENBERG:** I -- I just want to
 10 echo on that one. You know, obviously thank you to
 11 all the physicians around the room, but to da -- Dr.
 12 Isaacs and, you know, the small system that he works
 13 in slightly down south. You know, it's incredible
 14 work and it very much is reflected in the application
 15 that was submitted on behalf of nominating you for
 16 that and the work that you do on E.M.S., so thank you
 17 on that front.
 18 And to Dave and the team of people on
 19 your research project. For those of you who weren't
 20 aware, the Pre-hospital Research Forum that happened
 21 at Vital Signs this year had twenty-three poster
 22 submissions into it. This is the first year we've
 23 had a research competition. This is the first year
 24 that we brought the Pre-hospital Research Forum in
 25 for a three-day workshop. And even Dave Page, who,

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 2 you know, ran the program for the three-day workshop
 3 and attended with us at Vital Signs commented on, it
 4 was, you know, pretty amazing for a year one of a
 5 program to have that type of response, you know,
 6 looking at E.M.S., looking at research.
 7 We also for the first time in many,
 8 many years had the Commissioner of Health and our
 9 First Deputy attend the Vital Signs conference, and
 10 being able to bring them down and show the work
 11 that's being done around the State related to, you
 12 know, E.M.S. research and things like that was, you
 13 know, phenomenal opportunity. So congratulations
 14 both Dr. Isaacs and Mr. Chair on your -- you know, on
 15 the competition and -- and Physician of the
 16 Year. But also just to show the great work that's
 17 being done and, you know, the things that come out of
 18 here that sometimes you don't always directly see but
 19 is actually affecting things. So thank you.
 20 **CHAIR DOYNOW:** Thank you, Ryan. The
 21 next meeting will be in February and my -- I believe
 22 it's Saratoga Embassy Suites. Is that correct?
 23 **MR. GREENBERG:** As listed on the
 24 website.
 25 **CHAIR DOYNOW:** Okay. I believe that's

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 2 where it will be there.
 3 **MR. GREENBERG:** And there -- there was
 4 a question -- you know, just situational awareness
 5 for all the members in the room. There was a
 6 question at the Executive Committee. You know, next
 7 year you'll notice that we move around a lot. We
 8 move around because we know the dates that this
 9 council is asked to meet and then we have to fit into
 10 what's available to meet. So just so you understand
 11 a little bit about the movement, it has to do with
 12 either have to be flexible with space or you got to
 13 be flexible with dates. In this particular case,
 14 we're more flexible in being able to, you know, move
 15 to a different location in order to meet the dates
 16 that this group is looking to meet and when they're
 17 looking to meet. So just situation one, that's to
 18 give everybody that. Thanks.
 19 **CHAIR DOYNOW:** So confirming it is
 20 February 24th and 25th. Embassy Suites in
 21 Saratoga. So I wish everybody a happy holiday. And
 22 can I have a motion to adjourn? Unless you guys want
 23 to stay here for another hour I can --
 24 **MS. DORSETT:** Motion to adjourn.
 25 **CHAIR DOYNOW:** Second. Dr. Dailey,

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 2 thank you for your second. All right. Meeting is
 3 adjourned.
 4 (The meeting adjourned at 12:43 p.m.)
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 2 STATE OF NEW YORK
 3 I, MONIQUE HINES, do hereby certify that the foregoing
 4 was reported by me, in the cause, at the time and place,
 5 as stated in the caption hereto, at Page hereof; that
 6 the foregoing typewritten transcription consisting of
 7 pages 1 through 61, is a true record of all proceedings
 8 had at the hearing.
 9 IN WITNESS WHEREOF, I have hereunto subscribed
 10 my name, this the 31st day of December, 2025.
 11
 12 MONIQUE HINES, Reporter
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