

9/10/2025 – SEMAC Meeting – Troy, N.Y.
NEW YORK STATE
DEPARTMENT OF HEALTH

STATE EMERGENCY MEDICAL
ADVISORY COMMITTEE MEETING

DATE: September 10, 2025
TIME: 11:06 a.m. to 11:58 a.m.
CHAIR: Donald Doynow
LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

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(The meeting commenced at 11:06 a.m.)
CHAIR DOYNOW: If I can ask everybody to be seated so we can start the meeting. Give them a minute to sit down. Okay. I'd like to call to order the -- the September 10th meeting of SEMAC. Before we got started, just a few comments.
There is a helicopter up on the screen, obviously, and that is in remembrance of Kevin Roberts, who, if you folks don't know, has been a long-time flight paramedic. He was involved in a helicopter transplant -- transport where they loaded the patient into the helicopter.
Five minutes after liftoff, he became unresponsive and was a full arrest. And they made an emergency landing at a local hospital and they were unable to revive him. So, I'd like to have a minute of silence for Kevin Roberts, as well as those of 09/11.
Okay. Thank you all. If we could all 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.

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2 **APPEARANCES:**
3 AIDAN O'CONNOR
4 ALEX KACZOR
5 ALBERT SHIH
6 AMANDA SHULTZ
7 ARTHUR COOPER
8 BRIAN CLEMENCY
9 BRIAN WALTERS
10 DANIEL OLSSON
11 DAVID AFIENKO
12 DAVID KUGLER
13 DAVID VIOLANTE
14 DONALD DOYNOW
15 DONALD DUVALL, JR.
16 DONALD HUDSON
17 DOUGLAS ISAACS
18 GENE HASLIN
19 JASON WINSLOW
20 JEFFREY RABRICH
21 JON WASHKO
22 JONATHAN BERKOWITZ
23 KATHLEEN HALLINAN
24 KIRBY BLACK
25 MARK PHILIPPY
MARY ANN PORTORO
MERRY RUDINGER
MICHAEL DAILEY
MICHAEL MCEVOY
NAVEEN SESTH
PAMELA MURPHY
ROBERT CRUPI
RYAN COATES
RYAN GREENBERG
STEVEN KROLL
TERESA HAMILTON
TIFFANY BOMBARD

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CHAIR DOYNOW: Okay. Thank you all. If we could have a roll call, Amanda.
SECRETARY SCHULTZ: Dr. Afienko.
MR. AFIENKO: Afienko here.
SECRETARY SCHULTZ: Dr. Berkowitz.
MR. BERKOWITZ: Here.
SECRETARY SCHULTZ: Dr. Black.
MR. BLACK: Black here.
SECRETARY SCHULTZ: Dr. Bombard.
MS. BOMBARD: Bombard here.
SECRETARY SCHULTZ: Dr. Clemency.
MR. CLEMENCY: Clemency here.
SECRETARY SCHULTZ: Dr. Coates.
MR. COATES: Coates here.
SECRETARY SCHULTZ: Dr. Cooper.
MR. COOPER: Cooper here.
SECRETARY SCHULTZ: Dr. Dailey.
MR. DAILEY: Dailey here.
SECRETARY SCHULTZ: Dr. Dorsett. Dr. Doynow.
CHAIR DOYNOW: Doynow here.
SECRETARY SCHULTZ: Dr. Goldman. Dr. Gomez. Dr. Hallinan.
MS. HALLINAN: Here.

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 2 **SECRETARY SCHULTZ:** Dr. Isaacs.
 3 **MR. ISAACS:** Isaacs here.
 4 **SECRETARY SCHULTZ:** Dr. Kugler.
 5 **MR. KUGLER:** Present.
 6 **SECRETARY SCHULTZ:** Dr. Murphy. Dr.
 7 Olsson.
 8 **MR. OLSSON:** Olsson here.
 9 **SECRETARY SCHULTZ:** Dr. Rabrich.
 10 **MR. RABRICH:** Rabrich here.
 11 **SECRETARY SCHULTZ:** Dr. Seth.
 12 **MR. SETH:** Seth here.
 13 **SECRETARY SCHULTZ:** Dr. Shih.
 14 **MR. SHIH:** Shih here.
 15 **SECRETARY SCHULTZ:** Dr. Walters.
 16 **MR. WALTERS:** Walters here.
 17 **SECRETARY SCHULTZ:** Dr. Winslow.
 18 **MR. WINSLOW:** Present.
 19 **SECRETARY SCHULTZ:** Orin Barzile.
 20 Aidan O'Connor.
 21 **MR. O'CONNOR:** Good morning, present.
 22 **SECRETARY SCHULTZ:** Mark Philippi.
 23 Mary Ann Portoro.
 24 **MS. PORTORO:** Mary Ann Portoro here.
 25 **SECRETARY SCHULTZ:** Michael McEvoy.

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 2 Steve Kroll.
 3 **MR. KROLL:** Present.
 4 **SECRETARY SCHULTZ:** Jon Washko.
 5 **MR. WASHKO:** Present.
 6 **SECRETARY SCHULTZ:** We have quorum.
 7 **CHAIR DOYNOW:** Okay. Thank you very
 8 much, Amanda. If we can have approval of the May
 9 minutes. Anybody want to make that motion? Thank
 10 you.
 11 **MR. OLSSON:** Olsson, I'll make the
 12 motion.
 13 **CHAIR DOYNOW:** Thank you, Dr. Olsson.
 14 Second --
 15 **MR. WINSLOW:** Seconded.
 16 **CHAIR DOYNOW:** Okay. Dr. Winslow.
 17 Anybody against? Assume everyone is in favor? Any
 18 abstentions? Well, minutes are approved. Ryan, if
 19 we could have the Bureau report.
 20 **DIRECTOR GREENBERG:** Absolutely.
 21 Sorry, one second there. Good morning, everybody.
 22 So, couple things going on in the Bureau. Excited to
 23 be here. But on the operations side, you'll notice
 24 that there are a number of new investigators around
 25 the State.

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 2 We're excited to have hired six new
 3 investigators and have them out in the field doing
 4 field training. So, you'll see a lot of
 5 investigators showing up with two, that is the
 6 trainee and the trainer.
 7 Feel free to introduce yourselves, and
 8 let them know who you are, the agencies that you work
 9 with, particularly on the medical director's side.
 10 In the administration front, I know some of you have
 11 asked questions related to program agency contracts
 12 and REMSCO contracts.
 13 Just to give you an idea, both of
 14 those are -- the award letters are out and we have
 15 about half of our program agencies have entered into
 16 contracts and have signed executed contracts and
 17 about half of our REMSCOs have signed executed
 18 contracts. That also means that the other half do
 19 not.
 20 And I bring this up just to your
 21 attention. So, if you're sitting on a REMAC or
 22 REMSCO and you know, you do have some questions about
 23 it, to go to your program agency and talk about if
 24 there's any barriers or anything that maybe any of
 25 you can help in breaking down some of those barriers.

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 2 We would love to get everybody into
 3 contract because there are some additional
 4 initiatives that are included in the program agency
 5 contracts this year, including recruitment and
 6 retention, as well as funding at least two paramedic
 7 students, but we can't fund those unless they're in
 8 contract.
 9 So, those that are in contract are
 10 able to take advantage of those things. Those that
 11 aren't in contract are not able to take advantage of
 12 those right now. Year to date in aid to localities
 13 for those two things, we've paid out about a half
 14 million dollars to program agencies and REMSCOs that
 15 are in contract.
 16 And we've spent about two point one
 17 million in education and training. Just to give it a
 18 framework on the spending in the education and
 19 training. Last year at this time, we were about one
 20 point nine million, so we're about two hundred
 21 thousand dollars further along than we did last year.
 22 In the world of education, there is
 23 one significant thing to discuss here, and that's
 24 national registry. We are not technically a national
 25 registry State. We have a national registry

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 2 alternative pathway.
 3 National registry is going through a
 4 licensure software transition. They started in July.
 5 They have had copious problems with it, and I would
 6 encourage you, if you want to know more about some of
 7 the issues that they have, to go to their website.
 8 As medical directors, I don't know if
 9 your part has been affected. But on our -- on our
 10 side, both for reciprocity and the alternative
 11 pathway, it has had significant issues for us. We
 12 have to go on and verify information if somebody
 13 takes the alternative pathway, takes the national
 14 registry exam.
 15 We have not been able to -- to, in a
 16 timely manner, confirm that information. The license
 17 tran -- licensure software transition, during the
 18 transition, has moved some information to different
 19 areas, has inaccurate information coming across, and
 20 we can't confirm the information.
 21 Because of that, it takes about four
 22 to eight weeks now for something that we are doing in
 23 about fourteen days before. So, students can still
 24 take the National Registry, that's up to them, but
 25 they should be aware that it will take about four to

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 2 That will be posted shortly. Vital Signs conference
 3 registration is open and the new website is up. So,
 4 please go and register for the conference. A lot of
 5 new pre-cons this year based on what each of you have
 6 asked for or many of you have asked for.
 7 There's also a big shift this year in
 8 dates. So, our main conference, which is normally on
 9 Saturday and Sunday, this year is on Friday and
 10 Saturday. Why? To meet the need of both those on
 11 the volunteer side, as well as those who are career
 12 service members and want to be able to still have
 13 part of their weekend.
 14 So, we did make that shift as a
 15 recommendation from our constituents. Our E.M.S.
 16 Memorial is going up, will happen in May. For
 17 anybody who is wanting to submit an honoree, please
 18 make sure to submit that in the near future, so that
 19 we have enough lead time to add them to the wall this
 20 year.
 21 Also the Fire Memorial, which is held
 22 by State Fire is in October, so it's just in a couple
 23 weeks. They have a hundred and twenty-seven names
 24 going on the Fire Memorial this year. It is
 25 predominantly 09/11 related.

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 2 eight weeks for us to process them.
 3 And that's permitting the system will
 4 allow us to process them on the National Registry
 5 side. We have been in touch with them. They are
 6 working hard to fix the problem. I'm sure they're
 7 even more frustrated than we are with the process.
 8 And a student always can take -- even
 9 if they took the registry exam, they can always go
 10 and take the State exam at any point, and then they
 11 will get an immediate card if they take the State
 12 card.
 13 Are there any questions related to
 14 national registry and some of the complications or
 15 delays that this has caused? Excellent, all right.
 16 So, moving along. Our next STAC meeting is in
 17 October. We just had our last E.M.S.C. meeting and I
 18 think we're going to be talking about that one a
 19 little bit later today.
 20 We also got extended for our E.M.S.
 21 for Children grant funding. Which we only had half
 22 the year originally, so we're very excited about
 23 that. And we will be hiring a part-time position for
 24 the E.M.S. for Children position.
 25 So, keep your eyes open for that one.

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 2 Is a little bit of -- it's not just
 3 from what occurred in this past year, it's the past
 4 couple of years that are going on, but this is the
 5 largest number of names that they've had go on, I
 6 think, since the inception of the memorial.
 7 So, if you have the opportunity to
 8 attend, they -- they really put on a very beautiful
 9 event up not far from where our memorial is. Council
 10 dates, we are almost in contract for all of the 2026
 11 council dates.
 12 So, those will be coming out hopefully
 13 by October 1st. We'll have the -- out to all the
 14 members so you can put it onto your calendars.
 15 Regulations, the equipment regulations, very excited
 16 that will be coming up for a vote in SEMSCO.
 17 The blood regulations are being
 18 prepped for public comment. The ambulance build
 19 regulations should be out, I think, by the end of
 20 this year. And community paramedicine, we're
 21 continuing to working on those and working on the
 22 finalized drafts.
 23 The Mental Health and Wellbeing
 24 symposium that happened last June, there is another
 25 one that will happen this June, we're starting on the

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 2 planning on that one. And the fellowship program is
 3 really progressing -- well, I think we're going to
 4 update on that one -- excuse me, a little later
 5 today.
 6 Something new is the recruitment and
 7 retention symposium. So, we are doing a one-day
 8 recruitment and retention symposium, not in Albany.
 9 One will be held down in -- on Long Island and the
 10 other one will be held in the Finger Lakes, giving
 11 organizations the opportunity to send some of their
 12 team members or staff to some additional education
 13 related to recruitment and retention of their staff.
 14 The pre-hospital care research forum
 15 occurred in June. It was very successful. We had
 16 about forty-five people there. I think we're going
 17 to talk about that a little bit later on. As well as
 18 that Vital Signs is here, this will be the first year
 19 that we have a research poster competition, so
 20 excited about that one.
 21 The next meeting for SEMAC and SEMSCO
 22 is December 9th and 10th in Troy, right here. And
 23 that is it for my report before I make an
 24 introduction. Does anybody have any questions about
 25 the report?

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 2 **CHAIR DOYNOW:** Ryan, do you want to
 3 talk a little bit about the State Medical Director
 4 and where we are in progress?
 5 **DIRECTOR GREENBERG:** Sure. So, all
 6 the paperwork has been submitted for the State
 7 Medical Director in -- for the approval process with
 8 the Bureau of Employee Relations. We are waiting for
 9 that to clear and then you'll see it get posted.
 10 When it does get posted, it will be
 11 posted on the State jobs website and we will make
 12 sure that we distribute that to all of the SEMAC and
 13 SEMSCO listservs, so everybody's aware of it in case
 14 there's anyone who knows someone who would be a
 15 really good candidate for the position.
 16 **CHAIR DOYNOW:** Great, thank you. And
 17 if anyone's interested, please let Ryan know. We
 18 have a number of qualified people in this room as
 19 well as probably also at home watching. Let Ryan
 20 know if you have interest. And turn it back to you,
 21 Ryan.
 22 **DIRECTOR GREENBERG:** Thanks. And now
 23 it is my honor to introduce Dr. Gene Heslin.
 24 **COMMISSIONER HESLIN:** Thanks. We've
 25 done this a couple times now. So, I'm Gene Heslin.

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 2 I'm the First Deputy Commissioner and Chief Medical
 3 Officer for the Department of Health in the Office of
 4 the Commissioner. Just by way of background, a
 5 couple of things.
 6 I'm a family medicine doc by training.
 7 Started a practice back in 1992, still see an
 8 occasional patient or two because when you tell them
 9 you're going to take care of them for the rest of
 10 their lives, they hold you to it.
 11 That being said, I also had the
 12 privilege of being part of Diaz Ambulance back in the
 13 early 90s and was on their board of directors and was
 14 -- served as their medical director for part of that
 15 -- part of that time. And that's down in Ulster
 16 County.
 17 And so, E.M.S. has always been part of
 18 my world. You guys have come to my community. You
 19 have saved my patients in my office. And there's
 20 just a deep respect for the group and the work that
 21 is committed to and supported by this organization.
 22 So, I just wanted to do that by way of
 23 introduction. The reason why I'm here today is -- is
 24 several-fold. First, the Commissioner asked me to
 25 become more involved in the E.M.S. world recently.

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 2 And so, I committed to do that and I
 3 committed to being here more and also learning. So,
 4 one of the things that when I was a resident, I
 5 walked into my residency director's office a month
 6 into residency. And I told him all the things that
 7 were problematic.
 8 And then he told me I was right, but I
 9 didn't have the right to say it, come back in three
 10 years. And I learned that you have to listen and
 11 learn from the people that are in a room, and people
 12 that are part of an organization to understand not
 13 the ethos, but actually why things happen.
 14 And so, I was sent to deliver a
 15 message from the Commissioner that for E.M.T.C.C.
 16 that he's not going to accept the recommendation of
 17 the committees in terms of timeline. And he's
 18 referring it back to the Education and Training
 19 Committee, down the other end of the table there, to
 20 take a better look at that.
 21 And largely, it's due to workforce.
 22 It's due to the fact there's been major changes to
 23 the health ecosystem, particularly over the last few
 24 months period of time as we've all been witnessing
 25 and living through.

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 2 So, it's unfortunate that he made that
 3 decision, but decision is made. And now we're going
 4 to figure out how to go forward from there. The
 5 commitment is that we need to figure it out and we
 6 need to continue to work towards a solution.
 7 That being said, you know, we
 8 recognize from the commissioner's office how
 9 important E.M.S. is, which is again why I'm going to
 10 become more involved in this part of the process.
 11 Ryan and Steve do a great job.
 12 I mean, they're briefing the
 13 Commissioner all the time on issues. They have
 14 regular meetings with him. But he's busy, and he
 15 focuses on many things. And so I get a portfolio of
 16 smaller things to focus on and this is going to be
 17 part of that portfolio.
 18 So my commitment is that I'm going to
 19 listen and learn and not be like I was thirty-five
 20 years ago as a resident and find all the issues that
 21 I think might be there, but learn why, and then
 22 hopefully be an asset to this organization. And --
 23 and I'll stop there. Ryan, back to you.
 24 **DIRECTOR GREENBERG:** I think that's
 25 the end of our report unless you have anything else

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 2 or questions.
 3 **CHAIR DOYNOW:** Anybody have any other
 4 questions at all? Well, thank you, Dr. Heslin. We
 5 appreciate you being here. Hopefully, we'll be
 6 seeing you in a number of future meetings. Thank
 7 you. Dr. Cooper has some time limitations, so we'll
 8 move out of order for E.M.S.C. Report.
 9 **MR. COOPER:** Thank you, Dr. Doynow.
 10 E.M.S.C. had met two days ago prior to this meeting.
 11 Director Ryan Greenberg has already reported on our
 12 grant renewal and -- and the potential hiring of --
 13 of someone to work together with Amy Eisenhauer who's
 14 done just a great job, you know, serving the
 15 committee for the last several years, not to mention
 16 the children of New York State.
 17 Briefly, the meeting focused on, you
 18 know, the following really key items. First, the
 19 Always Ready for Children Program has really grown
 20 substantially. There are about thirty or so
 21 hospitals already involved in the program, but -- but
 22 Amy has received another dozen or so applications
 23 over the summer and those are being processed as we
 24 speak.
 25 A very important part of that -- that

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 2 -- that program, of course, is the National Pediatric
 3 Readiness Project. The National E.M.S.C. program
 4 invites all hospitals to participate in that program
 5 every five years or so. That is coming up this --
 6 this fall.
 7 For those of you that are American
 8 College of Surgeons verified trauma centers, you
 9 probably already know that completing that survey is
 10 -- is a mandatory requirement if you happen to be a
 11 trauma center.
 12 But it's really important that all
 13 hospitals participate in -- in filling out that
 14 survey, you know. So, we really get a really, really
 15 good glimpse of -- of how emergency care for children
 16 is proceeding in New York State.
 17 Let me just add that the last time the
 18 survey was -- was -- that was about five years ago in
 19 the middle of COVID. And you know, the response rate
 20 was -- was less than robust, shall we say. Not true
 21 only for New York State, it was a national
 22 phenomenon.
 23 But it's really important that this
 24 time around we get some pretty robust numbers. We're
 25 looking to get at least eighty percent, if not a

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 2 hundred percent of the hospitals in New York State
 3 participating. When that comes into your inbox,
 4 please take note.
 5 Third, some great news from the
 6 Pediatric Agitation Workgroup. The -- the videos
 7 that have been prepared to accompany the various
 8 scenarios that have been selected for -- you know,
 9 for distribution as educational materials have been
 10 shot. They're in the process of being edited at the
 11 -- at the present time.
 12 We are very hopeful that they'll be
 13 ready for viewing and approval at the -- at the -- at
 14 the December meeting, our December meeting. Those
 15 involved are aware that those videos have to be
 16 submitted by October 14th to meet the -- the
 17 requirements of the -- of the department for review
 18 prior to dissemination.
 19 And finally, we had a very, very
 20 lengthy discussion on pediatric sedation. And while
 21 there has been quite a bit of activity in and around
 22 pediatric sedation, both nationally and
 23 internationally, over the past several years, not --
 24 not to mention least of which is the formation of a
 25 new society on pediatric -- a society for pediatric

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 2 sedation.
 3 It's really become clear that -- that
 4 -- that while using pharmacologic means for sedation
 5 in children in -- in cases where non-pharmacologic
 6 means are, you know, largely are going to be
 7 unsuccessful.
 8 The fact is that there's been
 9 incredibly little effort put in to determine how to -
 10 - how to keep children comfortable during more minor
 11 procedures for which pharmacologic, you know,
 12 interventions may be necessary.
 13 Simple things like -- like blood
 14 draws, like starting I.V.s, like passing a, you know,
 15 a gastric tube if needed, passing a urinary catheter
 16 if needed. All simple things that -- that --
 17 frankly, traditionally, many of us grew up just
 18 making sure that kids were held down by four strong
 19 people.
 20 And you know, typically with their
 21 parents close by and having to witness all the -- all
 22 the difficulty that their child was suffering. So,
 23 we had a very, very lengthy discussion about that.
 24 There are discussions also taking place at a national
 25 level.

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 2 There's a potential opportunity to
 3 partner with the Pediatric Emergency Care Applied
 4 Research Network and doing some of the -- doing some
 5 of the legwork involved and focusing on this very
 6 important issue.
 7 And of course, the issue of keeping
 8 kids comfortable during minor procedures is something
 9 that I know will be very, very near and dear to our
 10 pre-hospital, you know, professional colleagues, you
 11 know, who deal with this -- this issue on a -- on a
 12 daily basis themselves.
 13 So the -- the aim is at the end of the
 14 day to come out with some kind of work product. I'm
 15 not clear what that would be. Could end up being
 16 some, you know, some, if you will, demonstration
 17 videos of how -- how comfort -- pediatric comfort
 18 could be assured in the emergency department and the
 19 -- and/or in -- in -- in a pre-hospital environment.
 20 It may -- it may be -- it may take the
 21 form of a -- of a guidance document to be determined,
 22 but we've put this -- this issue on the fast track
 23 because it's so important to -- to -- the work that
 24 we all do.
 25 I think that sums up most of the major

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 2 points for the moment. And thanks -- thanks to the
 3 federal government for their support of our program
 4 and for the division to moving ahead with some help
 5 for Amy who certainly needs it.
 6 Not that she hasn't done a great job
 7 by herself, but -- you know, more help is always
 8 useful. Thanks, I'll be happy to answer any
 9 questions.
 10 **CHAIR DOYNOW:** Thank you, Dr. Cooper.
 11 Anybody have any questions for Dr. Cooper?
 12 **DIRECTOR GREENBERG:** I just wanted to
 13 add one additional thing. So, we are per the funding
 14 was also some additional funding that we're going to
 15 be using to create what was, or in many places,
 16 called a teddy bear clinic, to where there's teddy
 17 bears and the children come in and they get to fix
 18 the teddy bear and learn about, you know, what would
 19 happen if they got injured or those in that context.
 20 So, with that additional funding,
 21 we're actually going to get some stuffed animal
 22 Olivers. If you've met Oliver, our K-9 companion,
 23 he's not here today, but it will be a Oliver Clinic
 24 where they can come and fix Oliver.
 25 There's actually going to be a kit

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 2 distributed to each of the REMSCOs that any of the
 3 agencies in the REMSCOs would be able to take that
 4 and do a community outreach event with their members
 5 and do a little outreach again, trying to focus on
 6 getting out into communities, and hopefully inspiring
 7 the future healthcare providers of the world. So,
 8 more to come on that.
 9 **CHAIR DOYNOW:** Thank you, Ryan. Any
 10 questions for Ryan? Okay. Moving right along, Dr.
 11 Rabrich from Med Standards.
 12 **MR. RABRICH:** Thank you, Dr. Doynow.
 13 So, Med Standards met immediately prior to SEMAC and
 14 while there's no seconded motions, there was some
 15 very good discussion on a number of topics. One item
 16 that was discussed was the update on the B.L.S.
 17 supraglottic airway implementation and the policy.
 18 The policy is very close to
 19 completion. It's gone through legal review and a
 20 number of other steps and should be released in the -
 21 - in the very near future. One of the issues that
 22 came up in that process was the fact that B.L.S.F.R.,
 23 so B.L.S. first response agencies or groups are not
 24 regulated the way that A.L.S.F.R. and A.L.S and
 25 B.L.S. agencies are.

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 2 So, therefore, B.L.S.F.R. is not
 3 included in the policy because they're not registered
 4 or regulated by the Bureau and there was some
 5 discussion about how to approach that going forward
 6 and perhaps there would be an opportunity for those
 7 agencies if they chose to to voluntarily register in
 8 some way and then participate.

9 But more discussion to come on that,
 10 but we've received several inquiries as to, you know,
 11 why a B.L.S.F.R. can't participate. There were some
 12 that had interest, and -- and that is the reasoning.

13 And as we learn more about that
 14 process, there's ongoing discussions about how to --
 15 how to address that to allow participation by E.M.T.s
 16 who may be part of a B.L.S.F.R. to participate. I
 17 don't know if you want to add anything to that, but
 18 that's pretty much.

19 **CHAIR DOYNOW:** Yeah.
 20 **MR. RABRICH:** There was a discussion
 21 of the blood implementation update for ground units.
 22 As a reminder, it's already being utilized by air
 23 units. The regulations are making progress. There's
 24 been a lot of good input, a lot of good progress on
 25 that.

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 2 And there are -- there's a TAG
 3 working, a group working on best practices type
 4 implementation for the best way to utilize it in an
 5 agency and regional approach and there's ongoing
 6 discussions.

7 If you have interest in participating
 8 in that or -- or hearing more about best practice
 9 implementation and participant group, both Dr. Dailey
 10 and Dr. Isaacs have been working on that as well,
 11 shock advised, or no?

12 All right. Clinical Data Integrity
 13 has been doing a large amount of work. One of the
 14 things they realized is one of the problems is in the
 15 standardization of definitions, and that there's
 16 problems with data mapping because of non-standard
 17 terms and definitions.

18 So, that group is looking at procedure
 19 codes and lists that are used and trying to use last
 20 year's data, understand, you know, which ones are
 21 used, which ones are appropriate, and then bring
 22 recommendations forward, as far as, addressing that
 23 so we can get better data collection.

24 There was also a discussion on R.S.I.
 25 training and credentialing process. The discussion

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 2 were that many regions have very robust process for
 3 this already, but that there is -- there could
 4 potentially be opportunity for standardizing a
 5 minimum standard of training and the didactics and --
 6 and approach to that across the State at a State
 7 level and Training and Ed has been so gracious to
 8 take a look at that and provide some input as well,
 9 and recommendations on that.

10 The MLREMS brought forth -- forth an
 11 issue about balanced crystalloid solutions as a
 12 regional option, being that they're not on the
 13 formulary, but research shows that balanced
 14 crystalloids are appropriate and useful.

15 So, that was being referred to the
 16 collaborative group for implementation on our regular
 17 cycle to look at formulary change regarding balanced
 18 crystalloid fluids in addition to normal saline.
 19 There was a good discussion about the specialty care
 20 transport TAG and what their work, which is just
 21 getting started, is going to entail.

22 If you have interest in a specialty
 23 care transport TAG, you can speak with the SEMSCO
 24 chair about that. And you can be referred to that
 25 committee. They are looking for input. They're --

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 2 again, they're just getting started in their work
 3 with the plan to present some best practice guideline
 4 and information for those that do specialty care or
 5 transport across the -- the State. And that -- that
 6 concludes the Med Standards report.

7 **CHAIR DOYNOW:** Any questions for Dr.
 8 Rabrich?

9 **MR. WALTERS:** I have a question not
 10 necessarily for Dr. Rabrich, and I know this is on
 11 the agenda and comes up in the context of
 12 supraglottic airways for B.L.S.F.R.s. But I guess in
 13 this day and age, when you talk about quality and
 14 oversight and standard of care, is there a reason --
 15 and I know it's not in regulation.

16 But is there a reason that B.L.S.F.R.s
 17 are not regulated and is that something to look at,
 18 at a broader perspective, not just --

19 **MR. RABRICH:** Yeah. So, yeah, it's a
 20 good question. And I don't know, do you want to
 21 address, I mean, because we've learned more about
 22 this recently in this discussion, but.

23 **DIRECTOR GREENBERG:** So, it's a good
 24 question. And I think just for a long time, there
 25 wasn't as much of a need for it based on clinical

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 2 practice and what they were doing and things on that
 3 front. I think, you know, this as well as other
 4 things going on has now raised that up of, is it the
 5 right time?
 6 Even if it's not mandatory, maybe it's
 7 a voluntary thing. And if you voluntarily
 8 participate, then you have more options of what you
 9 can do as an organization or as an agency. So, I
 10 think it's -- to be honest, it really is the i-gels
 11 that has been the tipping point now of saying, how
 12 can we, if we can, where's that?
 13 And so, I think between now and you
 14 know, next couple of months, we'll probably be coming
 15 with what direction does this group as well as the
 16 SEMSCO want to go with this. And is this the pathway
 17 that we want to go?
 18 **MR. RABRICH:** Yeah, and I -- and I
 19 think it's kind of just a natural progression, right,
 20 as more skills have been added to the B.L.S. level,
 21 right? Whether it's, you know, the glucometry, the -
 22 - you know, epi pen like over the years a number of
 23 things have been added, right, in that scope of
 24 practice.
 25 And could potentially be done by

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 2 B.L.S.F.R.s, right, that it's the right time to look
 3 at this and see, you know, what changes we need.
 4 **CHAIR DOYNOW:** Any other questions?
 5 **MR. DAILEY:** Sorry, the --
 6 **CHAIR DOYNOW:** Mic.
 7 **MR. DAILEY:** The corollary to that --
 8 sorry. So, the corollary to that's an interesting
 9 one, though. So, if you don't regulate them and
 10 we've decided that supraglottic airways are within
 11 the scope of practice of the B.L.S. provider, why
 12 can't they just start?
 13 **DIRECTOR GREENBERG:** So, I think these
 14 are some of the complexities that are coming up in --
 15 related to what would occur. Who's responsible?
 16 Who's responsible for the equipment that's on it?
 17 What's wrong if something happens to that equipment?
 18 Is it solely the provider? Who's the medical
 19 director?
 20 These are a lot of the questions that
 21 I think are now coming up related to these things
 22 that we would want to address and kind of move
 23 forward and figure out what that pathway looks like.
 24 **MR. RABRICH:** I mean, even something
 25 as simple as like the definition of what is a

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 2 B.L.S.F.R., that there's a lot of variation there as
 3 well of, you know, how people utilize that term
 4 B.L.S.F.R.
 5 **DIRECTOR GREENBERG:** Looks like
 6 there's a part two. No? Okay. So, I think -- I
 7 think these are the really good questions. And I
 8 think that it's an opportunity really to, you know,
 9 along with the feedback from the B.L.S.F.R.s, right?
 10 Like, what are they thinking? Where
 11 is it? And also you know, when you talk about
 12 putting together, whether it be regulations or
 13 something that further establishes, that doesn't mean
 14 you have to put together a twenty-page, you know,
 15 regulatory document.
 16 It could be as simple as there's five,
 17 that guy, Dr. Heslin -- Dr. Heslin has taught me a
 18 lot about regulatory change and what regulations
 19 should look like and what heat -- and now the mic's
 20 on, and -- and kind of where we want to go in the
 21 future with this.
 22 Like, it doesn't take a lot, but it
 23 takes something to have accountability and abilities
 24 to, you know, kind of drive things in a positive
 25 direction. Dr. Heslin?

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 2 **COMMISSIONER HESLIN:** Just in terms of
 3 regulation, when we think about them, what we're
 4 trying to do is we're trying to be able to grant
 5 authority to be able to make sure that people do the
 6 right thing and we have the ability to then police
 7 the industry.
 8 And so, when you're crafting
 9 regulations, the way we're thinking about it is we
 10 don't need to have every word in detail. What we
 11 need to have is the ability to convey the authority
 12 necessary to make sure the industry is appropriately
 13 functioning.
 14 And then, the rest of what we should
 15 have is really guidance. Because guidance is a
 16 little more liquid, it gives you the ability to, as -
 17 - as opposed to the very long State process, to go
 18 through regulation to make thoughtful and substantive
 19 changes after deliberation in that guidance.
 20 And so, where we used to write, you
 21 know, tomes. And -- and they were thousands of pages
 22 long. We're trying to move away from tomes to more
 23 plain-speak language that allows us to be able to
 24 function and not have these Byzantine and conflicting
 25 rule sets.

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 2 That's where we're really trying to
 3 get to. So, that's -- that's the regulatory part.
 4 **MR. WALTERS:** So, I -- I guess to that
 5 point, why would we want there to be any E.M.S.
 6 agencies that there is no regulatory authority over
 7 because that's what we have right now, right?
 8 **DIRECTOR GREENBERG:** If you're asking
 9 solely my opinion, I wouldn't. I think there's --
 10 there's some things that are here and that are
 11 working and that are, you know, functional and, you
 12 know, really not risen to an issue, so, I think
 13 that's important as well.
 14 But I think if we look at, you know,
 15 what does the future look like and is there any that
 16 aren't, I think we should look for the opportunity to
 17 be inclusive of all, and to have everybody have all
 18 these opportunities and guidance and -- and direction
 19 that come with it.
 20 **CHAIR DOYNOW:** Any other questions or
 21 discussion? It's a quiet group today. Okay. Don,
 22 it's all yours.
 23 **MR. HUDSON:** Hi, good morning. Don
 24 Hudson from Training and Education. So, we've been
 25 meeting throughout the summer virtually. We're on a

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 2 monthly cadence to do so. We met yesterday here in
 3 Troy. We were the first committee to be visited by
 4 the Deputy Commissioner and thank you for your
 5 presence and your cooperation. We're happy to have
 6 you.
 7 That being said, we have no seconded
 8 motions coming forth to either SEMAC or SEMSCO, more
 9 just informational at this point. The Bureau did
 10 give us a report about the current status for
 11 calendar year 2025 of E.M.S. classes around the great
 12 State.
 13 To date for 2025, there's nine hundred
 14 and fifty E.M.S. classes filed. So, that is good
 15 news. So, there are classes out there, if again,
 16 like anything else you come from an area or region
 17 where you have a hardship in either travel or
 18 finances or whatever the hurdle is that might be
 19 preventing somebody from either certifying or
 20 recertifying, please reach out to your region.
 21 Please reach out to, you know, the
 22 Bureau, or even myself, so that we can try and
 23 mitigate whatever those hurdles would be as much as
 24 possible. Again, our focus is to not only provide
 25 quality patient care but to keep the system up and

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 2 running as well as agencies.
 3 That being said, we have a number of
 4 functioning technical advisory groups that are
 5 working through their projects and tasks on top of
 6 seemingly endless new tasks that Training and
 7 Education seems to stumble in and across as the
 8 various committees do their good work.
 9 So, we are happy to participate. We
 10 do have to triage our time like everyone nowadays,
 11 but we're up and running and functional, so happy to
 12 take questions.
 13 **CHAIR DOYNOW:** Any questions for Don?
 14 **MR. HUDSON:** Just while I have the
 15 attention, so, to the B.L.S.F.R. conversation, I
 16 don't know, so I'll just ask for feedback later, not
 17 necessarily today, but -- so, I just did a quick
 18 search through Article 30. I don't see it mentioned
 19 at all.
 20 So, it clearly doesn't fall within
 21 that, which begs the question, where does it exist
 22 and how do we massage that into -- bringing them into
 23 the fold rightfully while also not putting in place
 24 financial hardships and everything else.
 25 Because I believe, you know, what I

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 2 heard around the room is the acknowledgement that,
 3 no, we -- we want them in our world and I'm sure if
 4 we ask without overburdening them with financial
 5 regulations, they would want to be in our world, and
 6 all the good that comes with that rather than
 7 whatever bad may be perceived.
 8 **DIRECTOR GREENBERG:** Sure. So, we
 9 have looked as well. There are some different
 10 avenues that we've worked with Legal on just to see
 11 is this even an option because it's come up kind of
 12 briefly. I will say not as much as a consentive
 13 voice.
 14 And so, we're -- you know, from the
 15 division, we're happy to look further into this now
 16 if that's the direction that people feel this should
 17 go.
 18 **MR. HUDSON:** Yeah, I think it's only
 19 through these questions that we stumble across things
 20 that we, like, wow, it's fifty years, how come that's
 21 never come up, you know, before? And although that's
 22 shocking and sometimes frustrating, that's what we're
 23 tasked with addressing and fixing. So, thank you.
 24 **CHAIR DOYNOW:** Any other questions or
 25 discussion before we move on? Okay. Moving on to

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 2 old business. So, SEMAC bylaws and term limits.
 3 What I'll say at this point is that Dave Violante and
 4 I are working on a compromise that hopefully will
 5 stay within the limits of the law and resolve all the
 6 issues that have been brought up.
 7 We should have something at next
 8 meeting to address all the issues that all of you
 9 guys have come to me about. That's what I'll say at
 10 this point. Any other old business? Jason.
 11 **MR. WINSLOW:** Yeah. At the May
 12 meetings, we kind of discussed Agency Medical
 13 Director credentialing, both at SEMAC and SEMSCO.
 14 And the final way we left it was we made a motion to
 15 develop regulation to have Agency Medical Directors
 16 qualifying in their region as medical control to tie
 17 their ability to serve in that role to their Article
 18 30 statutory, you know, function of a REMAC does.
 19 Having said that, I was wondering if
 20 there's been any update on Agency Medical
 21 credentialing and the development of this regulation
 22 from the Bureau.
 23 **CHAIR DOYNOW:** Go ahead, Dr. Rabrich.
 24 **MR. RABRICH:** Yeah. So one, we
 25 wouldn't develop regulation, right? That's -- we

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 2 would make recommendations, right? And regulation
 3 would be, go through the regulatory process. My
 4 understanding is where it sits now currently is that
 5 regions have criteria for -- for Agency Medical
 6 Directors.
 7 But I'm not aware of any Statewide
 8 type of requirement or regulation for this. That's -
 9 - you know, that's very specific beyond just -- you
 10 have to be a licensed physician and kind of --
 11 **DIRECTOR GREENBERG:** And so, I can say
 12 right now, you know, we have about eight different
 13 regulatory packets that are in the process of being
 14 either created, modified or anything else, which is
 15 the most we've ever had in my time here and the most
 16 in many, many years. So, we're excited about that.
 17 From the last set of conversation, I
 18 believe, with this body, and if I had it wrong,
 19 please feel free to, you know, we can change that
 20 direction. It seemed like the general consensus from
 21 this body was not to go with regulations for that.
 22 Because there were concerns in
 23 different regions on what would happen if there were
 24 very specific regulations related to, who can be a
 25 medical director, who couldn't. If that has changed

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 2 and that's the desire that we'd like to go down, that
 3 is something that the department is happy to look at
 4 and support.
 5 But it was the -- I think there were
 6 some conversations and -- and I think that's where it
 7 landed was, we'd rather make best practices
 8 guidelines than regulations that determine and were
 9 definitive on what qualifications you need to have to
 10 be an agency medical director.
 11 **MR. RABRICH:** Yeah, I think the
 12 concern was right what -- what might work in, like, a
 13 New York City region wouldn't work in a more rural
 14 region and those were some of the concerns that were
 15 brought up.
 16 **MR. WINSLOW:** Yeah, but right now
 17 there's -- there's nothing to prevent an agency from
 18 selecting an Agency Medical Director that doesn't
 19 meet a regional requirement. If you look at the
 20 Agency Medical Director verification form, it doesn't
 21 have REMAC approval on it.
 22 So, right now an agency can submit any
 23 physician with a license to be their medical director
 24 without getting the approval of the REMAC first. And
 25 if there are regional policies to it, how are those

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 2 policies enforced?
 3 And I do agree, it's a REMAC decision.
 4 REMAC physicians know the local climate. Know who
 5 would be a good Agency Medical Director. And that's
 6 what we're trying to foster as the physician group,
 7 we want to make sure that we are there for our
 8 agencies, attentive to them and responsive.
 9 **MR. RABRICH:** Right. And I think some
 10 of the discussion we had last time was that clearly
 11 the regions have control over their Q.I. plan and can
 12 require that medical director to participate in
 13 regional Q.I.
 14 You know, there was some discussion
 15 about, you know, does that person have to be, you
 16 know, online medical control credentialed in that
 17 region by the region, like, you know, those type of
 18 things a region could add because they control their
 19 medical control plan, right, in Q.I.
 20 So, I do think there are some avenues
 21 where the region can address that, but I think that
 22 where discussion left off was the concern about doing
 23 anything that was too specific that it would harm a
 24 region's ability or agency's ability to have a
 25 medical director.

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 2 **MR. DAILEY:** If I may. I -- I think
 3 the -- the core of this really falls to the reading
 4 of Article 30 and the definition of the REMACs and
 5 what they can do in terms of regional systems, right?
 6 That's something that has been very defined very
 7 differently by the physicians around this table.
 8 And some of the variety of members of
 9 the D.L.A. that we've had come through to support us
 10 over the years. I think really having a group of
 11 people sit down, have a conversation with -- with the
 12 D.L.A. about our understanding of this would probably
 13 be helpful.
 14 I would say the less filters on that
 15 opportunity for discussion would probably be more
 16 productive so that at least we can see what direction
 17 that most of us are interpreting this on, how this is
 18 functioning across much of the State, so we can use
 19 that precedent as a way of continuing to move
 20 forward.
 21 **MR. RABRICH:** Yeah, and I think that
 22 was part of the discussion we were having this
 23 morning about, you know, the intent of good medicine
 24 and ensuring good medicine and quality in the region
 25 and you know, how do we match that up with regulation

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 2 and D.L.A.'s advice and stuff, so.
 3 **MR. DUVALL:** If I could have a moment
 4 of your time. I brought this subject up. I'm sorry?
 5 **MR. RABRICH:** State your name for the
 6 record.
 7 **MR. DUVALL:** For those who don't know
 8 me, I'm Don Duvall from Southern Tier region, REMSCO.
 9 Ryan and I had this discussion back in May. And my
 10 region in particular is one of those regions through
 11 the evolution of healthcare where we're running very
 12 short of medical directors to meet the existing
 13 regulations.
 14 My region has four advanced life
 15 support agencies. We've downsized in hospitals since
 16 the Berger Commission, and of the remaining
 17 hospitals, two of those are staffed by mid-level
 18 providers, mostly in the E.R. who answer to
 19 hospitalists instead of to E.M. boarded physicians.
 20 And other hospitals in our region, in
 21 our area use travel docs. As our own homegrown
 22 emergency medical physicians have aged out, that's
 23 left us with a shortage of potential medical director
 24 candidates.
 25 I have one county that has roughly

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 2 forty E.M.S. agencies, mostly B.L.S., but we're
 3 struggling to find adequate medical control even for
 4 these small ambulances at a hundred calls a year.
 5 And now you're discussing bringing B.L.S.F.R.
 6 agencies into the fold, which are agencies that do
 7 P.A.D. and do the epi pens, already have medical
 8 directors on board.
 9 But we're -- we're struggling to find
 10 medical directors that are knowledgeable in the
 11 E.M.S. system. And we're struggling to find medical
 12 directors that are willing to step forward and be
 13 responsible even for our B.L.S. agencies.
 14 So, while I -- while I commend the
 15 idea of a more robust medical command system in New
 16 York, I -- I urge you to be cautious because a lot of
 17 our areas are not going to be able to find medical
 18 directors. And that is a statutory requirement for
 19 agencies.
 20 So, adding more statutory requirements
 21 to doctors, I think will make that problem worse.
 22 **CHAIR DOYNOW:** Thank you, Don. Dr.
 23 Bombard.
 24 **MS. BOMBARD:** I think we've scampered
 25 a little far afield from what Dr. Winslow proposed

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 2 beginning this discussion. What, unless I'm --
 3 correct me if I'm wrong, I think the -- the problem
 4 that you brought forth is the problem of regional
 5 approval.
 6 So, do we want medical directors
 7 directing our agencies who were not approved by the
 8 region? That's -- that was really the only question.
 9 It wasn't, do we want to layer on more hurdles or
 10 more requirements to become a medical director.
 11 It was, do we really want medical
 12 directors out there scampering around that don't talk
 13 to our REMACs, that our REMACs don't talk to, that
 14 are out of the informational loop, right? Like, this
 15 -- this is the question.
 16 And I suspect the answer is no. No,
 17 we want our Agency Medical Directors to show up at
 18 REMAC meetings or at least be on somebody's email
 19 list or something. So, I think that's really --
 20 that's what I'm asking for.
 21 I'm asking that the medical directors
 22 for agencies in my region be part of the region and
 23 be approved by the region, not by the State, not by
 24 the -- nobody else, that's all. Just -- just want
 25 them on my email list.

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 2 **MR. RABRICH:** I think that's what
 3 everyone is kind of saying. And I think the question
 4 is more the mechanism for that than actually that
 5 that should occur, right? I think that's -- I think
 6 everyone -- everyone here has said the same thing the
 7 last time, that they should be connected to the
 8 region and part of a regional system of care.
 9 The question is, you know, how do
 10 regions ensure that they do that, that meets the
 11 requirements of regulators, they do not, you know,
 12 that they're staying within their authority, which is
 13 why I think Dr. Dailey's suggestion of maybe a small
 14 group sit down with D.L.A. and discussing what we're
 15 trying to accomplish and how we can accomplish that
 16 remaining within regulation is a -- is a good idea.
 17 **CHAIR DOYNOW:** Any other discussion on
 18 it? So, Dr. Dailey, do you want to meet with Ryan
 19 and see if you can arrange a small group meeting with
 20 D.L.A. so we can work this out?
 21 **MR. DAILEY:** Absolutely.
 22 **CHAIR DOYNOW:** Thank you. Any other
 23 discussion? Any other old business before we move to
 24 new business? Okay. On new business, we already
 25 really spoke about the supraglottal airway and first

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 2 response agencies. So, that really is taken care of.
 3 Any other new business that anybody
 4 would want to bring up at this point? Sure.
 5 **MR. VIOLANTE:** So, since we don't have
 6 a policy out just yet, the Hudson Valley Region
 7 thought it would be a really good idea just to
 8 continue to collect the data and -- and analyze it.
 9 And what we found -- so, in '24 when we presented
 10 this, we had a total of four hundred and forty-five
 11 cases.
 12 In 2025, inclusive, we have eight
 13 hundred and forty-one. And across all the fields
 14 that we had looked at, which include time from
 15 dispatch to arrival, patient age, weight, gender, i-
 16 gel size used, E.T.C.02 values, time from patient to
 17 first attempt, and case distribution.
 18 They all really remained a few
 19 percentage points within the median from the previous
 20 year. Confirmation success in '24 was ninety-four
 21 percent. And in 2025, ninety-three percent. So,
 22 that went down one point.
 23 In terms of airway failure reasons,
 24 patient responses, adverse offense -- effects, ROSC
 25 outcomes, and reason for discontinuation, again,

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 2 those things were within a few percentage points of
 3 each other since the last time.
 4 So, it's good to see that with the
 5 increase in number of cases, things still really
 6 remain the same in terms of the ability to use the i-
 7 gel, how it's done, when it's done, and the effects
 8 and outcomes of it.
 9 So, thank you, and I -- I can provide
 10 this report for anybody who's interested, just let me
 11 know. Thanks.
 12 **CHAIR DOYNOW:** Any questions for --
 13 for Dave? Okay. Anybody want to bring anything else
 14 up before we close the meeting an hour early and have
 15 a long time for lunch? It's a really quiet group.
 16 We're going to have to ask the hotel folks to put a
 17 lot more caffeine up there, I think.
 18 All right. On the announcement, next
 19 meeting will be in Troy, December 9th and 10th,
 20 looking forward to seeing everybody there. We have a
 21 motion to close the meeting. Motion seconded by
 22 anybody. And also anybody against, I suspect not.
 23 All right. We'll see you guys in a
 24 few months.
 25 (The meeting concluded at 11:58 a.m.)

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 2 STATE OF NEW YORK
 3 I, DANIELLE CHRISTIAN, do hereby certify that the
 4 foregoing was reported by me, in the cause, at the time
 5 and place, as stated in the caption hereto, at Page 1
 6 hereof; that the foregoing typewritten transcription,
 7 consisting of pages number 1 to 48, inclusive, is a true
 8 record prepared by Associated Reporters Int'l., Inc. from
 9 materials provided by me.
 10 IN WITNESS WHEREOF, I have hereunto
 11 subscribed my name, this the 25th day of September, 2025.
 12
 13 DANIELLE CHRISTIAN, Reporter

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