3-22-2022 – EMSCAC Meeting - Webex

NEW YORK STATE
DEPARTMENT OF HEALTH
EMERGENCY MEDICAL SERVICES FOR CHILDREN ADVISORY COMMITTEE MEETING

DATE: March 22, 2022
TIME: 1:09 p.m. to 3:06 p.m.
CHAIR: DR. ARTHUR COOPER
VENUE: WebEx

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2 **APPEARANCES:**
3 JACOB DEMAY
DREW FRIED
4 KEVIN ALBERT
SARA GRUVER
5 CHRISTOPHER DEMETROPOLIS
PATRICIA RILEY
6 MARK PHILIPPY
DANIEL IMFELD
7 NATHANIEL DEGEAR
PAMELA FEBER
8
PETER DAYAN
NIKOL O'TOOLE
9
VERA FEUER
10 VALERIE OZGA
SHARON CHIUMENTO
11 BRUCE BERRY
PETER BRODIE
12 ELISON VAN DER JAG
KATE BUTLER-AZZOPARDI
13 JASON ALLEN WINSLOW
JOHN MAHONEY
14 JOHN VANAUKER
MARK DEAVERS
15
PAUL MARRA
THERESA ALLEN
16
VINCE COLLEO
CHRISTINE RUSSO
17
DR. BROOKE LERNER
18 ANTHONY TSENG
BRITTANY PYSODEE
19 BENJAMIN KASP
AMY JAGARESKI
20 BRIAN WIEDMAN
BRANDON ROSETTIC
21 MATTHEW HARRIS
JASON HAAG
22 AMY EISENHAUER
WILLIAM MICHAEL MASTERSE
23
RON HASSON
DONNA KAHM
24
JOSE PRINCE
25

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2 (The hearing commenced at 01:09 p.m.)
3 **MR. GREENBERG:** Ready to start on your
4 end, even if it's just by phone?
5 **MR. COOPER:** Just a second here. I'll
6 be ready in about ten seconds.
7 **MR. GREENBERG:** Not a problem.
8 **MR. COOPER:** But what I will do in the
9 meantime is call the meeting to order. And those of
10 you that have your agendas in front of you, you know
11 that the first item on the agenda today is welcome, a
12 housekeeping issue. Amy, I gather will be with us
13 very soon.
14 She was delayed, turns into the place
15 like ... So on our agenda today we have -- we have
16 updates from Ryan Greenberg, Director of Bureau. We
17 have E.M.S. for children grant reports of Amy who I
18 believe will be there shortly in time for different
19 report at 1:25.
20 We then have an opportunity to review
21 some old business which is actually very current
22 business focusing on the Pediatric Agitation
23 Subcommittee report, the E.M.S. Pandemic Triage
24 Protocol, a pediatric report, and any new business
25 and origin and updates at three fifteen from our

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2 advisory committees.
3 So that's who we are. I think you
4 have all received copies of the minutes from the last
5 meeting attached to one or more of your notifications
6 for today's meeting. And so I'd be happy to
7 entertain at this point a motion for approval and
8 request for any additions, deletions, and
9 corrections.
10 **MR. VAN DER JAGT:** Dr. Cooper, this is
11 Dr. Van Der Jagt. I vote for accepting them, but
12 with the corrections of the names to the participant
13 lists, many of them seemed to have been misspelled.
14 **MR. COOPER:** Okay. We'll ask Amy to -
15 - to address that. So it's been moved. Do we have a
16 second?
17 **MS. CHICMENTO:** I'll second it with
18 the changes ...
19 **MR. COOPER:** Okay. Moved by Dr. Van
20 Der Jagt, seconded by Sharon Chicmento. We have the
21 approval of minutes. Any further discussion
22 including further additions, deletions, and
23 corrections? Hearing none.
24 Is there any objection to accepting
25 the minutes as written with those corrections to the

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2 spellings of the names? All right. Well, hearing
3 none, then we'll deem the minutes approved and move
4 right onto the Bureau of E.M.S. and trauma system
5 updates from Director Greenberg. Ryan, please?
6 Thank you.
7 **MR. GREENBERG:** Thanks, everybody. I
8 will try and keep it short and brief and give you the
9 highlights of what's going on. Obviously, we
10 remained busy within the bureau. We are still on a
11 lot of COVID activities at this time, and people find
12 that a little bit surprising.
13 But we actually are not only still on
14 COVID assignments, but we still have federal assets
15 that are in state so FEMA assets that are helping us
16 with load balancing, patient movement and different -
17 - and different initiatives related to capacity and
18 things that are going on.
19 We continue to monitor that on a
20 regular basis within the Department of Health and
21 then within the Bureau of E.M.S. and our Surge
22 Operation Center which we operate continue to assist
23 any facilities and hospitals with that one.
24 We've seen, you know, I -- I will tell
25 you -- knock on wood. We've been pretty lucky and

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2 not many of our cases are in the pediatric realm, but
3 we do still, you know, see a number of patients that
4 need to be moved and load balancing occur and getting
5 them to the, you know, correct care that they need.
6 So that continues on with our COVID
7 front. We are really looking forward to the next
8 couple of months hopefully to getting back to our
9 normal operations within the bureau and within
10 E.M.S., within E.M.S. for children, within the -- the
11 trauma services world in order to be able to go back
12 to our inspections and things that are happening on
13 that one.
14 There is, you know, one interesting
15 number or figure that we brought up at the last
16 council meeting, the State -- SEMSCO meeting. I did
17 want to share with this group as well, which is the
18 number of active E.M.S. providers that are out there.
19 And so in New York State we have about
20 70,000 providers. Of which about ten thousand of
21 those are first responders. And so the first
22 responders don't always show up on a patient care
23 report. So if we take our seventy thousand and we
24 remove the ten thousand or so first responders, we're
25 left with sixty thousand providers.

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2 We did through Deputy Chief Brodie and
3 his team, did some analysis of that data, and found
4 that only about fifty percent of our E.M.S. providers
5 actually show up on a patient care report, which
6 means only about 50 percent of our providers are
7 actually providing E.M.S. care in a pre-hospital
8 environment or in an E.M.S. environment for a named
9 ambulance agency.
10 We know that because every patient
11 care report is required to be submitted to the state.
12 It must document who were the patient care providers
13 on the ambulance at that time. So this leaves, you
14 know, somewhere in the ballpark of about thirty
15 thousand providers that are certified, that are
16 providers that aren't providing care.
17 Now some of them may work for basic
18 life support first response agencies or for non-
19 transporting agencies that necessarily don't report
20 and there's definitely a portion there. But there's
21 also a large portion that, you know, we believe just
22 aren't working in E.M.S. anymore.
23 We did go back and look at the pre-
24 pandemic and during the pandemic, and now post-
25 pandemic, that number tends to stay about the same

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2 and it varies a little bit between fifty and fifty-
3 five percent of the workforce not showing up on a
4 patient care report is to, you know, that is an
5 interesting number to look at.
6 And this actually -- this number was
7 created or not created. This number was reviewed at
8 -- and looked at because we saw other states doing
9 similar activities. And so their numbers and ...
10 then ours were.
11 And -- and interestingly enough it is
12 not an uncommon number to see that fifty percent. In
13 some of the other states where you see the fifty
14 percent, sometimes it's -- because they're working in
15 E.R.s, they're working in other non-traditional
16 settings. For us, you know, it's not, we don't
17 believe that's as much the case because they're not
18 really permitted to with their E.M.T. certification.
19 We know that in some places they hired
20 as an education level, but not necessarily something
21 there. But -- so it's just interesting. And -- and
22 I bring that up to this group because as we look at,
23 you know, our pediatric care we look at, you know,
24 kind of, you know, who we're training, or how many
25 people we're training, or how much a lot of this, you

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2 know, this counsel and also our E.M.S. for children
3 program is able to get out to and the number of
4 providers that they're able to reach that, you know,
5 I think it's important to understand that we're
6 probably reaching a lot more on the active providers
7 to, you know, addressing it towards them, and, you
8 know, just show our success and programs and things
9 of that nature.
10 So again, just wanted to bring this up
11 more situational awareness because counsel, I feel
12 like you are E.M.S. for children. It's important to
13 understand what the workforce also looks like.
14 Another one that I wanted to touch on, and I'm going
15 to leave a portion of it for Mark Philippy, the Chair
16 of the SEMSCO, to talk about later on is the
17 technical advisory group that's within the SEMSCO
18 right now.
19 There's a technical advisory group
20 right now that is talking about E.M.S. or looking
21 into E.M.S. sustainability models and -- and what
22 that means for our profession for the industry. And
23 so right now, we know that, you know, E.M.S. had --
24 sometimes it isn't ... crisis, you know, with -- with
25 staffing, with -- with system models, with

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2 performance standards, you know, in trying to make
3 sure that our system is stable both today and going
4 into the future.
5 We've been very fortunate in New York
6 to have a very solid, you know, E.M.S. system for --
7 for many years. And what we're starting to see right
8 now is a little bit of a transition we think in many
9 different fronts. A transition from, you know, some
10 systems that were a 100 percent volunteer and now
11 becoming combination department a number systems from
12 just a -- a number of different dynamics.
13 And so this tag is really taking a
14 look at, you know, what does sustainability look like
15 in the future? How do we maintain that? And they're
16 doing phenomenal work and really just looking at
17 things that we haven't looked at in a long time.
18 So just wanted a shout out to the
19 SEMSCO members and then -- but again, I think it's
20 important for this committee to understand that too
21 because if they look at that system sustainability.
22 It is also about the care, you know, it's provided,
23 and what do we need to -- to make sure that our
24 pediatric patients obviously are always taken care of
25 and focused on as well.

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2 So just continuing on just a little
3 bit on what's going on in the bureau and things on
4 that side, our trauma world both for the pediatric
5 and adults, they -- we continue to do our assessment
6 with the American College of Trauma Surgeons and we
7 continue to do that via -- remotely.
8 So we participate in those, but they
9 are -- they're still virtual. Assessments that are
10 being done right now. So we continue with those. We
11 do have a couple of new applicants processes in new
12 trauma centers in the next couple of years. Haven't
13 seen on the pediatric side yet, but we are seeing it
14 on the other side. That's exciting to see.
15 On our operation side, we continue
16 again to really support a lot. The COVID mission
17 thirteen vaccination sites that are now also
18 vaccinating pediatric patients as well. And so that
19 continues on. Our executive orders still remain in
20 place that allow E.M.S. providers to continue to
21 vaccinate and to be a part of this team to get out
22 there as well as community paramedic programs.
23 Currently today, we have just over
24 fifty community paramedic programs that serve over
25 forty counties in New York State often working with

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2 the local health departments on those. In addition
3 to that, in the data and informatics side, we're
4 really working on a number of different projects
5 right now.
6 One of the biggest ones that hopefully
7 we'll see towards the end of 2022, beginning of 2023,
8 is a continued rollout of an analytic program that
9 we're working on having access for, you know, all
10 hospitals and E.M.S. agencies to be able to see their
11 own data on how things are working, how pathways are
12 going with different models that we're putting
13 together, different quality metrics that our SEMSCO
14 is putting together. And so hopefully, that software
15 will be able to help share that information and see
16 how you're doing compared to others.
17 Similarly, similar organizations have
18 that sort -- oh, similar organizations of your side.
19 Continuing on, just on the couple of initiatives
20 again and –- sorry, let me make sure I've gone
21 through everything here. We spoke about trauma in
22 the afternoon. So -- and Amy is actually also
23 walking in now. So she'll be joining us in a few
24 minutes. Sorry about a little bit of her delay,
25 completely out of her control.

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2 So sorry, it took me off a little bit.
3 Our emergency preparedness and response, we are
4 continuing now to look at a little bit more of our
5 emergency preparedness and response needs around the
6 state and coming up with a systematic plan.
7 So you may be hearing some more things
8 in that one as well on -- on the pediatric front and
9 the integration of hospitals and -- and where --
10 identifying where patients go and -- and also
11 identifying possible pockets of where patients and
12 where need might -- might be in order for just care
13 in general. So we'll -- we'll be looking at that one
14 as well.
15 There were some things that change on
16 the legislative side. So there was a blood bill that
17 was passed where -- our medical will now be able to
18 carry blood. So for those of you who, you know, are
19 trauma centers or things or interact often with an
20 air medical program that has passed an air medical
21 now can carry blood without it being a continuation
22 of blood.
23 And so you'll see more relevant
24 information coming up on that one in the near future.
25 There is a number of things currently right now also

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2 going on related to E.M.S. mo -- E.M.S. -- E.M.S.
3 modernization legislation that was proposed as well
4 as some other proposals that are out there. So we'll
5 see in most likely by next E.M.S. for children's
6 meeting, have more information on a lot of that and
7 where that is advancing.
8 I think that's about it of the -- the
9 main points of where we are and what's going on. I'm
10 happy to take any comments, questions or concerns.
11 **MR. VAN DER JAGT:** Ryan, this is --.
12 **MR. COOPER:** Are there any other
13 questions? Oh, Elise Van Der Jagt, please.
14 **MR. VAN DER JAGT:** Yeah, I'm sorry. I
15 had just put it in the chat box. I don't know if you
16 can see it, Ryan. When you said the E.M.S., you gave
17 all that information about the E.M.S. providers as
18 basically only 30,000 who were active.
19 Is there a way to break that down per
20 capita, per county? I know that up here in Monroe
21 County, we have seen a lot of delays in, you know,
22 E.M.S. being able to service calls. And I was just
23 wondering if there are differences across the state,
24 so that we could be focused in the encouragements
25 that E.M.S. providers need and to get new ones?

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2 **MR. GREENBERG:** Sure. I think we'd
3 have a harder time breaking it down. I -- I'm not
4 saying it's impossible to do, but I think it'd be a
5 lot, probably for us to -- to try and break it down.
6 There's definitely, you know, been issues in
7 different regions. And what we're seeing is really
8 the, you know, the healthcare ecosystem kind of, you
9 know, backup as -- you know, as we can't get patients
10 into nursing homes that makes the hospitals overflow
11 as the hospitals overflow the E.R.s get backed up.
12 And then what we end up seeing is, you
13 know, extended offload delays. And so we see given
14 regions where, you know, they're -- they're -- by a
15 normal day, it would be plenty of E.M.S. resources in
16 the region. But when we add another hour to two
17 hours of an offload delay, it becomes, you know,
18 really problematic for everybody involved in the
19 system.
20 How do you plan for that? How do you
21 do that? And the E.R. will turn to, well, I don't
22 have a bed to put them in E.R. or I don't have the --
23 the staffing to put them in the appropriate bed. And
24 then, you know, kind of where does that problem stop?
25 Where does it start?

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2 Currently, right now we work with the
3 Syracuse hospitals on almost a daily basis related to
4 diversion, offload delays and -- and concerns in that
5 area. You know, in the Rochester area is in a
6 similar boat. New York City, we're starting to creep
7 up on things so that right now, New York City, things
8 are looking a lot better.
9 So you know, I -- I think it's an
10 interesting thing to have to look at and it's
11 definitely that E.M.S. is being affected in -- in
12 multiple different ways both by staffing offload
13 delays and different complications that are coming up
14 with it.
15 **MR. COOPER:** Mr. Elise, does that
16 answer your question?
17 **MR. VAN DER JAGT:** Yeah, pretty much.
18 I mean, I -- I just thought that because they're --
19 they're looking at, you know, actual patient care
20 calls in which the E.M. -- E.M.S. providers are
21 provided. You would know where those calls originate
22 from, and would be able to sort of see what the --
23 the, you know, how many providers per -- or whatever
24 100,000 people there are in that certain area.
25 Again, there are multiple issues with

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2 this, but it would just give a little bit of a sense
3 of, you know, where -- where are the most difficult
4 areas. So I know it's not a simple answer, but
5 that's helpful.
6 **MR. GREENBERG:** And I -- I don't think
7 --.
8 **MR. COOPER:** Are there any other
9 question for Director Ryan?
10 **MR. GREENBERG:** Peter Brodie, I don't
11 think is with us right now, but I think maybe we'll
12 circle back to that at the end of the meeting and see
13 if that's something that we can look to him to see if
14 he can pull. Like I said, it's -- it's achievable
15 absolutely.
16 The -- the workload to get in there,
17 I'm not sure, but it could be one of those that --
18 that is worth the workload. Jacob's shaking his head
19 right now. I think he's saying no, because I think
20 he thinks the workload will come onto him.
21 **MR. COOPER:** Okay. Any -- any other
22 questions for Director Ryan? Hearing none. Is Amy
23 ready to go?
24 **MR. GREENBERG:** So Dr. Cooper, can I
25 make a suggestion that we possibly advance to the old

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2 business first and then circle back to Amy. She is
3 here and ready, but -- Patti in trauma? Have Patti -
4 - have trauma go first?
5 **MS. RILEY:** I was going to get her in
6 to see a report.
7 **MR. GREENBERG:** Okay. There's been a
8 request to have Patti Riley, who is our trauma
9 program manager do a -- a brief report on some things
10 that are going on with the trauma world. So maybe we
11 could do that.
12 **MR. COOPER:** Sure. Let's do it.
13 **MS. RILEY:** Hi, my name is Patty
14 Riley. I'm the New Trauma Program Manager working
15 with Dan Clayton. I don't have much to report. Dan
16 just wanted me to let everyone know that, you know,
17 we've both been very busy with the search flex since
18 the beginning of January. And he's also active -- as
19 the active financial person since Lynn Farrugia left.
20 So as soon as everything gets calmed
21 down, everything should go back to normal. And also,
22 that the staff meeting will be held Wednesday, May
th
23 4 , at the Troy Hilton Gardens, and it will be a
24 hybrid meeting. It's the end of my report.
25 **MS. EISENHAUER:** Thank you so much,

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2 Patty. Dr. Cooper, while my computer is logging in,
3 if you want to -- hi, now you can see me. If you
4 want to go to old business, and then I'll do my
5 report after that.
6 **MR. GREENBERG:** Dr. Cooper, I think
7 we're getting an echo on your computer. Sorry, it's
8 a little bit hard to hear you.
9 **MR. COOPER:** Sorry. I said -- I said,
10 if Amy's computer is going to be booted up very
11 shortly, I'll -- I would -- I thought I would
12 actually prefer to wait for her report. ... follow
13 nicely from yours, but I think it's going to take a
14 while. Yes, let's go to the -- let's go to the old
15 business.
16 **MS. EISENHAUER:** All right. So my
17 computer is ready. It has agreed to participate. So
18 hello, everyone. It's so good to see you. I'm happy
19 to see you all and to be here and so I finally made
20 it.
21 So my report -- so first, I want to
22 give a brief review of -- I'm going to go a little
23 bit out of order. We're actually on -- on this
24 survey, it's in order. In my mind it was out of
25 order then.

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2 So our E.M.S. for children survey is
3 still ongoing. As of a day-and-half ago, we had
4 thirty-one percent which sounds terrible, but during
5 the pandemic and since last year, it has improved
6 greatly. We still have about a week left of the
7 survey.
8 So I did send out another email
9 reminder yesterday morning. And then so I will check
10 in on that later this afternoon, tomorrow morning,
11 and then I will be following up with phone calls and
12 talking to the program agencies see if they can
13 provide any assistance encouraging people to complete
14 their survey. So that is ongoing.
15 And if you haven't completed your
16 survey and you want to and you're an E.M.S. leader,
17 it's emscsurveys.org. And, of course, I'll put it in
18 the chat in just a moment. So you can go there,
19 click New York, click your county, and then pick your
20 agency link.
21 So your name should already be in
22 there. If it's not in there, please email me. I'll
23 make sure that your survey was received or I will fix
24 whatever issue that it was not in there. So again,
25 please complete your survey. It helped me here in

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2 our office to know what's working, what's not
3 working, or what we could do better to better provide
4 you guys support for training.
5 If you need a PECC. If you're curious
6 about a PECC, it -- it really just helps us drive
7 decision-making here. And it also helps the federal
8 program drive their decision making about what kinds
9 of education E.M.S. providers need, what kind of
10 support E.M.S. agencies need, so that they can be
11 best prepared for pediatric patients.
12 So then the other part of -- of my
13 report has to do with our PECC program. So if you're
14 not sure what a PECC is, and you haven't heard me
15 talking about it, it's a Pediatric Emergency Care
16 Coordinator. And so the program has been available
17 in New York State for the last three years, prior.
18 About three years it started prior to
19 the pandemic when Martha Volsky was here with the
20 assistance of Donna Kahm and Alicia from Southern
21 Tier Health Care Services and they've been doing an
22 excellent job managing the program for us.
23 And last I checked, again, a day and-
24 a-half ago, we had about two hundred and fifty
25 agencies. So E.M.S. agencies in New York State that

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2 have at least one Pediatric Emergency Care
3 Coordinator. Some of them have more than one
4 Pediatric Emergency Care Coordinator. They split the
5 responsibilities of their agency. And so I would
6 estimate it's about two hundred and sixty actual
7 PECCs in the State currently. So that's great.
8 So I would like to say thank you to
9 Donna and Alicia for doing an amazing job setting
10 everything up, working with all the stakeholders,
11 getting through all of what I know must have been an
12 extraordinary effort to get it started and to put it
13 all together, and for hosting everything for the last
14 several years.
15 Unfortunately, due to E.M.S.C. budget
16 restraints -- as you know, we have talked about this
17 before. The budget is not so large. We should not
18 continue to use them to -- to host the program sadly.
19 So we have moved the PECC information over to our
20 website.
21 So it's very easy. If you Google New
22 York State E.M.S.C., our main page should pop up.
23 And at the top of that page is the link for the --
24 the PECC page. And there is several other resources
25 on our page.

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2 I will also post the direct link to
3 that -- that area, so that you can get there
4 directly, and of course, we'll do that after we move
5 on our way. Do you have anything to add, Ryan? I
6 know that -- that you were really here at the -- at
7 the beginning.
8 **MR. GREENBERG:** I just want to give a
9 shout out to Donna and Alicia as well. The work that
10 they did, everything they put together, the beginning
11 things really got us to where we are today. And just
12 to give everybody a little bit of a snapshot. We
13 have just about eleven hundred licensed agencies and
14 other factors that are so B.L.S. at bars.
15 And so to see that number, you know,
16 and -- and I believe that the bulk of our programs
17 that are -- that have a PECC, are licensed agencies
18 to see, you know, just about twenty-five percent of
19 our agency is being that active in -- in committed to
20 pediatric care, I think is phenomenal.
21 And so, you know, hopefully we'll
22 continue to see that growth, continue to internally
23 be able to grow those numbers and to bring up more
24 agencies. But just again, a shout out to Donna and
25 Alicia to look forward to, you know, more great

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2 things. And hopefully more funding from E.M.S.C. in
3 the future.
4 **MS. EISENHAUER:** Yeah, hopefully,
5 hopefully. There was -- there was some promise, but
6 you know how it is. So we're waiting to find out --
7 we're waiting to find out from E.M.S.C. federal if
8 that was able to be put in their budget. So does
9 anybody --?
10 **MR. COOPER:** So thank you so much to
11 Donna and Alicia for your incredible work and on
12 behalf of us all and we will all go home and pray
13 hard for the -- that the -- our Federal partners find
14 a way to restore the funding for this program. Thank
15 you. Amy, please?
16 **MS. EISENHAUER:** Oh, yeah. Thank you.
17 So does anybody have any questions about the survey
18 or about the PECC program, or anything else related
19 to the -- the E.M.S.C. program?
20 **MR. GREENBERG:** And -- and I'll --
21 I'll just add, you know, one other thing, Dr. Cooper
22 on that side. You know with the funding we do
23 constantly, you know, speak with the -- the federal
24 grant providers for E.M.S. for children.
25 We often try and encourage back to --

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2 for those of you who don't know. New York State
3 accurately receives the same amount of money or I
4 should say since every state receives the same amount
5 of money for E.M.S. for children regardless of how
6 many agencies you have or how many providers you're
7 trying to reach.
8 So even if we just take one of our
9 lovely local neighbors like Rhode Island, they would
10 receive the same budget as we would for New York,
11 even though Rhode Island has just about, I think,
12 under one hundred agencies and a couple thousand
13 employee -- E.M.S. providers, I think they're under
14 ten thousand, if I remember correctly.
15 Opposed to our seventy thousand
16 providers and eighteen hundred agencies. And so
17 we've spoken to them about that. We've learned a
18 little bit too over the years about the breakout of
19 where E.M.S. funding comes from, how much makes it to
20 the state versus how much as part of the -- the
21 federal program. And it's -- it's less than half the
22 money actually gets distributed to the State.
23 So we've, you know, been trying to
24 talk to him about that and seeing if there's maybe
25 additional components or more of that percentage that

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2 can come back for the states to be able to further
3 engage these programs. So we are very fortunate, you
4 know, almost every year in the federal budget
5 E.M.S.C. in the first discussion.
6 And then hopefully, so far, we've
7 been, knock on wood, very lucky that -- that the
8 funding does come back. This year was similar. We
9 you know, I think first cuts -- we -- we were cut,
10 then we got partial, and now it does look like the --
11 the full amount that we get on an annual basis will
12 be coming through.
13 So the programs that we do have in
14 place, including, you know, for this counsel will be
15 able to continue, but it is -- it is an endless
16 struggle and -- and a unique one for New York because
17 of our size and geographic and just population
18 because unfortunately, the funding is not necessarily
19 associated with that.
20 So again, I just think good
21 information for this council to understand as well.
22 **MS. EISENHAUER:** And just for
23 reference. We are third in the nation as far as
24 amount of E.M.S. agencies and amount of hospitals.
25 The only two that are ahead of us are California and

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2 Texas. So if that gives you a reference, yes, you
3 know, if that gives you a reference of all of that.
4 We're number three and supposedly they say they
5 understand us we still only get --.
6 **MR. GREENBERG:** Even -- even simple
7 things like the hospital survey last year and --.
8 **MS. EISENHAUER:** Yes.
9 **MR. GREENBERG:** Our collection of the
10 number of hospitals. If we were to look at it by the
11 number of hospitals that responded, we probably
12 exceed most states.
13 **MS. EISENHAUER:** Yes.
14 **MR. GREENBERG:** We look at it by
15 percentage, you know, we were lower than several
16 states. So you know, again, it becomes challenging
17 when you have a state that only have, you know, a
18 dozen or two dozen hospitals, your ability to pick up
19 the phone and call the person who needs to, you know,
20 make that happen fill out the survey becomes a lot
21 more achievable.
22 **MS. EISENHAUER:** Yes.
23 **MR. GREENBERG:** Opposed to when you
24 have, you know, nearly or over two hundred. So a lot
25 of different dynamics that we face.

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2 **MR. EISENHAUER:** Okay. So --.
3 **MR. GREENBERG:** If I --.
4 **MS. EISENHAUER:** Yeah. That is the
5 end of my report.
6 **MR. COOPER:** Is there any questions
7 for -- for Amy? Okay. Well then let's move on to
8 the next item on the agenda which is old business
9 which is really not so old. Actually, very current.
10 We have two items under old business
11 to discuss. We have a report from the Pediatric
12 Agitation Subcommittee and a report from the E.M.S.
13 Pandemic Triage Protocol working group. So a lot of
14 work has been done and -- and with respect to both of
15 these projects since our last meeting.
16 And we're fortunate that we have Matt
17 Harris as one of our members as well as being the
18 current chair of the pediatric committee, as well as
19 Vero Feuer, one of our psychiatry colleagues who
20 worked with us on the development of this protocol.
21 So Amy, what I will do at this point
22 is ask that -- ask that you bring that document up on
23 the screen, so everyone can see it. This -- this --
24 this project as a result of -- I would say three or
25 four ... focusing on the -- the issue of agitation in

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2 the pediatric patient.
3 And really just something's up in a --
4 in a couple of words. The group felt we needed to
5 get away from the agitated delirium or excited
6 delirium if it's -- if it's -- some call it now, you
7 know, approach in choosing the adult patient and
8 understanding that for most children, de-escalation
9 will be the, you know, the, you know, the most
10 successful and earliest intervention that, you know,
11 that -- that would likely to -- would likely to, you
12 know, be used.
13 In addition, the -- the
14 pharmacological agents which are -- are utilized in
15 children are also a big ... So Elise, I think that
16 you had as much of a hand in this protocol as anyone.
17 Would you like to take the lead on –- on going
18 through this protocol step by step?
19 I can do it as well if you don't -- if
20 you're not prepared to do so.
21 **MR. VAN DER JAGT:** No, I'm -- I'm
22 happy to -- I'm certainly happy to do that, Dr.
23 Cooper. Again, my understanding is -- Dr. Cooper,
24 that the -- the idea is to discuss this a bit and
25 then to hopefully pass this, so that it can go to

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2 SEMAC. Isn't that correct?
3 **MR. COPPER:** That's correct.
4 **MR. VAN DER JAGT:** Okay. Just want to
5 make sure that we're on the same page. So -- so you
6 -- what you see here in front of you is obviously
7 doing -- this comes at -- it would be part of the
8 collaborative protocols as we -- we -- we -- this was
9 include -- would be included.
10 And as you can see here the criteria,
11 the first blank -- blank is for use of the patients
12 who were deemed to pose a danger to themselves or
13 others. And then we spent a lot of time as a
14 committee really in this next section. If you could
15 scroll up just a little bit, Amy, so we can get the
16 C.F.R. and first responder and all provider levels
17 there.
18 Yeah, that's perfect. Perfect. And
19 as you can see here, a lot of this section deals with
20 after initial, obviously medical stabilization,
21 there's no airway issues and there's vital signs.
22 But it's really about the ability to de-escalate.
23 And if verbal de-escalation, there are
24 some very specific factors in here that we felt it
25 was very, very important to highlight in this -- in

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2 this algorithm. So things like what precipitated the
3 -- the agitation, what are the usual ways to calm the
4 patients, any psychiatric or developmental issues,
5 medications that help or worsen the behavior, and
6 then consider some of the techniques.
7 And in fact, Amy, if you could scroll
8 down to that because they're both referenced as box A
9 and box B and C. If you could scroll down to those
10 boxes, so we can look at those.
11 Okay. So here our -- here's box a,
12 ten rules of verbal de-escalation. So these are very
13 specific directions, I think. And these were taken
14 from a document that had been put together, I think,
15 including Dr. Feuer and trying to look at some very
16 specific directions on this box -- box B. So what is
17 verbal de-escalation box B is behavioral
18 interventions. And there's always in box C, to make
19 sure that the patient's in a safe comfortable area,
20 so that -- that the environment itself does not
21 trigger any further problems. If you can scroll back
22 up?
23 Yeah, right there. Very good. Thank
24 you. And then as you see here, we spent a lot of
25 time actually looking at the order of these. If none

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2 of these initial verbal and behavioral de-escalations
3 occur, there may need to be the option of applying
4 some restraints. We put that in the very last bullet
5 point because we felt that that was the -- sort of a
6 -- the -- the other ones did not work. That was
7 certainly not something you go to at first.
8 There's a little bit about law
9 enforcement and how that is to be. Again, this is
10 about safety. The ability to re -- remove any of
11 these restraints that might be necessary. Please
12 scroll down, Amy, if you could.
13 A little bit about hyperglycemia off
14 the status. I think that that's relatively okay.
15 That's under paramedic and keep going. And then, we
16 had a lot of discussion about what medications would
17 be appropriate if verbal, behavioral, and
18 environmental de-escalations did not work, and the
19 patient continued to be a danger to themselves or to
20 another person.
21 And these were the three that we felt
22 were nationally recognized as being the most helpful.
23 In particular, we removed ketamine, which I think was
24 the original medication that was listed here. And we
25 really provided a lot of information about the

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2 midazolam which is on most ambulances as ... advanced
3 level Haldol. And then we kept a diphenhydramine,
4 which was also on the old -- old algorithm as well.
5 And then we finally put a few key
6 points in here which we felt were really important.
7 Had some discussion about, you know, how much of this
8 should be more education versus it being incorporated
9 into this algorithm.
10 I think the consensus was that these
11 were -- all of these areas were critical areas. And
12 we felt we should not leave it up to just an
13 educational session here or there. But they really
14 needed to be front and center available to the E.M.S.
15 provider.
16 And that is a review of this. I'm
17 certainly glad to answer any questions. But again,
18 Dr. Feuer's part of this committee and was extremely
19 helpful. And then, I don't know, Dr. Harris, but
20 that sounds like he would be -- be ... some comments
21 as well. Thank you, Dr. Cooper.
22 **MR. COOPER:** Thanks, Doctor. Dr.
23 Feuer, do you have any -- any comments you'd like to
24 make at this time?
25 **MS. FEUER:** Yeah. So thank you so

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2 much for presenting that. No additional comments. I
3 did put in the chat the original article, which is
4 the pediatric beta guidelines, the best practice
5 parameters that was published a few years ago by our
6 consensus work group.
7 And our hope was to have that be
8 revised with the considerations for pre-hospital and
9 the medication availability. You know, on the
10 ambulances and that's how these considerations were
11 finalized by the group.
12 And yes, so heavy focus on de-
13 escalation and environmental considerations prior to
14 going to medications is the other really important
15 point that we would like to stress. Happy to answer
16 any questions.
17 **MR. VAN DER JAGT:** And maybe, Dr.
18 Feuer, maybe I could just say, since the data --.
19 **MR. COOPER:** This is for Dr. Feuer?
20 **MR. VAN DER JAGT:** Uh-huh. If I could
21 just add, Dr. Cooper on that beta consensus document.
22 **MR. COOPER:** Please.
23 **MR. VAN DER JAGT:** I believe, as I
24 recall, that that was initially focused primarily on
25 the emergency department. And so it had a lot of

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2 medications in there that just were not available in
3 the pre-hospital. And we had a, I think, a very
4 robust discussion about, you know, E.D. versus pre-
5 hospital and the differences between those two.
6 And this was really sort of extracting
7 from that, actually more comprehensive document, and
8 saying what part of that document could be brought to
9 -- to folks out in the field where they didn't have
10 all the resources that an E.D. might have.
11 **MS. EISENHEUER:** Exactly.
12 **MR. COOPER:** Matt Harris, do you have
13 any thoughts you'd like to share with us?
14 **MR. HARRIS:** You know, thanks for ...
15 I think that I'm just going to echo the work that
16 Mary's done. I think that there's a need for this.
17 We've seen this in, you know, my experience including
18 Colorado prior to coming here. I'm not sure I have
19 anything terribly germane to what's been done here,
20 but thanks for the opportunity.
21 **MR. COOPER:** Okay. I will note that I
22 did pick up a couple of typos in reviewing this --
23 this morning prior to our -- our meeting today. Amy,
24 if you would just scroll up just a bit? Perfect. I
25 think down just a little bit, if you don't mind. A

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2 little further. A little further, please. There we
3 are.
4 The -- the wording under paramedic,
5 check blood glucose level ... and highlight -- seems
6 like there's a word missing. Given the high
7 likelihood of hypoglycemia or something along those
8 lines, I think there's a word that needs to be
9 inserted there. We can wordsmith that. I, you know,
10 the -- the purposes of -- of approval today. That's
11 a simple technical change.
12 And if we can slide down just a little
13 bit more. I think there's two areas where we need to
14 insert spaces between words under the second bullet
15 point, drug ingestion, second line, it looks like
16 there should be a space there.
17 And I'm not sure in the third bullet
18 point, first line, whether there's supposed to be a
19 space between autism and spectrum or not. But both
20 of those issues can be corrected before we send this
21 on to SEMAC. Dr. Feuer, I know that you always have
22 wise words and issues such as this deep. Do you have
23 anything you might want to add at this point?
24 **MS. FEUER:** I just had a question
25 about discussion that came up in the last meeting

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2 about the S.C.C.M. putting out clinical practice
3 guidelines for management of pain, agitation, and
4 neuromuscular blockade.
5 And we had talked about whether, you
6 know, making sure that they're not in conflict with
7 something like this. And I have to admit I did not
8 see them first, but while we're sitting here, it --
9 the guidelines were published in February 2022, but
10 then are an online special article.
11 So I'm about to download the P.D.F. I
12 could add it to the chat. But I think before some
13 final approval, just make sure that there's nothing
14 so diametrically opposed. I know that Dr. Conway
15 apparently was part of that group, or, you know, or -
16 - or had some oversight for that. Had he mentioned
17 any issues with this protocol versus that?
18 **MR. COOPER:** He did not mention any
19 issues to me.
20 **MS. FEUER:** Okay.
21 **MR. VAN DER JAGT:** Dr. Feuer, Dr.
22 Cooper, I did look at that -- that -- the guidelines
23 that came out, you know, that the population I think,
24 is quite different. That meant to address, if I'm
25 not mistaken. I don't have it in front of me. You

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2 can see it, but I think it's -- is this the
3 guideline, Dr. Feuer, that was related to sedation in
4 the I.C.U. You know, and it included patients who
5 were on mechanical ventilation. It included patients
6 undergoing procedural sedation.
7 There was a number of aspects of this.
8 What medications would be useful and included things,
9 you know, like dexmedetomidine versus benzodiazepines
10 versus ketamine, neuromuscular blockade. And I'm
11 just wondering although I agree that we need to be
12 consistent. I think the population is a little bit
13 different maybe.
14 **MR. COOPER:** Yeah, I -- I --.
15 **MS. FEUER:** You're correct, that's
16 I.C.U., but --.
17 **MR. COOPER:** Yeah, I too had looked at
18 these guidelines. I think they actually -- I got a -
19 - I think I got -- I got somehow a copy by a blast
20 email of some sort. I did not see any major
21 discrepancies between what we're proposing here and -
22 - and, you know, what the S.C.C.M. has, you know,
23 proposed for, you know, for the I.C.U. sedation.
24 And again, as Dr. Van Der Jagt points
25 out, this is a very different population. And I

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2 think -- personally, I think the major issue for us
3 pharmacologically was the issue of whether ketamine
4 had a role in -- in pre-hospital, you know, care.
5 And I think all of us felt that it did
6 not at least as of this time. And so, you know,
7 while it might be useful in certain circumstances in
8 an I.C.U. setting, certainly not -- certainly --
9 certainly not in the pre-hospital environment for I
10 think all the reasons that we -- that we know or have
11 discussed, I should say, perhaps.
12 So I -- I personally see no barrier to
13 our -- our adopting this or approving this for a
14 forwarding to the SEMAC. Certainly, I think Dr.
15 Pamela Feuer taught that we should probably, you
16 know, go over this one last time with a fine-tooth
17 comb, you know, before it's actually presented at
18 SEMAC is -- is -- is reasonable. But I don't think
19 that should ... approval today in any way, shape, or
20 form.
21 And as I say, I think, you know, I saw
22 nothing in those guidelines that would -- that would
23 speak against what we've adopted here for the pre-
24 hospital world. Any other comments?
25 **MR. VAN DER JAGT:** ... just comment

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2 just quickly again. I -- I agree with some of the
3 typographical things that you mentioned. There is
4 one more I'd like to point out to Amy, where it says
5 in that first bullet point under key points.
6 It says assessing for safety and if it
7 is not, it really should be added if it is not safe,
8 just to make it grammatically correct.
9 **MS. EISENHAUER:** I will go through and
10 faces and ...
11 **MR. COOPER:** I think we're a little --
12 I think we're going down a little bit, Amy, it's the
13 first -- first line on the second page, if I'm not
14 mistaken.
15 **MR. VAN DER JAGT:** It's under that
16 first key point.
17 **MR. COOPER:** The first bullet point.
18 **MS. EISENHAUER:** Okay.
19 **MR. VAN DER JAGT:** It says, assessing
20 for safety and if it is not safe, retreat to ...
21 **MS. EISENHAUER:** I will add that word.
22 **MR. COOPER:** Okay. One moment.
23 **MS. CHICMENTO:** I was just looking --
24 just one second. I -- the SEMAC was actually looking
25 at the adult protocol for behavior emergencies. They

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2 do have ketamine in the adult protocol, paramedics
3 only. So you know, just -- so that you know that it
4 is around in the State, but whether or not we want to
5 use that for pediatrics, of course is a totally
6 different matter.
7 **MR. COOPER:** Yeah, we had pretty
8 extensive discussions about that, Sharon. I mean,
9 really very extensive discussions and -- and I
10 believe the -- the strong consensus was that ketamine
11 did not belong in a pediatric protocol.
12 **MS. CHICMENTO:** Okay.
13 **MR. VAN DER JAGT:** Dr. Cooper?
14 **MR. COOPER:** Okay. Well, hearing --
15 hearing no further commentary at this point, I'd like
16 to ask if someone would make a motion for approval of
17 this -- of this revised protocol to be forwarded to
18 SEMAC for approval.
19 **MS. CHICMENTO:** I'll make the motion.
20 **MR. COOPER:** Thank you. Can I have a
21 second?
22 **MS. EISENHAUER:** Can you share your
23 name, Sharon? Can we share our name?
24 **MS. CHICMENTO:** I'm sorry, what?
25 **MS. EISENHAUER:** We need to share a

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2 name.
3 **MR. HARRIS:** Matthew Harris is second.
4 Matthew Harris is second.
5 **MR. COOPER:** Okay. Sharon Chicmento
6 moves and Matthew Harris seconds. Is that right,
7 Sharon, you're -- you're -- you had a -- you had a
8 funny look at your face there, for a second. What --
9 you regretted saying about making the motion.
10 **MS. CHICMENTO:** Amy was starting to
11 say something. I couldn't hear what Amy was saying
12 that was about it. Just trying -- I was trying to
13 figure it out.
14 **MR. COOPER:** Okay. All right. So
15 it's been moved and seconded that we adopt this
16 protocol. Is there any further discussion? Okay.
17 All in favor, please signify by saying aye.
18 **ALL PANELIST:** Aye.
19 **MR. COOPER:** Aye for me too. Any
20 other -- does anyone object to the approval of this
21 motion, say nay. Well, hearing no nays. Any
22 abstentions? So no nays or abstentions. So this --
23 this motion carries without dissent with the
24 typographical corrections that have already been
25 noted.

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2 Okay. So this will go forward to
3 SEMAC with the packet for them. And I'm really
4 grateful to everyone especially our colleagues from
5 the psychiatry world. And of course, Matt, your
6 group as well, you know, for your input into this --
7 this protocol.
8 Okay. So now we move on next to the
9 pediatric pandemic protocol and Sharon, you're
10 welcome. And now we move on to Sharon Chicmento, who
11 kindly and in her own inimitable style, you know,
12 chaired the working group for the E.M.S. pediatric
13 viral pandemic triage protocol.
14 So Sharon, please take it away. And
15 of course, with great thanks to Amy for all the work
16 you did with the -- the modern equivalent of
17 typesetting this thing.
18 **MS. CHICMENTO:** Okay. So we start
19 back in February, the end of February, we had a
20 subcommittee meeting looking at the adult protocol
21 and decided that there definitely needed to be a
22 separate pediatric protocol. There was a lot --
23 there was enough differences that there definitely
24 needed to be a separate protocol.
25 Also, thank you my -- Mark Philippy

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2 for giving me the name of nurse finders -- or nurse
3 navigators leader who sent me some information about
4 how they do this pandemic protocol by phone in a
5 couple of our cities around New York State including
6 Rochester. And that gave us a couple of ideas as
7 well.
8 So as we went through the discussion,
9 the first big point we made was that, should there be
10 an age difference. Should we make it so that
11 children under two would be automatically transported
12 that there -- there really should be much less
13 consideration of ever leaving children that young
14 because of the issues with assessment and not being
15 able to really do as -- as good a job of -- of
16 evaluating them, as well as the fact that they can
17 destabilize so quickly.
18 So as you will notice, there is a box
19 in -- so in the third box down. So the box that
20 starts with, does the patient have any signs and
21 symptoms of influenza like illness. You'll notice
22 that there's a box at the bottom of that that highly
23 recommends transport. So that was something that we
24 had quite a long discussion about, but I think we
25 really came to a good consensus on that.

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2 The symptoms in that particular box,
3 we modified a bit. There was a couple that were
4 really much more specific to adults which we removed.
5 And then we added in a couple that were more specific
6 to -- to children such as the signs and symptoms of
7 gastrointestinal distress that we added in.
8 I think that was all for that
9 particular box. Do you want to slide down a little
10 bit, Amy, please? So the next box down then had some
11 criteria and those we change -- changed considerably
12 because obviously, we needed to have different vital
13 sign parameters.
14 So Amy was able to take the vital
15 signs boxes that are currently in the B.L.S.
16 protocols and insert them directly into this
17 protocol, so that we would have the vital signs to
18 refer to for each of the different age groups.
19 Also, we did include capillary refill.
20 We added in modeling. We added poor distal repulses.
21 We include a decreased muscle tone. So there were
22 several things that were incorporated here that were
23 not in the adult protocol.
24 Then there was two boxes in the adult
25 protocol that -- where they had different aspects

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2 related to history -- historical facts. We decided
3 to put that all into one because we were able to then
4 add in some things that were very specific to
5 pediatrics.
6 So the chronic illnesses we added in -
7 - they had diabetes already, but we added in sickle
8 cell disease, for instance. Also, we wanted to know
9 if the patient had any cardiovascular, respiratory,
10 or neurological disease. If they had any special
11 health care needs, advanced airways, obesity, or if
12 they were technologically assisted. And then at the
13 -- the immunocompromised I believe was already in the
14 adult protocol.
15 So those are the -- the basic changes.
16 So again, we just kind of modified things to make
17 them much more pertinent to the pediatric population.
18 And I think we, you know, really were able to -- and
19 again, Amy did a great job.
20 Oh, Amy, we did add in a couple extra
21 references. So we did add in the information from
22 the pediatric assessment cards that we had done
23 several years ago about the assessment of children
24 and forming the general impression and as well as --
25 do we have another one, Amy? There's something below

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2 that.
3 **MS. EISENHAUER:** I was able to fit the
4 vital signs in above.
5 **MS. FEUER:** Right. Yeah, perfect. So
6 again, Amy, you did a great job with the -- with
7 putting this all together and I appreciate your
8 effort.
9 **MS. EISENHAUER:** Thank you.
10 **MS. FEUER:** Anyone else on the
11 committee have anything else? So subcommittee, you
12 have anything else that they want to touch on?
13 **MR. COOPER:** Please anyone chime in
14 now. Who -- who worked on the protocol. One second,
15 Pamela. Anybody else on the committee who -- who had
16 any comment?
17 **MR. VAN DER JAGT:** Yes, I -- this is
18 Dr. Van Der Jagt. I just have a question -- in
19 reading this over again. First of all, thanks for
20 all the work that was put into this. But then I
21 realized that in that box that is currently on the
22 screen, the age there, I -- I don't know that that is
23 correct because the idea was that you want to screen
24 out patients that really don't have to go to the E.D.
25 They might have COVID and they -- you know, they

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2 don't need to go there potentially.
3 According to this box, it says,
4 patient assessment reveals any of the following.
5 This means that any patient less than fifteen
6 automatically goes to the E.D. automatically. And I
7 don't know that that was the intent.
8 Isn't the intent that for, if you go
9 up to the very top and here's a suggestion I'm
10 thinking of maybe that would make it work. If you go
11 to the very top again, just scroll up. It should be
12 -- okay, that first box. During a pandemic, all
13 patients less than fifteen must be screened for the
14 following.
15 And I'm wondering if that is what we
16 intended because the way it stands right now is every
17 kid less than fifteen automatically, they just got to
18 have to go -- follow standard protocols.
19 **MR. COOPER:** It is exactly what we
20 intended, Elise, and thank you for pointing that out.
21 **MR. VAN DER JAGT:** So this means then
22 any patients -- all patients are going to go to the
23 E.D. less than fifteen. Is that correct? There's
24 not going to be one single patient who will not go to
25 the E.D. because they're all going to be less than

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2 fifteen.
3 **MR.:** My understanding of this --.
4 **MR. COOPER:** No, Elise, I think you're
5 right. I think -- I think we're -- we're limiting
6 this protocol to patients under age fifteen, and that
7 should go in the first box rather than in the fourth
8 box.
9 **MR. VAN DER JAGT:** All right.
10 **MR. COOPER:** And the less than
11 fifteen. If we can scroll down just a bit, Amy,
12 please? If -- if -- if we could add a patient less
13 than fifteen have any of these signs or symptoms, or
14 we could just presume that it's covered by the first
15 box.
16 **MR. VAN DER JAGT:** Yeah, that's
17 exactly why this meeting, yeah, uh-huh.
18 **MR. COOPER:** Yeah.
19 **MR. GREENBERG:** But I think it's also
20 important to understand too. This is Ryan Greenberg
21 by the way speaking. That it doesn't necessarily
22 mean that everybody goes to the hospital. It does
23 mean that they follow their standard E.M.S. protocol.
24 **MR. VAN DER JAGT:** Correct.
25 **MR. GREENBERG:** Pandemic. It doesn't

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2 make, you know, through your normal B.L.S. and A.L.S.
3 protocols that parent may determine after an
4 assessment that, you know, the child is okay and they
5 don't want to go and they'll ... their patient, but
6 it does -- it -- it wouldn't qualify them necessarily
7 for, you know, automatic that they would fall into
8 this, you know, situation of a non-transport.
9 You know, the -- the other thing that
10 I think, you know, might be worth consideration. And
11 I -- and I don't know, but again, you know, this is -
12 - this committee is the consideration somewhere here
13 or is the consideration maybe put differently up in
14 this box and actually, Amy, if you can scroll down.
15 And -- and the -- the SEMSCO -- the
16 SEMAC and the SEMSCO didn't want to make every
17 patient have to call medical control, which is how
18 they ended up with, you know, to follow their -- to -
19 - to contact medical control for the regional
20 guidance. But maybe it's a situation to where it's,
21 you know, contact medical control or regional
22 guidance for if the patient is less that is the
23 physician consult, if you make it down to this
24 component for their ...
25 **MR. VANDER JAGT:** I guess the -- the

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2 question I have is that as soon as that age less than
3 fifteen is the only criteria that controls
4 everything, then why are we even putting this
5 together? Because there'll be no point in, you know,
6 looking at poor distal pulses or not. If they're
7 good distal pulses, if the kid is fourteen, they're
8 going to go, you know, it's going to go to the right.
9 And so I have a hard time
10 understanding, you know, I know they may not go to
11 the hospital but I thought the idea was that what
12 patients ultimately meet criteria for non-transport
13 or treatment, you know, or ... for treatment in place
14 so.
15 **MR. COOPER:** Well, let's just go back
16 to the -- to the beginning of this discussion. I
17 think that we want to be sure that this protocol
18 reflects that it applies to patients that are less
19 than fifteen years of age.
20 **MR. VANDER JAGT:** Right.
21 **MR. COOPER:** I think the bug --
22 patient assessment is meant to identify patients, you
23 know, who are, you know, within that category less
24 than fifteen years of age but have additional
25 symptoms or signs or abnormal vital signs. Okay. So

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2 I think what we're -- what in effect, what we're
3 saying is that when we strike the wording age less
4 than fifteen years in the patient assessment box and
5 move it up to the top, in where we just define who
6 the patient or who the protocol actually refers to.
7 And then that leaves us, excuse me,
8 that leaves us with, if we can scroll that down, Amy,
9 please. That leaves us with the question that Ryan
10 raised, okay. The last line is really, if we've got
11 a parent, for example, who is insisting that their
12 child be transported, I think the child does not meet
13 any of the criteria that would necessitate transport,
14 that medical control, you know, should be contacted
15 for regional guidance.
16 I think that's appropriate, okay. So
17 if we were to modify that line, I might suggest that
18 we say if the, you know, if the caregiver insists on
19 transport or something along those lines. Because
20 it's really not the patient who is going to be, you
21 know, demanding to go to the hospital, I would guess
22 under most circumstances.
23 Although we could say if the caregiver
24 or the patient insists on transport, something along
25 those lines, I see Elise nodding yes.

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2 **MR. VANDER JAGT:** Yeah, I agree.
3 **MR. COOPER:** Yeah. Contract medical
4 control. So I think and I appreciate you very much,
5 Elise, is picking this up. I think we were all
6 focused on seeing the boxes put together so nicely by
7 Amy that -- that I didn't pick that up until just
8 now. But I think Elise is exactly right, that we
9 should remove age less than fifteen years from the
10 patient assessment box.
11 And going back up to the top. Amy, if
12 you would, okay. We would probably say during a
13 pandemic, all patients less than fifteen years of age
14 must be screened for the following, okay. All right.
15 And then, okay. Again, if we go down to the bottom,
16 the Greenberg manifesto, if the caregiver or patient
17 insists on transport, contact medical control for
18 regional guidance. Does that -- Elise, Sharon, does
19 that work for you guys?
20 **MS. CHICMENTO:** Yes.
21 **MR. VAN DER JAGT:** Yes, the one thing
22 is to also remove the age less than fifteen years in
23 that box that's currently on the screen.
24 **MR. COOPER:** You know, I think I -- I
25 think I mentioned that but yes, absolutely.

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2 **MR. VAN DER JAGT:** Yes.
3 **MR. COOPER:** In the patient assessment
4 box, right.
5 **MS. FEUER:** I have all of those notes.
6 **MR. COOPER:** And I think, you know, we
7 certainly have respiratory distress in terms of
8 shortness of breath in the previous box. So I think
9 with those changes, I -- and unless there are other
10 comments. I know Pamela Feuer had a -- had a
11 comment. Pamela, can you chime in at this point?
12 **MS. FEUER:** Yes. First of all, I want
13 to say the content in the boxes is fabulous, you
14 know, to put it concisely and, you know, and captures
15 so much. On my first read, which was before the
16 meeting, I'm having trouble following those nice,
17 pretty left-hand arrows. Some say next, one says yes
18 and then two say no.
19 And just visually, I had to reread
20 back and forth to figure out which way I go. So
21 that's -- that's my brief interpretation. I don't
22 know if anyone else sees it that way. And whether it
23 would be a potential problem or hold up in the field.
24 **MR. COOPER:** You know, panel, that's a
25 great point. I hadn't thought of that. As usual,

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2 you're sort of way ahead of the road --.
3 **MS. FEUER:** No, just very visual.
4 **MR. COOPER:** Yes, you are very -- you
5 are indeed very smart. We all know that, you know,
6 and the --.
7 **MS. FEUER:** Visual, that's smart. I -
8 - I work with my eyes so.
9 **MR. COOPER:** We -- just F.Y.I., we
10 built this off the adult pandemic triage protocol,
11 which uses the same sort of arrow format that we used
12 here. And but now that I look at it, with your
13 comment, you know, it does -- it does make a -- it
14 does make some sense, some good sense, I think, that
15 -- that if you're mixing yeses and no’s in the -- in
16 the arrows on the left that that could result in some
17 confusion in the, you know, in the heat of the moment
18 in the field, you know, one -- when one is
19 constructing the document like this, one would prefer
20 to have all the yeses on one side, all the no’s on
21 another side so there's no confusion.
22 I think that's more of a formatting
23 issue. And maybe that's something, Amy that we can
24 discuss, you know, with -- with Lee Marshall, who
25 heads the medical standards for SEMAC. And Elise, I

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2 don't know if Jeremy Cushman was deeply involved in
3 the development of this protocol or not, you know.
4 **MS. CHICMENTO:** I think -- I think --.
5 **MR. COOPER:** Go ahead.
6 **MS. CHICMENTO:** I understand your
7 concern but I think isn't this similar to what's done
8 with trauma triage and some of the other protocols
9 that are done in this format, where you just keep
10 going down the boxes, if the -- if the answer is --
11 is -- is -- is no, then you keep going down. But in
12 this case, it's like the top boxes -- the top two
13 boxes have to be a yes, before you proceed down.
14 So I don't know, it's kind of a --
15 it's -- it's a -- I'm not sure that there's a way to
16 -- to easily change this and have the same concept.
17 **MR. COOPER:** No, I understand that
18 point, very much, Sharon.
19 **MS. CHICMENTO:** Yes.
20 **MR. COOPER:** And I -- and I'm not
21 suggesting that we change the -- the arrow format at
22 this time, particularly because we want it to be
23 similar to what the adults are doing. But what I'm
24 suggesting is that we raise the issue of the fact
25 that the arrows are a mix of yes’s and no’s, so to

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2 speak, with Lou Marshall, who chairs of medical
3 standards and see if they -- if they would want to
4 reformat the protocols, both protocols, adult and
5 pediatric.
6 So that they were, you know, so that
7 they would follow, you know, -- you know, a similar
8 format that was all the yes's and no's are in
9 separate sides. I'm just making -- I don't think
10 that's something that's necessarily something we
11 should focus on today. Because I don't think that's,
12 you know, necessarily germane to today's discussion.
13 And this does have to be reviewed yet
14 by SEMAC. I think as Pam Feuer pointed out that the
15 content is really what we're focusing on here, more
16 than the formatting. And I think if we can approve
17 this protocol to be forwarded to SEMAC, you know, we
18 can alert Lou and, you know, and, you know, ask if,
19 you know, there's a way that the formatting could be
20 rearranged so that the yes's and no's are on the same
21 side. That would be my thought anyway.
22 **MS. JAGORESKI:** Dr. Cooper?
23 **MR. COOPER:** Yes, please.
24 **MS. JAGORESKI:** This is Amy. So I
25 would also like to point out that this is not going

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2 to be a document that rests upon providers, you know,
3 during a call. This has to be, as we noted above,
4 right, it has to be issued and activated by the
5 REMAC. There will be some basic education that goes
6 with this. There will probably be some basic
7 pandemic education that goes with this.
8 So it's -- it's not necessarily going
9 to be a surprise. They will have seen this document
10 prior to actively using it. And I'm sure that that
11 wouldn't be something to be taken lightly by the
12 REMAC or -- or our office to issue this. So yes, I
13 understand the concern about the next thing, yes and
14 no. But it won't be a blind viewing if somebody is
15 going to use this as a tool on a call.
16 **MR. COOPER:** Understood, understood.
17 Any other comments?
18 **MR. HARRIS:** I have a comment. Is
19 there any utility to adding anosmia among the symptom
20 list?
21 **MR. COOPER:** It's a thought.
22 **MR. HARRIS:** I mean, it's not an
23 influenza-like symptoms. So it would have to be, you
24 know, maybe in that box but say, anosmia or
25 influenza-like symptoms.

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2 **MR. COOPER:** Thoughts, folks? I mean,
3 I don't work in the emergency department, you know,
4 taking care of COVID kids, for the most part. I
5 usually don't see them until they have abdominal
6 pain, which is its own special issue. But ... my
7 intention is that that huge numbers of patients in
8 the pediatric age range are necessarily, you know,
9 able to express, you know, -- you know, issues about
10 loss of ... pains. You know, so I would ask -- I
11 would ask, you know, in addition to Kevin, I would
12 ask Elise and -- and -- and Pamela what they think.
13 **MR. HARRIS:** Or I would say almost
14 never get to ask anybody to ... It's Matt, I think
15 it's really not a symptom that's readily screened for
16 or easily verbalized.
17 **MR. COOPER:** Thank you, Matt, I'm
18 sorry, I should have mentioned your name in that
19 list. Thank you for -- for chiming in, because you
20 are the only one of us who works regularly in the
21 emergency department. So thank you for -- for making
22 that point. Elise and -- and Pamela, do you have
23 anything to add to that?
24 **MS. FEUER:** No, I -- I agree. I think
25 it was a very rare finding that we heard in, you

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2 know, I'm talking about in I.C.U. patients, so, you
3 know, in their later teenage years, so it wouldn't
4 impact the screening or -- or bringing a patient to
5 the hospital.
6 **UNIDENTIFIED MALE SPEAKER:** Yeah, I
7 agree with --.
8 **MS. CHICMENTO:** Also, this is not a
9 protocol specific to COVID. That's for any viral
10 pandemic. So to anything else, so that particular
11 symptom, I think is pretty much unique to COVID.
12 **MR. COOPER:** Fair enough.
13 **MR. HARRIS:** Could I ask --?
14 **MR. COOPER:** That's a good point and
15 thank you for raising that. Matt, did I hear you
16 again? Someone just said he had a comment.
17 **MR. HARRIS:** It was -- yes. Dr.
18 Cooper, I had a -- I have a comment. I just looking
19 at this the second box here, this wheezing worries me
20 a little bit because if the patient has wheezing, it
21 moves into the next box, which is looking at
22 basically shock, right. If you could scroll down a
23 little bit, Amy.
24 If the patient doesn't have any of
25 these things in that box where the, you know, the

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2 table is and there's no chronic illnesses, like
3 diabetes or sickle cell, but the patient is still
4 wheezing. I worry that the patient may not be taken
5 in and I --.
6 **MR. COOPER:** It may not ...
7 **MR. HARRIS:** May not ... that then the
8 patient meets criteria for non-transport. And I
9 would say that a patient who was wheezing out there
10 may very well be in their, you know, have react
11 airway disease from a viral thing they're having and
12 they may very well need to be seen, you know. And so
13 I have a little bit of a difficulty with that. I
14 didn't catch that initially, when we were looking at
15 this. But we see so much --.
16 **MR. COOPER:** ... a very good point.
17 And in addition to that --
18 **MR. HARRIS:** We see so much asthma and
19 so much reactive airway disease that the last thing
20 we want is to have a ... get out there with in the
21 middle of, you know ... and then say, oh the kid
22 didn't meet criteria for transport, you know.
23 **MR. COOPER:** Well, let me just say two
24 things. First of all, I mean, if a child did have
25 wheezing, okay, you know, we would obviously need to,

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2 you know, recognize that really more as a typical
3 sign than as a symptom. And if we look at the other
4 -- if we look at the other criteria, with the
5 exception of fever in the box, all the other -- all
6 the other, you know, criteria are actually symptoms
7 rather than signs.
8 Whereas, if we look in the following
9 box, okay, patient assessment, prevailing any of the
10 following, those are all signs rather than -- rather
11 than symptoms. And so, you know, for both conceptual
12 reasons and for the reason -- the very reason that
13 you mentioned, you know, the wheezing probably ends
14 up probably belonging in the next box, rather than
15 the one that it's located.
16 But -- but, you know, I think either
17 way, you know, whoever it is, if I'm not mistaken, I
18 could be wrong, you do end up following standard
19 A.L.S. and B.L.S. treatment protocols either way.
20 But I agree with you, I think it makes more sense to
21 move wheezing to the third box.
22 **MR. HARRIS:** You know, my -- my
23 concern is, is that actually it doesn't automatically
24 because that second box with where it talks about
25 modeling and distal pulses and all that, that's

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2 really to look at circulatory issues, primarily. And
3 so then you get to the next box that the patient has
4 never had a ... because before it's finally triggered
5 or something or it's two-and-a-half year old, who
6 could still get bronchiolitis and is pretty ill but
7 without a drop much in their sats, you know, then you
8 really end up going down to that red box where they
9 meet criteria for non-transport.
10 So I just am concerned that, you know
11 -- it's one thing if you're talking about nasal
12 congestion, you know, that's one thing, you know, but
13 if you're talking about, you know, lower airway
14 disease or mid-airway disease, bronchial, I just -- I
15 want to say that we don't -- this ...
16 **MR. COOPER:** No, I think we're -- I
17 think we're -- I think we're saying the same thing, I
18 mean --
19 **MR. HARRIS:** Yeah, probably.
20 **MR. COOPER:** -- if you were to take
21 wheezing out of -- out of that box, okay. Then you
22 would follow standard A.L.S. and B.L.S. treatment
23 protocol --
24 **MR. HARRIS:** Correct.
25 **MR. COOPER:** -- to do ... wheezing

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2 would be noticed, right, right. ... you know,
3 stethoscope on the chest and that would -- that would
4 result in, you know, in the appropriate transport.
5 But I -- but I agree with you totally that wheezing
6 belongs in the third box rather than the second,
7 whichever number it is.
8 **MR. HARRIS:** Yes, and I like to add,
9 Dr. Cooper, you might want to put in there in that
10 second word, that where that table is right now is
11 that if the patient shows, say wheezing or increased
12 work of breathing, you know, those patients really
13 need to go to the right.
14 **MR. COOPER:** We could do that. We do
15 have shortness of breath in the previous box but
16 that's fine. We can do -- we can do wheezing or
17 increased work of breathing as well. That's fine.
18 Sure.
19 **MR. HARRIS:** If that becomes
20 assignment.
21 **MS. FEUER:** Yeah, actually, your --
22 you can't be taking aged less than fifteen out of
23 there. So that would make sense. And you already
24 have the SPO2 a less than ninety-four percent in
25 there. So moving wheezing down there would really

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2 makes very good sense.
3 **MR. HARRIS:** Yeah. So wheezing, no
4 wheezing, and no increased work of breathing because
5 then that also makes it refer to the assessment
6 triangle, you know, so.
7 **MR. COOPER:** Right.
8 **MR. HARRIS:** ... just basically food
9 for thought, I mean, first of all, it's already been
10 a ton of work that's been put into this. And it's
11 really quite incredible. But I think in the last
12 twelve minutes, we've made several content and format
13 recommendations, I think are really crucial and key.
14 And I think it obviously warrants
15 ongoing discussion but I just want to raise the
16 possibility that maybe we're not quite ready to pass
17 this on. I think perhaps we should make these
18 adjustments. Not necessarily table to the next
19 meeting but perhaps we can do something by email but
20 there's just a lot of contents and formatting changes
21 we're recommending.
22 **MR. COOPER:** Matt, I understand that.
23 The problem with that is that SEMAC will not meet
24 again until late in the fall. And if we don't
25 approve this now, you know, if we don't approve this

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2 now, you know, we'll lose the opportunity to, you
3 know, to -- to -- to get this approved, possibly
4 prior to the next, you know, viral pandemic.
5 **MR. HARRIS:** When is this SEMAC
6 meeting?
7 **MR. COOPER:** SEMAC is meeting in
8 April, just a couple of weeks from now.
9 **MR. HARRIS:** Thank you.
10 **M. COOPER:** And I don't we have any
11 provision for electronic voting under our -- under
12 the State guidelines.
13 **MR. HARRIS:** Okay. Thank you.
14 **MS. FEUER:** Just to clarify, yeah, for
15 voting, it has to be done in the public meeting and
16 needs to be recorded by our wonderful Court Reporter
17 here. So everything has to be on the record when it
18 comes to protocols to be passed forward. And also in
19 med standard SEMAC and SEMSCO those are recorded as
20 well.
21 **MR. COOPER:** I don't think the changes
22 are that dramatic. If we could just run to the top
23 of the protocol again, Amy, if you don't mind? But
24 Matt, you do raise a good point. And if we weren't
25 crunched by time, I would certainly absolutely agree

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2 with you, okay. So I think the changes we're
3 suggesting need to be made here are as follows in the
4 first box.
5 During a pandemic, all patients less
6 than fifteen years of age must be screened for the
7 following. That's the first change, adding less than
8 fifteen years of age after the words all patients,
9 okay. We now move to the third box, okay. And we
10 remove wheezing from that box.
11 We now move to the fourth box. We add
12 wheezing and/or increased work of breathing. And
13 then we go to the last box. And it has the words if
14 the caregiver or patient insists on transport. Maybe
15 others disagree with me. But I think those changes
16 are pretty straightforward. And I think that -- I
17 think that, you know, even though we've had a fair
18 amount of discussion about it, I think that, you
19 know, I think that they're pretty straightforward and
20 pretty simple.
21 You're welcome to disagree with me but
22 to me, you know, particularly given the time element
23 here, I think we really need to make those -- we
24 really want to get this protocol out there, you know,
25 in a timely manner, which I think we do. You know, I

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2 think we really need to move along -- move along and
3 get this out there.
4 Any other comments? It's been a great
5 discussion. Sharon, thank you so much for your work.
6 And that of all who participated in this. Can I hear
7 a motion for approval?
8 **MR. HANNG:** Jason Hanng motion to
9 approve the document with the discussed corrections.
10 **MR. COOPER:** And that's Matt Harris?
11 **MR. HANNG:** No.
12 **MR. COOPER:** Who made the motion?
13 **MR. HANNG:** Jason Hanng.
14 **MR. COOPER:** Jason, I'm sorry, ...
15 **MR. HARRIS:** I am happy to second,
16 Harris.
17 **MS. JAGORESKI:** Excuse me.
18 **MR. HARRIS:** Harris, second. Jason
19 Hanng.
20 **MS. EISENHAUER:** Dr. Cooper?
21 **MR. COOPER:** Yes.
22 **MS. EISENHAUER:** This is Amy. We need
23 vetted members to make the motion. So --
24 **MR. COOPER:** Okay.
25 **MS. EISENHAUER:** ... we need -- both

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2 of those cannot be accepted because they are still in
3 the vetting process.
4 **MR. HANNG:** All right. So sorry,
5 okay. All right.
6 **MR. HARRIS:** I will be glad to make a
7 motion.
8 **MR. COOPER:** ... member that can make
9 the motion.
10 **MS. EISENHAUER:** Okay. So Bruce Barry
11 made the motion and Dr. Vander Jagt, you second it,
12 correct?
13 **MR. VAN DER JAGT:** Second it, yeah.
14 Sounds good.
15 **MR. COOPER:** Thank you very much.
16 Okay. All right. Further discussion, okay, hearing
17 none. Please, if you approve of the changes in this
18 protocol and wish it to be forwarded to SEMAC for the
19 meeting on in early April, please signify by saying
20 aye.
21 **MR.:** Aye.
22 **MS.:** Aye.
23 **MS.:** Aye.
24 **MR.:** Aye.
25 **MR. COOPER:** Opposed? Hearing none,

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2 abstain. Hearing none. So it carries without
3 dissent. And Amy will get those changes made and
4 we'll -- we'll move on to the next item on the
5 agenda, which is new business. Does anybody have any
6 new business to bring forward at this time?
7 Let me just say that I am really
8 pleased with the work of the group, you know, as I
9 know you all are too, these are two very important
10 current issues facing the children of New York State.
11 And, you know, I think that these will materially
12 improve, you know, their care. That's why we exist
13 as a committee. And I'm so grateful for all of your
14 support of these protocols and especially the groups
15 that work to put them together.
16 Okay. So let's -- let's move on now
17 to the next item on the agenda, which I believe is
18 reports from our sister committees. And the first,
19 sorry, I lost my screen for a moment, give me a
20 moment please. So the next item on our agenda is a
21 report from our P-Card partners, Dr. Lerner, Dr.
22 Diane, are you on the line?
23 **MS. LERNER:** Hi, Brooke Lerner on.
24 I'm not sure about Peter.
25 **MR. COOPER:** Hi, Brooke.

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2 **MS. LERNER:** We have --.
3 **MR. COOPER:** Go ahead.
4 **MS. LERNER:** We don't have a big
5 report for you. We appreciate the support for the
6 ... study, which is the pre-hospital seizures study.
7 We have completed the notification and consultation
8 requirements by the I.R.B. And it looks like we
9 likely will be able to start enrolling in July.
10 So we'll keep you kind of informed
11 about how that goes. But very exciting, I think the
12 first use of emergency exception from informed
13 consent for an E.M.S. study in Buffalo. We also are
14 very close to having N.I.H. approval for a pilot
15 study looking at asthma treatment in pre-hospital
16 care.
17 So hopefully next time you meet, I'll
18 be able to tell you that we were funded and we'll be
19 proceeding with studying asthma in children in the
20 pre-hospital setting. Thank you for your time. I'm
21 happy to answer any questions.
22 **MR. COOPER:** Thank you. I can't help
23 but note on the agenda that while it is true that
24 Brooke is a Lerner and teacher also. There is
25 actually no A in the spelling of her last name. So

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2 we'll get that fix next time, the next time, Brooke,
3 and our apologies.
4 **MS. LERNER:** No worries.
5 **MR. COOPER:** So next is Amy, unless
6 there are questions for Dr. -- for Dr. Lerner.
7 Hearing none. Let me just add, Brooke, that I think
8 it's really exciting to hear about the asthma program
9 or a project that you guys are going to be, you know,
10 shepherding through and hopefully we'll hear about
11 that next time.
12 Next, we have Amy Jagoreski from the
13 Bureau of Occupational Health and Injury Prevention,
14 for an injury prevention update. Ms. Jagoreski, are
15 you with us?
16 **MS. JAGORESKI:** Hi, can you hear me?
17 **MR. COOPER:** We can. Thank you.
18 **MS. JAGORESKI:** All right. Good
19 afternoon, everyone. I am Amy Jagoreski. I'm a
20 Program Coordinator with the Bureau of Occupational
21 Health and Injury Prevention. A few updates,
22 apologies in advance if these are repeats from our
23 last meeting. So first off, we are continuing our
24 child passenger safety technician trainings in
25 coordination with the governor's traffic safety

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2 committee who we partner with.
3 The next training is going to be a
4 safe transportation for all children, which will be
5 coming up April 19th and 20th. We're expecting about
6 twenty certified technicians to be trained in these
7 best practices for special healthcare needs.
8 Secondly, in our bureau, we are looking to create a
9 survey tool to conduct a needs assessment to
10 determine how best to support family service partners
11 in improving child passenger safety.
12 The collected data will be used to
13 guide the development of an educational tool to
14 assist service programs and staff to educate their
15 patients about C.P.S. best practices. Some partners
16 that we would like to involve and help implement some
17 of these tools are going to be the New York State
18 Department of Health Outreach and Education Group who
19 we work with closely.
20 The Department of Social Services, the
21 Women Infant Children program, as well as early Head
22 Start and Head Start programs. Once this -- this
23 assessment is conducted and best practices are
24 developed, we'll also be sharing this in the New York
25 State Department of Health Commissioner's newsletter.

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2 We also have many outreach and
3 education media projects happening right now for our
4 grant year and they cover various motor vehicle
5 topics. We will be developing a child passenger
6 safety vehicle and traffic law roll call video this
7 spring. And so actually, within the next month or
8 two, that'll be produced.
9 I think I mentioned on our last
10 meeting but we updated, revised and reposted our
11 Driver's Education Research and Innovation Center
12 Project, which is a curriculum for driver instructors
13 to have a consistent curriculum across the state. So
14 that's specific to teen driving safety.
15 We also have another project that we
16 are beginning, which will be exploring ideas and
17 collaborations to expand the understanding of shared
18 risk and protective factors among teen drivers. We
19 are going to use this to identify evidence based and
20 evidence informed strategies to improve -- improve
21 teen driver safety in the upcoming years.
22 Then lastly, I just wanted to extend
23 an invitation to anyone who might be interested.
24 We're hosting our injury community implementation
25 group meeting tomorrow from one p.m. to three forty-

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2 five p.m. We have two presentations slated. The
3 first is on falls prevention program instructor
4 certifications.
5 And the second is on the New York
6 State partnership against drowsy driving. So if
7 you'd like to attend, just shoot me a quick email. I
8 also just want to mention briefly that we do have a
9 new employee who I invited to this meeting today.
10 Her name is Brittany Pysodee. So she'll be joining
11 me and potentially giving updates at future meetings.
12 Thank you.
13 **MR. COOPER:** Thank you, Ms. Jagoreski.
14 I personally have the I.C.I.G. on my calendar. If
15 you'd be able to send me an invite, that would be
16 great. It's AC38@columbia.edu. Okay.
17 **MS. JAGORESKI:** Sure.
18 **MR. COOPER:** Once again,
19 AC38@columbia.edu. I may already have signed up, I'm
20 not sure.
21 **MS. JAGORESKI:** Okay. I can send that
22 to you.
23 **MR .COOPER:** Thank you.
24 **MS. JAGORESKI:** Absolutely.
25 **MR. COOPER:** Are there any questions

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2 for Ms. Jagoreski?
3 **MR. PHILIPPY:** Yes, so Dr. Cooper,
4 good afternoon. Amy, thanks very much and if you
5 could potentially throw your email address in the
6 chat, that would be awesome. I would -- I would
7 pretty much appreciate any opportunity to attend the
8 meeting tomorrow. I had the recent honor and
9 privilege to be appointed to our local traffic safety
10 board.
11 And one of the things that we did when
12 reviewing Governor's Traffic Safety Committee grants
13 was reach out through our Regional Council and also
14 through a number of other stakeholders to get the
15 word out to local E.M.S. agencies to apply for these
16 grants. So there are a number of different avenues
17 that E.M.S. agencies can take, including, certainly
18 child passenger safety, helmet wear and so on.
19 And I think it's an untapped resource
20 for E.M.S. agencies to look for ways to not only
21 improve their presence and community outreach but
22 also improve safety and survivability. So kudos to
23 you and your team and anything we can do either here
24 at the E.M.S. or on a Traffic Safety Board side, let
25 me know, I'm happy to help.

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2 **MS. JAGORESKI:** Thank you so much. I
3 really appreciate that.
4 **MR. COOPER:** We really appreciate it.
5 Any questions, other questions to Ms. Jagoreski?
6 Well, hearing none, we'll move on to Family Health,
7 Marilyn Cassia, I don't see her name in the -- in the
8 manifest to the right. Is there anybody here from
9 the Division of Family Health? Okay.
10 **MS. EISENHAUER:** Dr. Cassia could not
11 join us today.
12 **MR. COOPER:** Okay. Very good. Thank
13 you very much. Next, then we have a Health Emergency
14 Preparedness and I see that a Kate Butler as a party
15 is with us today. So, Ms. Butler as a party, if
16 you're willing, the floor is yours.
17 MS. BUTLER-AZZOPORDI: Thank you, Dr.
18 Cooper. The Office of Health Emergency Preparedness
19 still remains active in a lot of the response
20 activities as it relates to COVID-19. Although
21 things are definitely shifting to a little bit more
22 of a D.M.O., we still have a lot of things happening.
23 And that's inclusive of working with the state E.O.C.
24 to monitor any of the requests and calls coming in
25 from both the mass vaccination sites and testing and

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2 a lot of the other county efforts.
3 We do still have some significant
4 activity at our medical response cash warehouse,
5 including the ongoing vent right sizing and the test
6 kit distribution. And we do still work very closely
7 to get some of the contract staffing arranged first
8 at those mass vaccination sites and the few remaining
9 test sites.
10 As far as our grant, our staff is
11 working, we are heading towards the end of our budget
12 period three. So we're doing a lot of close out
13 items on the public health emergency preparedness and
14 the health care preparedness program grants. And
15 that is inclusive of one of the functional annexes
16 that we need to complete for this year, which is the
17 infectious disease functional annex.
18 And I do want to put a thank you out
19 to this group because I know a lot -- some of you
20 have sat on both, either some of these states expert
21 in groups as it relates to those and/or have provided
22 feedback to some of the regions as we've been doing
23 those annexes each year. We are also working to
24 outline those same two grants for deliverables for
25 next year for both all of our sub-awardees and our

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2 state related activities.
3 Right now, we have the continuation
4 guidance for the public health side, we are still
5 waiting on some of the continuation guidance for the
6 healthcare preparedness side. So we are kind of in a
7 little bit of a holding pattern. But we are kind of
8 work towards a lot of those -- those things as we
9 move into the next grant year starting in July.
10 And that -- unless there's any
11 questions, that is the end of my report.
12 **MS. EISENHAUER:** We can't hear you,
13 doctor.
14 **MR. COOPER:** I wanted to thank Ms.
15 Butler as the party and just ask if there were any
16 questions for her as a representative of the Health
17 Emergency Preparedness Program Central Office. Well,
18 hearing none, let's then move on to Drew Fried, who
19 was with the Health Emergency Preparedness Program
20 Regional Office in, I believe, Suffolk County. Mr.
21 Fried.
22 **MR. FRIED:** Good afternoon, everybody.
23 Thank you for letting me speak over today, just a
24 couple of things. The narrow office, which includes
25 Long Island and low Hudson Valley, has been looking

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2 at pediatric capability capacity since about 2014.
3 This year, we are trying to get back on track with
4 many of our activities. We are slowly demobilizing
5 from our COVID response and moving into the normal
6 activities.
7 We did this year with the Long Island
8 facilities put out a -- a survey to them to determine
9 what their capability would be particularly on blue
10 sky days, on a normal day. We're also in a disaster
11 response so we can gauge our planning for a future
12 pediatric ... These are what we need to do.
13 We continue to look at our regional
14 pediatric response plan, which was completed in 2020.
15 In consultation with the state plan, which I know
16 many of you come to help us prepare that on the
17 statewide level. We continue looking at pediatric
18 training. We are supporting the Finger Lakes region
19 by providing their analysis to their pediatric ... to
20 our facilities and also our pre-hospital, E.M.S.
21 folks. We are trying to become more engaged with the
22 E.M.S. agencies within our region, not only on
23 pediatrics but on many of the activities that they do
24 daily.
25 We continue, of course, the training

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2 based on our healthcare threatening hazardous
3 assessment, which does include pediatric related
4 risks and threats. Hopefully, this work group will
5 reinvent itself, coming out of COVID. And we look
6 forward to our next budget period, which Kate
7 mentioned starts in July, with future pediatric
8 activities and ... for both our hospital and pre-
9 hospital folks. Thank you, Dr. Cooper.
10 **MR. COOPER:** Thank you, Mr. Fried.
11 Are there any questions for Mr. Fried and
12 representatives from the marrow region of the Health
13 Emergency Preparedness Program? Well, hearing none,
14 Mr. Fried, I'd like to reach out to you offline, if
15 you don't mind, regarding the New York City
16 initiatives, which I mentioned ... familiar and I
17 presume you're drew.fried@health.ny.gov. Is that
18 right?
19 **MR. FRIED:** Yes, I am. I look forward
20 to speaking to you, sir.
21 **MR. COOPER:** Great. Thank you so
22 much. Unfortunately, I just learned that George ...
23 from the census initiative is not with us today. I
24 know we had really hoped to get an update from the
25 census program at this particular meeting. And for

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2 reasons unknown to me, they were unable to be with us
3 today. So we will sadly have to wait until next
4 time.
5 **MS. JAGORESKI:** Dr. Cooper?
6 **MR. COOPER:** Yes.
7 **MS. JAGORESKI:** This is Amy. Just
8 quickly, I know ... we have had discussions with the
9 ... looking at E.M.S. data and criteria, et cetera.
10 So they did reach out to myself and Peter and we will
11 be working with them on -- on discussing what we
12 discussed at the last meeting.
13 **MR. COOPER:** Sure, yeah, they had
14 also, as I recall, indicated that they'd be able to
15 give us an update on the, you know, the pediatric
16 data, you know, the statewide pediatric data, not
17 just the E.M.S. data. So next time, we'll -- we'll
18 be able to get a report on all of that, I hope. So
19 there we are.
20 Okay. If my memory serves me
21 correctly, neither STAC nor the pediatric trauma
22 subcommittee has met since the last meeting. Jose,
23 am I correct or am I not correct?
24 **MR. PRINCE:** That -- that's right, Dr.
25 Cooper. We have not met since last time. I don't

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2 know if you discussed the reasons why at the
3 beginning of the call. I'm sorry, I was a few
4 minutes late to join.
5 **MR. COOPER:** No, we didn't. So, you
6 know, I've just jumped over this SESCO SEMAC report
7 because I know Mark Philippi has a great deal to
8 share with us. And I -- I know how busy you are.
9 **MR. PHILIPPI:** Yeah. No, no, no.
10 **MR. COOPER:** ...
11 **MR. PHILIPPI:** I think -- sure. I
12 think for the group, you know, Dr. Marks' death was
13 instrumental as an instrumental force in the state.
14 And it -- to some degree in deference to -- to his
15 unexpected death as the chair of the STAC, that the
16 STAC meeting was postponed. The ARTECH meeting
17 similarly was postponed. That one has been
18 rescheduled for the ARTECH New York City will be
19 occurring in April. And I believe the STAC has a new
20 date that they're working on, correct?
21 **MR. COOPER:** I believe that's correct.
22 I think we were told it was May 4th. Is that right,
23 to Amy?
24 **MS. JAGORESKI:** Yes. After much
25 discussion, the last that I heard it will still be

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2 May 4th, because there will only be a few members
3 missing that are attending that conference, I don't
4 remember the name of it. But there will be only one
5 or two people that will miss the meeting.
6 So trying to reschedule the whole
7 thing and everybody involved and the staff was more
8 crazy than two people missing.
9 **MR. COOPER:** Yes.
10 **MS. EISENHAUER:** May 4th, at the Troy
11 Hilton Garden.
12 **MS. JAGORESKI:** Thank you, Betty.
13 **MS. EISENHAUER:** Yes. Yes, ma'am.
14 **MR. PHILIPPI:** And I think --.
15 **MR. COOPER:** And the call ... refer as
16 the blood conference?
17 **MS. JAGORESKI:** Do you know the name
18 of the conference that is ... Amy?
19 **MS. EISENHAUER:** That I don't know.
20 **MR. COOPER:** Okay.
21 **MR. EISENHAUER:** I can find out.
22 **MR. COOPER:** All right.
23 **MR. HASSON:** So I think the only thing
24 I could add to the group, Dr. Cooper, is that the --
25 in the interim the American College of Surgeons

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2 Committee on trauma did meet in Seattle and, you
3 know, I was able to partially participate, myself. I
4 was present physically but under a COVID quarantine.
5 So not myself but due to an exposure.
6 So -- but that was the 100th anniversary meeting of
7 the American College of Surgery Committee on Trauma.
8 There is a new guideline that version that's coming
9 out. And actually that will be dedicated to Dr.
10 Marks, because he was chairing that group at the
11 time.
12 And so there'll be a great deal of
13 information that comes out from as a result of that
14 for future verifications that would be impactful to
15 centers across New York State as a participating
16 state.
17 **MR. COOPER:** Great.
18 **MR. HASSON:** That's it. So thank --
19 thank you, Dr. Cooper for letting me present.
20 **MR. COOPER:** Yes, for those of you who
21 did not know Dr. Marks, he was -- he chaired the STAC
22 for close to 15 to 20 years, I believe. And was
23 instrumental not only at our -- in our state system
24 but also nationally in terms of ensuring that
25 standards of quality for trauma were, you know --

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2 were maintained. His loss will be a great loss not
3 only to the state but to the nation.
4 Okay. So now, unless there are no
5 questions -- unless there are any questions, I should
6 say, for Dr. Prince or myself. Mark Philippy, the
7 chair is yours -- or the floor is yours. And hope
8 you're sitting in a chair. The floor is yours to
9 tell us about what the State Council has been doing.
10 I think we're all particularly
11 interested, as Director Greenberg intimated early in
12 our meeting, in your remarks on the sustainability
13 issues that council has been working on, so please
14 take it away.
15 **MR. PHILIPPY:** Thank you, Dr. Cooper.
16 Good afternoon, everyone. So first to speak with
17 some alacrity on the matter of our technical advisory
18 group on sustainability. One of the first things we
19 realized early on when Chief brought this forward,
20 was that we really need to understand the scope of
21 the problem. Of the initial meetings of the group,
22 there were over forty-five participants in the very
23 first meeting, which is unheard of.
24 We have folks involved in this process
25 from every walk of the E.M.S. and emergency

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2 management community from 911 center coordinators to
3 insurance companies, from medical directors,
4 practitioners, to emergency management, folks. So
5 every aspect of this is looking at the problem.
6 And so we have established seven
7 subcommittees, if you can imagine, so the tag is
8 actually taking -- taking something of a life of its
9 own, which is great to see because this is an
10 obviously very important issue. As Dr. ... pointed
11 out and said earlier today, we were talking about the
12 issue of sustainability in terms of staffing and ...
13 but there are -- there are many facets to it, as the
14 director pointed out.
15 So currently, we have a government
16 support and public information group that's working
17 to figure out some of our stakeholders exist in
18 government and public service. We're looking at
19 operations. So there's a lot of E.M.S. Leadership on
20 that -- on that group. The identifying the problem
21 group is probably one of the most interesting because
22 we're really trying to hash out what sustainability
23 means and in what facets.
24 So not just in terms of staffing but
25 also in terms of business models and in terms of

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2 geography. And many of the things that were actually
3 brought up in the governor's budget proposals talking
4 about changes in Article 30 and the process are
5 probably well -- well placed in this committee to try
6 and identify how we attack that. The agency group
7 also another one predominantly involved with
8 leadership but also trying to look at different
9 models of operation.
10 Talking about education, how does
11 education impact this and we certainly understand
12 that there has been throughout COVID a considerable
13 challenge to bringing new E.M.T.s and paramedics into
14 the profession. There have been many times issues
15 with the availability of practical skills training,
16 as I was going to mention earlier but now that I have
17 the -- now that I have the seat, so to speak.
18 The protocol discussion earlier was
19 poignant in the fact that there's a very specific
20 section on de-escalation listed in there. And that
21 is not a skill set that E.M.T.s or paramedics are
22 well trained in. That is something we've locally
23 recognized. And I think that is something that needs
24 to be taken up further through the SEMAC and SEMSCO
25 in our next meetings as a discussion of how we

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2 incorporate verbal de-escalation skills into our
3 E.M.T. training.
4 We are very skills focused in E.M.S.
5 and perhaps at the detriment of our verbal abilities
6 and verbal skills. So I think that's one area that
7 as we talk about particularly the rising scope of
8 behavioral health issues in our community, we need to
9 train our E.M.T.s and paramedics to deal with that
10 effectively.
11 So while I applaud that the M.S.C.
12 group for putting that in the protocol, I also
13 caution that we need to address the training aspect
14 in that and that's something that the sustainability
15 tag is going to look at as well. There is a hospital
16 subgroup that involves a lot of hospital
17 administration folks looking at their issues. And
18 then certainly among those, as the director
19 mentioned, is the -- the wall time or drop time
20 issue, which has definitely impacted our
21 availability.
22 Certain agency that I have some
23 knowledge of, has statistically analyzed that over
24 thirty percent of their available unit, our
25 utilization was tied up on the wall, if you will, or

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2 waiting in hospitals for a patient drop off. So that
3 could be as many as -- as ten ambulances now being
4 tied up, not available for a call.
5 And again, there's no finger pointing
6 here. It's a fact. We just need to figure out how
7 to address that and work through it. And then
8 finally, of course, the -- the eight-hundred-pound
9 elephant in the room is the staffing issue, now we're
10 going to address staffing holistically through not
11 just retention or not just through recruitment rather
12 but also retention issues, provider mental health,
13 provider resiliency. Those are all things that we've
14 tried to address in other ways.
15 But I think the tag has got a great
16 handle on that as well. So in short, seven subgroups
17 of forty-five members and total group working on
18 things that we as a council have been wrangling with.
19 The end result of this is we are hoping to produce a
20 white paper that addresses these seven areas. This
21 white paper will be hopefully as influential as the
22 workforce -- workforce study that Steve Kroll did
23 back in 2019.
24 And to that end, I know that Mr. Kroll
25 and director have also worked on revamping and

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2 revising that 2019 workforce study so that we can
3 send that back out and get a -- kind of a new
4 perspective on post COVID. We knew we were facing
5 problems back in 2019. How have things changed over
6 the past three years?
7 So those are some of the major
8 projects that that group is working on. Going
9 through our normal committee groups, there is not
10 anything that I know of involving E.M.S. systems
11 right now. Finance Group is kind of on hold right
12 now. And we try to look into see what the governor's
13 budget and the legislature do with that coming
14 forward. Medical standards, as you know, Dr.
15 Marshall and his team will be working on protocol
16 revisions throughout our next meeting.
17 There's nothing going on in safety,
18 per se. There's some old business there they're
19 trying to work through. And the two new committee
20 standards of excellence and quality metrics -- sorry,
21 E.M.S. innovations and quality metrics, my apologies,
22 have had meetings. It's very positive work on those
23 as well. Mr. Hanng is here today.
24 And they have Dave Villante working
25 with his team, quality metrics. They are working

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2 with doctors ... and Dorset to bring -- ... finally
3 revised the statewide quality improvement quality
4 assurance processes. That has been an ongoing
5 concern of ours. And I'm very pleased to see that
6 they're making some great progress there.
7 So we are cranking away. I'm very
8 pleased that we are going to be able to meet in
9 person in April, because I think as we -- we proved
10 in October, we got far more work done when we were
11 able to meet in person than we did in either January
12 or in prior meetings, which were wholly virtual.
13 So I'm hoping we continue down that
14 trend. And it was said that most of the work of the
15 council was done not in the council chambers but in
16 the hallways. And I do firmly believe that is the
17 case. There's a lot of things that we can do and I
18 think that we -- the pressure on so this will be a
19 very interesting meeting. That's all I got. Thanks,
20 Dr. Cooper and I'm happy to answer any questions.
21 **THE REPORTER:** Dr. Cooper, you're
22 muted, sir, sorry.
23 **MR. COOPER:** I'm sorry?
24 **THE REPORTER:** You are muted so.
25 **MR. COOPER:** Can you hear me?

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2 **THE REPORTER:** We can, now, yes, sir.
3 **MR. COOPER:** I think I'm unmuted now.
4 I just asked when you anticipated the white paper on
5 sustainability might be -- might be available.
6 **MR. PHILIPPY:** I think it was our
7 intended -- our intended goal to have it done by the
8 end of 2022. I did initially, I had kind of a pie in
9 the sky idea that we would have it done by the
10 summertime but there is just so much work going on
11 and active work, I have to admit, that these folks
12 are meeting almost weekly if not twice weekly in some
13 cases.
14 So I can't fault them for wanting to
15 take a little bit longer to look at the problem from
16 these different perspectives. So I think it's very
17 fair to say that we're going to aim for the end of
18 2022 and potentially have this ready for the council
19 meeting first in '23.
20 **MR. COOPER:** Thank you so much. Any
21 questions for Chief Philippy? Well, hearing none.
22 Mark, I want to thank you for a very comprehensive
23 report. I -- I know all of us are, you know, deeply
24 indebted to you and the Council for taking on the
25 issue of sustainability. Director Greenberg had set

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2 a big role in supporting that initiative, for which
3 we thank you, Ryan. You know, this is, we all
4 recognize perhaps, you know, the most important issue
5 facing E.M.S., in this day and age.
6 We all understand that the staffing
7 issue is huge and difficult. But knowing the
8 brainpower that you've been able to amass, I have no
9 doubt, though, that you'll come up with some really
10 solid suggestions and recommendations that hopefully
11 can be implemented in short order and we look forward
12 to that report.
13 So that concludes our -- our published
14 agenda. We do have a bit of additional time that I
15 had not quite anticipated. I might add that for one
16 of our shortest meetings on record, we have
17 accomplished quite a bit in terms of getting those
18 two protocols discussed and forwarded to SEMAC. That
19 will really make a huge difference to the lives of
20 children in New York State.
21 Does anybody else have any issues that
22 they might want to bring up at this time? Well,
23 hearing none, I guess we can give you an hour back
24 out of your busy day. And all of your busy days and
25 we will see you next time. Amy, we have a June

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2 meeting. Do we not?
3 **MS. EISENHAUER:** We do not have a firm
4 date yet. But if we go the quarterly route, June
5 would be the timeframe.
6 **MR. JAGORESKI:** Okay. Very good.
7 Well, we will see. So I know Amy will be working
8 hard on that. And we'll hope that we will have a
9 June meeting and maybe our assessments colleagues
10 will have something for us at that particular point.
11 And Dr. Vander Jagt and I will be working with you
12 Amy to, you know, come up with -- with an agenda
13 worthy of our collective time. So there we are.
14 Amy, Director Greenberg, any last comments?
15 **MR. GREENBERG:** Nothing for me.
16 **MS. JAGORESKI:** Nothing here either.
17 Please complete ...
18 **MR. COOPER:** Okay. It did. Okay.
19 Well, thank you all so much for attending and we will
20 see you in June or --.
21 **MS. JAGORESKI:** Okay. Wait, we need a
22 motion for adjournment. Motion for adjournment.
23 **MR. COOPER:** I was --.
24 **MS. JAGORESKI:** Okay.
25 MR. Barry: Bruce Barry, so move.

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2 **MR. COOPER:** Move, okay, very good.
3 Thank you so much, everybody.
4 **MR. PRINCE:** Jose Prince, second.
5 **MS. JAGORESKI:** Thank you, Bruce.
6 **MR. COOPER:** All in favor?
7 **UNIDENTIFIED MALE SPEAKER:** Aye.
8 **UNIDENTIFIED FEMALE SPEAKER:** Aye.
9 **MR. COOPER:** Okay. All right. Thank
10 you. Have a good day, everybody.
11 **UNIDENTIFIED MALE SPEAKER:** Yeah.
12 Thank you all.
13 **MS. JAGORESKI:** Thank you all. Have a
14 good day.
15 **UNIDENTIFIED MALE SPEAKER:** Thanks
16 everyone.
17 **MS. JAGORESKI:** Enjoy the spring
18 weather.
19 (Off the record)
20 (The proceeding concluded at 3:06
21 p.m.)
22
23
24
25

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1 3-22-2022 – EMSCAC Meeting - Webex
2 STATE OF NEW YORK
3 I, ANTHONY McCLAIN, 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 1 hereof; that
6 the foregoing typewritten transcription consisting of
7 pages 1 through 96, is a true record of all proceedings
8 had at the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 1st day of April, 2022.
11
12
13 ANTHONY McCLAIN, Reporter
14
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