1/31/23 - EMS for Children Meeting - WebEx

NEW YORK STATE

DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICE FOR CHILDREN MEETING

DATE: January 31, 2023

VENUE: WebEx (virtual)

CHAIR: ARTHUR COOPER, M.D.

APPEARANCES:

AMY EISENHAUER
RYAN GREENBERG
ELISE VANDERJAGT
JOSEPH PATAKY
SHARON CHIUMENTO
MATT HARRIS
JEREMY CUSHMAN
PAMELA FEUER
EDWARD CONWAY
AMY JAGARESKI

DAVID VIOLANTE
MICHAEL REDLENER

DARLENE REDA
JENNIFER SALOMON
BROOKE LEARNER
MARILYN KACICA
KATE BUTLER
DREW FRIED
GEORGE STATHIDIS
JOSE PRINCE

(The meeting commenced at 1:13 p.m.)

MS. EISENHAUER: Good afternoon, everyone. Thank you for joining us. We are all here now and we'll get started. So I'm sharing the agenda on the screen.

Also, Court Reporter, we can go on the record.

THE REPORTER: Okay. I have us on the record.

MS. EISENHAUER: Excellent. I'm sharing the agenda on the screen, but you can also find this in your Boardable account with the other associated documents attached under the subject that they're in.

And when you speak, as you know, we have the court reporter here, just say your name beforehand. It makes it easier for them to take the minutes. And with that, I will turn it over to Dr. Cooper.

DR. COOPER: Good morning, everyone -- or good afternoon, I should say. Thank you for your patience in getting started this afternoon. Unfortunately, Boardable would not let me in and I needed Amy's immediate assistance to overcome that --

that obstacle.

Amy's already introduced the agenda to you. The first item of business today will be a roll call. Amy, if you want to do that or if that's something you want to do, just off the -- the Webex?

MS. EISENHAUER: I have to do the -- the roll call and folks have to say that they're present for -- for our record.

DR. COOPER: Okay.

MS. EISENHAUER: So -- so I'll start that and I'll start with you, Dr. Cooper.

DR. COOPER: I'm here; thank you.

MS. EISENHAUER: Dr. van der Jagt?

DR. VAN DER JAGT: Yes, I'm here.

MS. EISENHAUER: Thank you.

Dr. Albert?

DR. ALBERT: Present.

MS. EISENHAUER: Wonderful. Bruce Barry?

DR. COOPER: I know Bruce said he was going to be here.

MS. EISENHAUER: I -- I -- I saw him on the list.

DR. COOPER: Yeah, he's on the list.

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MS. EISENHAUER: Okay. Sharon Chiumento?

MS. CHIUMENTO: I'm here.

MS. EISENHAUER: Awesome. Dr. Conway?

DR. CONWAY: Here.

MS. EISENHAUER: Hi.

Dr. Pamela Feuer?

DR. FEUER: I'm here.

MS. EISENHAUER: Thank you.

Dr. Jose Prince?

DR. PRINCE: Present.

MS. EISENHAUER: Thank you.

Dr. Jennifer Havens is excused for this meeting.

Dr. Vincent Calleo?

DR. CALLEO: I'm here.

MS. EISENHAUER: Hi.

Doug Hexel is also excused for this meeting.

Nickol O'Toole?

MS. O'TOOLE: I'm here.

MS. EISENHAUER: Thank you.

Dr. Bombard?

DR. BOMBARD: Dr. Bombard here.

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MS. EISENHAUER: Thank you.

Dr. Harris?

DR. COOPER: He was on a minute or two ago. I just don't see him now.

MS. EISENHAUER: Okay. Chief Pataky?

MR. PATAKY: I'm here. Good afternoon.

MS. EISENHAUER: Good afternoon.

And Jason Haag?

MR. HAAG: I'm here.

MS. EISENHAUER: Excellent.

And we have two other members that their vetting is still in process. Ben Kasper?

MR. KASPER: Here.

MS. EISENHAUER: And Sara Gruver?

MS. GRUVER: I'm here.

MS. EISENHAUER: Excellent.

And Bruce, I see that you raised your hand?

DR. COOPER: Yes, Bruce Barry just joined as well, yes. Thank you.

MS. EISENHAUER: Awesome. Okay. All right. Well, we have quorum, and I will turn it back over to Dr. Cooper.

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DR. COOPER: Thank you so much. And I will turn it over now to Professor Ryan Greenberg, Director of the Division of -- the Bureau of Emergency Medical Services and Trauma Services Bureau.

Thank you, Ryan.

MS. EISENHAUER: Actually, before -- before Ryan gets started, we need to have --.

DR. COOPER: Thank you. Sorry. Sorry. Sorry. And yeah, let's -- has everyone had an opportunity to review the minutes from September? In that case, I'm -- I'm taking the silence as a yes. And can I have a motion to approve, please?

MR. BARRY: I move, Bruce Barry.

DR. COOPER: Bruce Barry. Second, please?

MR. HAAG: Jason Haag, I'll second that.

DR. COOPER: Jason, thank you.

Any additions, deletions, corrections, or discussion? Hearing none, all in favor, please signify by saying aye?

ALL: Aye.

DR. COOPER: Any -- any opposed?

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Motion -- the motion is unanimously approved.

Okay. Ryan, it's all yours. Thank you.

MR. GREENBERG: Good morning -- good afternoon, everyone. Not good morning, good afternoon. Time flies. So I'm going to talk about a couple things with the Bureau, and things going on with E.M.S. in general right now for situational awareness.

And then, I know Amy's going to step in and really talk about the -- the E.M.S. for Children's portion of this. So the biggest thing, kind of the main things going on right now is next week is state council meeting so starting to prepare for that one.

And there's been a technical advisory group set up about a year ago now, probably a little over a year ago now to look at E.M.S. sustainability. And so that group has concluded and -- and they're working writing a white paper for the State Council.

And so they, we believe, you know, so getting approval process and everything and that white paper will be released next week, and really goes into an amazing analysis of, you know, where we

are today, where the system is today.

This was, you know, chartered by Chairman Philippe from the SEMSCO to look into these issues. And that task, under the ... really pulled together this group of about fifty subject matter experts from all different parts of -- of E.M.S. So from volunteers to career to commercial services to fire based non-profit, they all really were well represented.

And so the collaboration was just incredible. And you know, when -- when they were getting towards the end, the nice part was that you look at it and it really is about the system and about the design and it's about, you know, kind of what -- what will the future look like.

And so we're -- we're excited to see that, you know, come to fruition and move forward. E.M.S. has been a hot button topic lately. It was mentioned in the budget, so we're still waiting to see, you know, what that will yield as well.

And you know, just the importance of where it is, what it can do and -- and also access to care. So we, you know, we are working on more getting out the emergency triage treatment and

transfer emergency triage treatment for transport program, which uses telemedicine, and which uses a number of different people. We've never used any kind of support.

And so you know, through a pilot program that the federal government -- that program is really starting in New York, just starting to -- to move forward now.

And I bring it up -- this up to this committee because if that program is moving forward, there's going to be another focus on pediatrics. I -- I can tell you, as a parent myself, I had two sick kids at home, we needed to go and, you know, and see -- go to urgent care. We walked in and the urgent care said, no problem, we can see you today, come back in six hours. And they wrote my name down and six hours later I came back, and we were seen.

But the point is that, you know, we need to look at different ways of delivering health care that we do. And that's not just to adults, but that is equally as important for children, both for the care of the children as well as for the parents who are, you know, wanting to care for their children.

So we're really excited to kind of see what the next chapter will bring. And I think this committee, you know, E.M.S. for Children will really be a critical component of that, both in the pre-hospital setting, and then, obviously, what I think Amy's going to be talking about on the actual moving into the hospital, and how prepared are our emergency rooms.

Yesterday, Dan Clayton, myself, and Patty had the opportunity to go to a hospital which is looking to become a level three trauma center. And you know, they were showing us -- talking about pediatric care, talking about the program, they were very well aware of it.

Why? Because it's part of the standards coming out in the future to these E.R.s that are trauma centers as well to be pediatric prepared. Know what they're doing, and how they're going to treat these patients. And so as we went into trauma rooms, they had pediatric equipment, they had the ... and everything else, and were quick to show hey, you know, we have everything here, should we, you know, need to care for -- for -- for anybody from infants all the way up.

So again, these programs are making a difference. These programs are -- are getting out there. People are engaging in them and then hopefully, you know, we'll start seeing the outcomes as well.

Other things going on the year right now, we have a lot of contracts that are just finally being finalized for our program agencies and for our regions. On the education front, we continue to, you know, look at new and different ways to -- to get education out there.

And during my drive back up from the Broome County for that general area, you know, I was talking to our education staff to find out where are there E.M.T. and paramedic classes between here and Albany.

And you know, the problem with it is pretty sparse and so, you know, we want to build a workforce, we want to build people who can go out and provide the care. But we might -- you know, part of our problem might be, we don't have the education in the right places. So we're going to take a look at that one to see where our core sponsors are, and not just being a core sponsor, but actually offering

classes and putting them out there.

For data and informatics team doing some really great stuff, both using Tableau for a number of reports a number of things that we've been looking at lately, as well as using biospatial, which is a platform that we'll be rolling out during 2023. We're just getting started on the rollout now.

The agencies can start to look at how they're doing, how they -- they're benchmarking their care. Again, really important on our pediatric side. And the important part of biospatial is that most agency see only a small amount of pediatric patients.

And so if we can start to say, well, we can compare the small amount that you're seeing, to a bigger picture, so you can understand how your care is doing, that's huge in being able to allow them to continue to improve.

I'm very excited to have Jacob here on the -- on the E.M.S. for Children side, officially. I can't remember if that was the -- the case at the last meeting or not. We have Vital Signs coming up in October, but the important part right now is our Vital Signs call for speakers is open.

And again, bringing up to this group

who are subject matter experts in pediatrics, you know, if you are interested in speaking at our Syracuse conference, please go to Vital Signs conferences webpage and take a look at there and please ... We'd love to have some more pediatric topics there, you know. Amy will be pushing for more pediatric topics.

And, you know, in addition, we -- we've seen it. We see it, you know, in both our patient population, but also as well as, you know, in our providers, but -- is our mental health.

And so we're really excited to have the substance abuse and mental health course that is going around the state by one of our ... It's an eight-hour course for E.M.S. providers to be better prepared on how to deal with patients with substance abuse or mental health issues, as well as for their own health and what to do there.

So that class can be offered for free anywhere around the state and we're looking for locations. So if you are an agency or a hospital or something and you think you want to offer that in your community, we'll send the instructor, literally traveling around the state. I will set dates and

send them out to you. So if you want to be a champion and help us out, if you have some space to hold that class, it's a wonderful class and a great opportunity.

Two last thing, kind of, on our side, from a regulatory point of view, we have two regulatory packets that are going up. One which is for education, which is, you know, to really modernize some of our education's needs. The other one's for operations where we're going to update our equipment ... of that nature.

And that's really important on the pediatric side, because those -- some of the things weren't a requirement prior to that will be a requirement now related to pediatric care in New York State.

We continue to have the executive order four in place, which is for staffing crisis. That helps us a lot related to paramedics being able to work in alternative locations and community paramedicine and things like that, so that was renewed for another thirty days.

And then, a -- a really important one, and hopefully, starting in February -- actually, will

start in February, I don't know when, is a Rural Health Taskforce. The Rural Health Taskforce is put together through -- through the legislative action and they've had about twelve or fourteen members on it.

And they'll be doing a study just looking at E.M.S. in rural settings and the care that they're delivered, and what we need to look at in the future.

So again, pediatrics, I'm sure will be a portion of that in making sure that even if you live in a rural part of New York that you're still able to get the care that you need.

That is everything that I have. I'm happy to answer any questions, comments, or concerns. I know there'll be a lot happening in the next week or so. So look forward to hearing from any of you. If you do have any questions that didn't come up, please, by all means, feel free to reach out and I'm going to pass it to Amy.

MS. EISENHAUER: So --.

DR. COOPER: Ryan, thank you so much. I -- I -- I do have a question. The mental health course that you referenced, do you know, regarding

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the mental health course that you -- that you referenced, as you well know, we're working very hard on the pediatric education training for New York State.

I wondered to what extent if the statewide eight-hour course includes any information relative to pediatrics ... on de-escalation of the pediatric age range?

MS. EISENHAUER: So yeah. So it does include pediatrics. And the crux of the course, which is funded by OASAS is substance use disorder and behavioral health and how those intersect. So there is some information on pediatrics because, as we know, pediatrics in New York State, you know, for E.M.S.C., we cover up to the age of eighteen. In our protocols, we cover up to the age of fifteen as pediatrics. So there is some information on rates of substance use disorders among older children and how those things intersect with behavioral health.

There is some information on basic de-escalation for all patients and there's also information on trauma informed care and how to converse with patients that might have had poor experiences in health care previously, and how we can

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better relate to patients, so they trust us to help them.

And Jenny will be on in the end half of our meeting to talk about the program.

DR. COOPER: Great. Will -- will it be possible for those of us who were on this committee to attend one of the programs, so we can learn more about it and have a very clear understanding of what -- what it addresses and what it doesn't from a pediatric point of view?

MS. EISENHAUER: Absolutely. That would be wonderful.

DR. COOPER: Okay. Amy, let's you and I converse about after the meeting and we'll figure out a way to make that happen. Okay?

MS. EISENHAUER: Yeah.

DR. COOPER: Any other questions to Dr. Greenberg?

DR. VAN DER JAGT: Yes.

DR. COOPER: Elise?

DR. VAN DER JAGT: Yeah. Thank you. Dr. Van der Jagt here. Just two things. First, I want to endorse what Dr. Cooper said about that eight-hour course. I'm glad we're hearing a little

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bit more about it later.

But I think it would be great to just look at it and see whether there's some areas that, you know, could include maybe more -- a little bit more pediatrics.

But what I wanted to ask you, Ryan, is you mentioned Vital Signs is in October and you're looking for pediatric speakers. If we know of, you know, a few people who might be relevant for that, who do we contact?

Is it you or is it someone else who is running -- who was developing the program for that Vital Signs?

MR. GREENBERG: Yeah. So anybody can apply. So -- so what I would recommend for them to -- to submit, to present on the Vital Signs academy -- sorry -- Vital Signs conference website. And then, if you know the person or you've heard the speaker, you know, have a strong recommendation of them, I would recommend that you pass it along to Amy. And Amy can make sure that Val Ozga, who's our conference coordinator, is aware of that so when we're looking through and evaluating all the speakers, definitely give weight to those who we, you know, know have a

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great course, great content, is a good speaker.

DR. VAN DER JAGT: Okay. So what I'm hearing here is go to the Vital Signs website to look a little bit over the conference, and then use Amy as the person to refer folks for who might be good speakers for that?

Because you have to sort them out if you have ten zillion speakers, which I don't think you'll have and you might have in pediatrics, and you would have to obviously decide which ones to do so. Thank you very much.

DR. COOPER: Elise, Tiff Bombard just posted in the chat the link to the -- to the speaker's site that Ryan referenced. So let me just also add that Amy and I had a very brief discussion about -- about presentation at Vital Signs.

And I know she's planning on two presentations at the present time.

That's not actually listed in your -- your grant report, Amy, but do you want to share with the group what -- what your thoughts were about at least two programs at the Vital Signs conference?

MS. EISENHAUER: So yes, Dr. Cooper and I talked about some potential programs and

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topics. And one of them was de-escalation, which obviously right is -- is a big topic for all patients at this time. So I know Sara Gruver, who is awaiting vetting for -- for our committee, she does quite a bit of education on de-escalation for pediatric patients. And it's kind of her wheelhouse, so I hope that Sara will submit that topic.

And then, also triage, so triage update which is one of our subgroups, obviously, having some -- some information on that so that providers can be up to date on that topic and have all the most relevant information.

DR. COOPER: Thank you, Amy. I see that Sara put a note on the chat, saying that she is working on her submission, and will get it in this week. Thank you.

Thank you so much, Sara.

Any other questions for Ryan Greenberg, or -- or Amy part one? All right.

MR. GREENBERG: One more --.

DR. COOPER: Sure. Ryan, go ahead.

MR. GREENBERG: One more thing, I want to thank Chief Pataky who will be joining us on our training and education committee over on the SEMSCO.

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And I bring that up to this committee because you talk about education, you talk about the importance of pediatrics and the different options, you know, that are there. This could be another great opportunity to bridge those two and make sure that, you know, pediatric is, you know, well represented within the training and ed committee on the SEMSCO.

So again, just something else that's worth thinking about that and I know there's a lot of crossover views, but I don't know if anybody on the committee or on this council asked this on training and ed committee within SEMSCO so that can be another great bridge to talk about, you know, pediatric education.

DR. COOPER: Thank you, Ryan. Your -- your comment just reminded me of another mental health issue with respect to children. The National Advisory Committee on Children and Disasters met last week and in its -- in its -- one of its semi-annual public meetings.

Children's mental health during disasters figured very prominently in that -- in that discussion. But one of the points that -- that was made is that there seems to be a sense that

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psychological first aid is almost, you know, sort of something that comes naturally to E.M.S. providers.

While I won't disagree that that's true, at least in principle, there are -- there are certain, you know, tenets that really need to be addressed during, you know, psychological first aid discussions. And -- and I do hope that this will be part of any future discussions that we have going forward regarding pediatric mental health for individual cases that E.M.S. encounters every day in a disaster situation.

So just something to make note of for all of us. And, Amy, I'll now turn this over to -- to you for the grant update. Thank you.

MS. EISENHAUER: Dr. Van der Jagt, you have your -- your hand up.

DR. VAN DER JAGT: Yeah. I just want to -- thank you very much. I just want to endorse what you said, Dr. Cooper, about the importance of -- of approach to children who have challenges, anxiety, or other mental health disorders.

And what I -- I think the -- the effort should be is the statement of that every phrase or every word is to be considered in

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medication, you know. And so if we take think about it in those terms, then, it becomes very clear that what you say does matter, how you say it does matter. And that some guidance, very specific guidance about those words that might be said might be very helpful to the E.M.S. provider.

DR. COOPER: Thanks, Elise. I'm -- I'm -- I've not heard that -- that phrase before that for pediatric mental health issues that every word is like a medication. I think that's a beautiful way to think of it.

I -- I will share those thoughts with David Schonfeld who is, as you know, a major pediatric mental health expert and is currently chairing the National Advisory Committee on Children and Disasters.

And I know that point was made during the recent meeting, not in those words, but I -- I think that -- that it deserves reinforcement. And I really appreciate your -- your bringing that up again. Thank you.

So now, unless there are other comments, I think Amy, it is your turn, at long last. Thank you.

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MS. EISENHAUER: Thank you all. And I would -- I would like to add that we have a lot of -- we were very lucky on E.M.S.C. that we have a lot of the training and ed folks. You know, in addition to Chief Pataky being drafted, we have Jason Haag and, of course, Mike McEvoy is here, so lots of folks to help us with -- with any trainings that we might need.

So E.M.S. for Children grant update, I know that and let's -- let's see if I can get my computer to work.

So welcome, Jacob DeMay. So excited, if only you knew. So Jacob is here in the background right over here. You can't see him, but he is the one making all the tech things happen and all our data things happen. And so I'm very excited that Jacob is here to help. So welcome again, Jacob.

So E.M.S. for Children grant submission update. Our last meeting, I believe, was in September. And in that time, in November, we submitted our next four-year grant submission. And it covers April 1st of this year to March 31st, of 2027. It was submitted by H.R.I. in November and I'm hoping that they tell us before April that we are re-

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funded because the next grant year starts April 1st.

So hoping that they notify a little sooner, but by April we will know if we are funded again.

So specific performance measures, as we had this last five to six years, there was a booklet with all the performance measures and information and where you can find the resources. That document has not been released yet.

But the notice of funding opportunity highlighted some focus areas that we needed to respond to. And obviously, that's the pre-hospital and emergency department, pediatric emergency care coordinator programs. Those will be -- those will be a major focus and also recognition programs to coincide with the pediatric emergency care coordinator programs for both pre-hospital and emergency department.

Also, pediatric disaster response has an increased focus with both hospitals and E.M.S. involved. So prior to now, hospitals have been involved in disaster preparedness for pediatric patients and also patients with special needs has been a focus of the E.I.I.C., but E.M.S. is now

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included in that -- in that focus for E.M.S.C.

All right. Hang on. I feel like -- here we go. Okay. So E.M.S.C. advisory committee participation is going to be a highlight, which thankfully is great for us because we already have a really robust participation with all of you.

They are highlighting the specific work of the family advisory network, or the FAN, members in E.M.S.C. programmatic work, which we already have, which is wonderful. Sara Gruver and Nickol O'Toole are both practicing paramedics and work in E.M.S. education, so they've already been doing that work so I feel very confident with that -- with that highlight.

Also continued focus on including pediatric skills in education for both E.M.S. and hospital providers. Ryan mentioned that E.M.S. at large sees a small portion of pediatric patients, which really highlights the need for -- for continued education in peds, especially using the tools, practicing skills, practicing scenarios.

And then, also weight measured in kilograms, not converted from pounds, actually weighing in kilograms for hospital-based providers.

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So those are the highlights that were in the notice of funding opportunity that we responded. And hopefully, the performance measures will come out soon so we can get the specifics of what things they're looking for under each of those.

Other E.M.S.C. initiatives, many of you may have received my email about the E.M.S. for Children's survey for pre-hospital agencies. As of maybe thirty minutes ago, I checked it out. We're at twenty-seven point eight percent. So that's really great for just a month in. It started on January 4th, and it assesses E.M.S. agencies' use of pre-hospital pediatric emergency care coordinators and skills training during pediatric-centered education.

So that's currently a performance measure two and performance measure three. Ryan, do you have a question?

MR. GREENBERG: Can you just explain to everybody who that survey went to, so that they know maybe who they can help in getting those numbers up?

MS. EISENHAUER: Absolutely.

MR. GREENBERG: Hospitals, all ... just certified ones?

MS. EISENHAUER: I can do that. So this survey surveys pre-hospital agencies. And for -- that would be nine-one-one responding agencies and B.L.S. ambulance and above. So B.L.S. C.F.R. was not included. B.L.S. ambulance, A.E.M.T., paramedics, A.L.S. fly cars. So that's included in the survey. And you can find that at E.M.S.C. surveys dot org.

And who has not submitted their survey is still listed and it's listed by state, and then by county. So if you have a -- a specific county or regional area and you want to reach out to those agencies that have not responded yet, you can find them all there or you can contact me, and I can let you know who has responded and who hasn't.

Dr. Van der Jagt had a question.

DR. VAN DER JAGT: Yes, I just wondered whether it might be good to send information about that to all the REMAC chairs because that's -- for dissemination in their region, that you may get it back, you know, maybe there'll be some additional emphasis to get that filled out.

MS. EISENHAUER: That would be great.

So I have sent it out to the program agencies for -- for their assistance, and they've

been very responsive. I also sent it out to the E.M.S. coordinators and many of them have also been very responsive.

Tomorrow, I am planning to send out more reminders to both agencies and all of those groups. So I will include the REMAC also. That's a great idea.

So it concludes March 31st, so we still have a little bit of time for everybody to get their survey in. And if you have any questions about the survey, about any event, you can email me, or Jacob, and we'll be happy to help you.

So E.M.S.C. E.I.I.C. has some quality improvement collaboratives. The E.D. Stop Suicide Q.I. collaborative starts tomorrow or Thursday. So registration for that was open until, I believe, January 27th, and a bunch of emails were sent out.

Last I saw, we have one hospital participating. So that will be great. But also all that information can be found on the E.I.I.C. website.

There's also a collaborative that is open for emails, right, so for interests is the Pediatric Readiness Quality Collaborative, and that's

for any emergency department.

And the -- the link's on the screen that'll -- that will take you right to the collaborative so that you can view all of that. You can also Google E.M.S.C. E.I.I.C. and the whole website will come up and you should be able to find it that way as well.

Does anybody have any questions?

MR. PATAKY: Amy, I have one question. Just regarding the survey, is -- is there a person to email, just email you on that to see who has and who hasn't completed it?

MS. EISENHAUER: Yeah. You can email me and -- and I can get you that information, Chief.

MR. PATAKY: Thank you.

MS. EISENHAUER: You're welcome.

DR. COOPER: Any other questions for Amy?

MS. EISENHAUER: We have one other topic that was not included in my slides. So many of you may have heard we're doing a medication project with Handtevy. So just a short update on that, I got one this morning that is in the process of loading all the protocols and information into the Handtevy

app and that continues -- that work continues.

And so once the app and everything is set up, there'll be some education going out to those agencies, and then the process will begin. So more -- more on that in May as we move forward.

Go ahead, Ryan.

MR. GREENBERG: Has there been any movement related to that topic ...? I know the REMAC chair on there was talking about that at our last meeting.

MS. EISENHAUER: I have not heard anything, but I can follow up on it.

MR. GREENBERG: That will be great.

MS. EISENHAUER: Okay. All right. If there's no other questions for me, I give it back to Dr. Cooper.

DR. COOPER: Thank you, Amy, very much.

So we now move on to old business and we're going to speak about the pediatric education protocol. I will begin this discussion just by saying that we had an excellent meeting before the holidays, I recall, with our -- many of our colleagues, particularly from the collaborative

group.

And I think in summary, it's fair to say that all were in agreement that -- that reasonably intensive education needed to be, you know, utilized, prepared in order to, you know, ensure that our field providers are familiar with the approach to dealing with, you know, education and pediatric patients.

Work in that -- in that realm is ongoing and, as Amy mentioned, there is some hope that we might have presentations be made at the Vital Signs conference. And Amy and I had actually talked about potentially putting together a, you know, a program for the E.M.S. academy, which is, as you all know, part of the -- the Bureau's educational programs on the website.

And, of course, we have the fact that Sara Gruver has been working very hard on getting something together for Vital Signs, which presumably could also be potentially utilized for there's something on the learning ...

So that's what I have at the moment. Amy, do you want to add anything about this? You probably have more up-to-date information than I do

at the moment.

MS. EISENHAUER: No, I think that -- that covers it. We had one meeting, kind of getting everybody together. And those folks at that meeting are just getting the content together that we discussed. So that work is -- is ongoing and in the process.

DR. COOPER: Ryan, I see you have your hand up. Please, Ryan, did you have a comment?

MR. GREENBERG: Yeah. Just forgot to take it down. I apologize.

DR. COOPER: That's all right. No problem. Okay. So next is the emergency department pediatric emergency care coordinator program. Amy did briefly comment on this during her report.

Is there more than needs to be said at this time, Amy?

MS. EISENHAUER: So this is also in progress. We had our first meeting, kind of reviewing what is -- what has been expected in the past by E.M.S.C. for this program. And we reviewed the program that many of the E.M.S. for Children programs in the northeast are using.

So edits to those documents is

underway and our next meeting should be shortly, I hope in the next few weeks. I'll set that up for them. So my hope is that we will review the document, make any updates, and then, get that into the process for E.D.C.C.

DR. COOPER: Thank you.

Any questions on the education issue or the PECC program at the moment?

Okay. Pediatric triage recommendation, that was another group that we formed after the last set of SEMAC and E.M.S.C. meetings.

That group also met. If you -- if you all recall, the focus was on the fact that -- or the initial focus was on the fact that the -- the way the -- the new national triage protocol is structured, it provides a great deal of explicit guidance as to areas that an E.M.S. provider should consider in sort of gray areas when it's unclear as to whether a patient ought to be taken to a trauma center or not.

And the focus of our review was to see if there were any areas that might have been excluded from that -- from that -- that grouping. And, you know, and to make the point, of course, that the advice that was included in the -- in the -- in the

second box, yellow box on the right was meant not to be exclusive, but inclusive, sort of, if you will, these are examples of conditions that might need to be considered, there could well be others.

Now, of course, the issue here is that, you know, STAC had previously approved the -- the national triage criteria that had been promulgated in 2013. And the question was whether STAC had actually, at the time, endorsed that protocol or -- or -- or that -- or that field triage protocol and all subsequent versions of same, or whether it was just limited to that particular protocol.

I don't know that we know that for sure as of this moment, but certainly when the STAC meets next week -- sorry -- not next week, the beginning of March, I think it's March 1st now when STAC meets. At that time, it's likely that they will, if they had -- did not officially endorse the national triage criteria, that it will do so at that time.

And I think all on our call understood that that was likely to be the case, but it felt that what was really needed more than -- than any change

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to the protocol or modification thereto by us, which would be difficult in and of itself, would be creation of some educational materials that really sort of set out our view of, you know, of the -- of the triage issues.

That led us to recognize that, after 2013, a document was created, talking -- or that set out the guidelines for triage of pediatric patients to regional and area trauma centers, both adult and pediatric.

I had thought I had a copy of that document on my computer. It turns out I did not. And I know Amy has been diligently searching for that. I don't know if that's turned up yet or not.

So Amy perhaps, you have some additional information on that at this time?

MS. EISENHAUER: I do have some unfortunate additional information for that. I went through all the archived E.M.S.C. documents. I went through Martha's documents. I went through the program managers that were here before her. And I do not find any document related to trauma triage. So I think, unfortunately, we may need to recreate the wheel on this one.

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DR. COOPER: All right. Well, let me do -- let me do a couple of things here. Let -- let me reach out to Trish O'Neill. Trish may have a copy.

MS. EISENHAUER: Okay.

DR. COOPER: I don't know. And it's also possible that, you know -- I will make another -- another search in the electronic files here and see if I can send something up. I vaguely remember this could -- this might or might not be true that in the white paper document that was put out, around 2014 and 2015, a copy of that document may have been included. It's very vague in my memory. I don't know.

And I'm just going to ask Sharon Chiumento, who keeps everything, if she might have a copy of it somewhere in her electronic files.

So -- so more work to come on that and policies to the group that we have been unable to locate that -- that document and so more to come at our -- at our next meeting, no doubt.

And speaking of electronic files, the next item on the old business list is review and update the E.M.S.C. document. First, I'm going to

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ask Sharon to update us on where we are with the pediatric assessment reference card, and if she believes that there are any updates that need to be made.

And Sharon, I don't mean to put you on the spot here, but I think you're -- you have been instrumental in -- in helping us create these documents, and wondered if you had any information for us on this -- on this document at this time?

MS. CHIUMENTO: Yes. Dr. Van der Jagt and I have worked very closely on this going back and forth. I had the old files and so was able to bring it -- bring it up. And we were reviewing through it and we were -- we found there wasn't much we needed to change. On the first page, the logo needs to be changed and the date at the very bottom of the page.

But this is -- this is basically just vital signs and assessment steps, there really was no need to do very much on that page.

The second page, however, there were a few items that we needed to -- to update. Dr. Van der Jagt found several different things, I'll let him talk about it in just a second. I'll just briefly point out the areas, and then Dr. Van der Jagt, do

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you want to go into a little more detail on that.

One of the big things, of course, was in the ventilatory rate for the infants and child -- and child related that the American Heart Association had increased that. So we made that change.

We also did a lot of updating in the C.P.R. notes to -- to bring things either into more compliance or to make it more easily understood. And then, in the protocols below, the A.L.S. guidelines, we changed a lot with the intubation, been brought in the advanced airway since more people are now using advanced airway mechanisms rather than just a laryngoscope -- I mean E.T. tubes. So -- so we modified that.

And then, again, did some additional explanations or enhancements to make sure that the epinephrine doses were a little clearer, that type of thing, especially with the change in the dosing on the bottle, since it's no longer the one to ten thousand, one to one thousand, but instead, the zero point one or the point one, or the one milligram per milliliter.

So Dr. Van der Jagt, I'll turn it over to you at this point, if you want to update?

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DR. VAN DER JAGT: Sure. Thanks a lot, Sharon. As Dr. Cooper said, you -- you keep everything so you -- it was nice that you still had the electronic version of this originally.

As Sharon said, we really basically updated the card using the -- the most current A.H.A. guidelines. And as you know, that was largely in the respiratory area for infants and children that we -- that ventilatory rate is higher than it -- than it was initially.

We also cleaned up just sort of the redundancy of words and just, you know, made it -- made that so it read a little bit easier. We also -- if you can go down just a little bit further, you know, that the epinephrine issue, as you can see in that first box under asystole, there's an asterisk and there's a plus sign so that it's really clear what concentration of epinephrine needs to be used for I.V., I.O. versus endotracheal tube.

And then, we did add this capnography. And I don't remember that that was there as clear, but we know that there are E.M.S. providers that have capnography capabilities, and we would like them to use that, particularly in -- in C.P.R. because the --

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the recommendation is that the end-tidal CO2 be attained up to twenty, if at all possible during C.P.R.

And if they have capnography, then that would be an important thing for them to use in assessing the adequacy of C.P.R. And this relates a little bit to the concern, I think, is nationally we still worry about cardiac arrest in pediatric patients and the -- the -- the very low survival from that. So we want to make sure that we can optimize that and give direction where we possibly can.

And I think everything else you covered, Sharon. Thank you so very much.

DR. COOPER: Any questions or comments for Sharon and or Elise?

MS. EISENHAUER: There is -- there is one --.

DR. HARRIS: It's -- it's Matt. I -- I have one question if that's okay.

DR. COOPER: Sure.

DR. HARRIS: Hey, guys, I apologize for my tardiness, and I'm on my phone so this could just be a Zoom issue.

Are we specific in stating or

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discussing on the card where end-tidal CO2 is concerned, using it on a bag valve mask prior to intubation or is this only post-intubation evaluation of end-tidal adequacy of C.P.R., because now most of the inline end-tidals can be hooked up to V.D.M.?

DR. VAN DER JAGT: Yeah, so this is -- this is actually a very interesting question, Matt. You know, we had put this on this card because clearly if there's an advanced airway, whether it's an L.M.A., whether it's an E.T. tube, that's really reasonable.

To my knowledge, there is not an update available, you know, if it's bag valve -- bag mask ventilation. I know that actually in some hospitals, Johns Hopkins, notably, in their I.C.U. and in their E.D., they do measure capnography during bag mask -- bag mask ventilation.

I just am not aware that there are very good studies on that, unless some of the -- maybe Dr. Calleo or some of the other E.D. docs are -- are aware of that, I'm not aware of it. And so I was a little hesitant to put that in there because I wasn't sure it was supported by data.

But -- but that doesn't mean it can't

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be done. It's just that I -- it's a document here that we're making recommendations, obviously.

DR. HARRIS: Yeah. I also wonder, Elise. You and I have dad this conversation before. Is this an opportunity for E.M.S.C. to advocate for, you know, the -- this -- this is an F.D.A. approved device. Maybe this is something we advocate for a trial for in our state.

DR. VAN DER JAGT: I -- I would totally agree that Matt. I didn't know -- this was a course, it's -- it's -- we didn't want to put E.M.S. providers in a bind, you know, either, that if they didn't have it and they couldn't afford it, for one reason.

But I do think that in the E.M.S. world, I think where capnography can be extremely useful, this would be a wonderful thing to advocate for. And this is maybe -- maybe we've only taken the first step towards that. I don't know if we can do it stronger than that.

But I didn't want to put E.M.S. providers in a bind that they -- if they didn't have it now or maybe it's -- it's out of order, they haven't gotten it yet, you know, and now they've got

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a kid and now they say, well, we -- we gave some optimal care.

I -- I didn't -- I was worried about that. So that's why I put it this way. But I think your point is extremely well taken and I wish everybody had a capnograph out there.

DR. COOPER: If I can just add the one -- one -- one point here. Probably the one person that I know of who might have any kind of data on this, how good it is I don't know, might be Dan Spade from -- from Arizona. He's done a lot of work with -- you know, with ventilation and pre-hospital care, so might be worthwhile.

Matt, I believe you know him pretty well, as well.

DR. HARRIS: I can reach out. Yeah. I can reach out.

DR. COOPER: Yeah. Might be worthwhile reaching out to him. He's collected a lot of -- a lot of good data on -- you know, on ventilation of head trauma patients. You know, it's authentic. So he might have some data that can help us here.

DR. HARRIS: I know that -- I know

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that our colleague, Kathy ... out in Colorado has published a small paper from -- I -- I believe it was from an E.D. study that looked at children, the accuracy of end-tidal CO2 by ...

But again, I think to Elise's point, it's limited but happy to pursue this. I think it's probably something that's in the future. Thanks for considering it.

DR. VAN DER JAGT: And I think it's -- .

DR. HARRIS: Sure.

DR. VAN DER JAGT: And I totally agree that I think exploring this to the best of our abilities across the country, what's published, what the experiences are would inform, you know, any further, you know, information on this.

But the accuracy of it certainly is -- Matt, if I could ask you, do -- do you currently do end-tidals on bag mask ventilation in the E.D.?

DR. HARRIS: This is a very timely question. We just started, and actually Northwell C.E.M.S. will be doing this, as well.

DR. VAN DER JAGT: Okay. Because we had discussed it and I -- I -- if --.

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DR. HARRIS: Yeah.

DR. VAN DER JAGT: ...

DR. HARRIS: That would be great. Thanks Elise.

DR. COOPER: Wonderful.

MS. EISENHAUER: We also have -- also Dr. Cushman has his hand raised and has a comment.

DR. COOPER: I'm sorry. Jeremy, please.

DR. CUSHMAN: No problem. If I could perhaps speak to that? A couple -- a couple of things for consideration. Amen to capnography, so I appreciate the discussion and E.M.S.C. support of that. There's a few considerations, though.

Number one is that it is not currently within the scope of the E.M.T. to be able to evaluate a capnographic waveform for effective ventilations. That is exactly why there is a demonstration pilot in project -- in progress as we speak, supported by Hudson Valley REMSCO that addresses not only the placement of the i-gel by B.L.S. providers, but more importantly, the ability of E.M.T.s to be able to monitor a capnographic waveform to determine whether or not ventilations are effective.

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Although, it is not in the national standard curricula yet, there are a number of states that have added that to the scope. So the first step, again, completely support this, is that it has to be within the scope of an E.M.T. to be able to expect an E.M.T. to do it.

You know, number two to the-- to the data perspective, I -- I -- I would be hard pressed to find at least an E.M.S. physician that is not making the expectation that when a bag valve mask is used, if capnography is available, it is expected that it is on even if it's not being ventilated through an E.T. or an i-gel.

Dan Spade's date on the epic T.B.I. trial very -- very conclusively demonstrated that ventilation makes a huge difference. And -- and I think that -- I mean, honestly, I don't think we need a study to extrapolate it to kids who are notoriously more difficult to ventilate.

What -- what capnography is doing is simply telling you that you're actually getting air in and out, which we know sometimes we have no idea whether that's really effectively happening. So again, completely support that.

I -- I had the -- the comments in there, I would encourage Sharon that advanced airway with capnography period, end of story. It's not an if-available. It is a requirement within the State of New York that if there is an advanced airway, it has capnography attached, whether it's an E.T. or an i-gel, particularly as part of this project. I don't want anyone to get the idea that it's okay to have an i-gel without capnography -- or sorry -- an advanced airway without capnography.

But overall good stuff. Sorry, but context for everybody.

DR. VAN DER JAGT: Dr. Van der Jagt here again. Dr. Cushman, that's great, actually. You know, I -- I mean, I think we just toyed around. We weren't sure it was always going to be available. But I am completely fine with saying advanced airway with capnography, you know, and we will be if available.

If that is the standard that E.M.S. is being held to, then, that's what the card should say for absolutely for sure. So it's just that I did not know that at this point. So you're saying that is extremely helpful and I think --

DR. COOPER: I totally agree.

DR. VAN DER JAGT: -- if we could remove that, if available from the card, then I think we're all in agreement that that's the way to go. So thank you very much for that insight.

DR. COOPER: Is there any objection from any member to removing if available from the -- from the advance airways with capnography phrase? Well, hearing none, let's remove it.

MS. EISENHAUER: I will make that -- I will make that note.

DR. COOPER: Any other changes or discussion points regarding the reference card? Okay. Then, I guess, did everyone have an opportunity to -- to -- to receive this prior to the meeting and review it prior to the meeting, or is it just being presented here today for the first time?

DR. FEUER: I saw it.

DR. COOPER: Okay. So in that case, we are in a position to -- as a committee to approve the -- the updates. And I'm going to take it as -- as, if you will, a seconded motion from the -- our -- our task force consisting of Sharon and Elise to, you know, the -- the committee accept these changes and -

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MS. EISENHAUER: Dr. Cooper?

DR. COOPER: Yes.

MS. EISENHAUER: Sorry. We need to have like -- have somebody make a motion, and then someone else second it just because we are -- we are -- in the record, it needs to be recorded.

DR. COOPER: I -- I'm aware that many other committees are doing it the way I just suggested, but I'm happy to do.

MS. EISENHAUER: Okay.

DR. COOPER: I'm happy to have you -- I'm happy to have you make us a -- make -- make the recommendation that we have a motion and a second.

DR. VAN DER JAGT: This is Dr. Van der Jagt. I'd like to make a motion that the changes in this card be accepted with the proviso that if available under -- with the advance airways that capnography be removed.

DR. HARRIS: I would second that. It's Matt.

DR. COOPER: Discussion? I see Pam Feuer had her hand up.

DR. FEUER: I was just going to second

it. Third.

DR. COOPER: Thank you, Pam.

Okay. Any discussion? All in favor, please signify by saying aye.

ALL: Aye.

DR. COOPER: Opposed?

UNIDENTIFIED SPEAKER: Aye.

DR. COOPER: Any -- okay. I hear -- heard an aye after opposed. Was that meant to oppose or -- or still on the approved?

Let me put it another way. Are there any objections to approving the -- the changes in the reference card? All right. Hearing none, then we don't need a roll call vote because we're not a rulemaking body. So -- but we will note in the -- in the record that the vote was unanimous in favor of approving the changes, absent the -- the words if available after the word capnography at the bottom left in the second page.

Okay. So we now move on to the -- the minimum pediatric care standards for New York State hospitals emergency department, the intensive care unit.

And now, this is a set of standards

that is actually in code. And so I -- I imagine this is going to take a bit of time and effort for us to -- to look over and make appropriate recommendations.

These standards were approved, you know, around 2013 or '14 in the aftermath of extensive discussions regarding pediatric sepsis with the quality and patient safety group. And so anything that we do in this regard, we might want to, you know, share our thoughts with the quality and patient safety group if the group so decides.

But I think at this point, Amy, unless you had different thoughts, I think we should probably form a small group to look at these standards and see if there are any changes that need to be made.

I will note that in a prior time when we were participating in the E.I.I.C. collaborative regarding patient quality and -- and safety, New York State had put together a -- you know, a quality improvement initiative looking at our data, and, you know, with the help that that data would lead us to make some, you know, recommended changes to this document.

The -- it was decided at senior levels

in the Health Department that because the data that we were collecting was based on survey data, that it needed to be validated. Then Covid came along, and the attention of the Health Department was certainly distracted away from that project, not -- not for anything less than a very good reason.

But that put us in a position where the data was really very old data, pretty stale, almost ten years old now. And, you know, so the question became should we be pursuing, you know, this initiative based on more recent data from the pediatric readiness projects.

The difficulty there arise is in that Amy's predecessor, Martha Gohlke, had been able to obtain about eighty percent participation in terms of the pediatric -- pediatric ready --readiness project, but in the aftermath of Covid -- or during -- during and after Covid, which we're not really after -- after the ... shall we say, you know, the -- the number of agencies that have actually responded, emergency departments and E.M.S. agencies that have actually responded to the rate of this project has been at a much lower level, you know, making the, you know, the survey data perhaps even less compelling.

So that's sort of the bind that we're in. But at the same time, you know, the minimum care standards are about ten years old, and do need to be looked at. So I see no, you know, alternative, but to put together a small group and, you know, take our -- you know, take our best crack at it and see what we come up with in terms of making improvements to the -- you know, to the -- to the -- to the standards.

So unless, Amy or Ryan, you have anything else to add on this issue, I will ask Amy to, you know, collect names of people who wish to participate in this project. I will certainly be participating, personally, and I invite any others who have a strong interest in that area, please let Amy know of their interest so we can get a working group together.

Amy or Ryan, any additional comments on that -- on that subject?

MS. EISENHAUER: No. I do have a few people that had reached out to me that were -- were interested in working on this. So I do have their names and I will send out a survey for a first meeting soon.

DR. COOPER: Okay. Just as a -- you know, one issue that did arise sort of nearing the -- the end of our discussions last time, really had to do with whether, you know, that standards ought to be different for more and -- more comprehensive and less comprehensive emergency departments.

You know, as you all know, on -- on the more general side, the -- the -- the state code designates an emergency department as -- as a group that's seeing or -- or a department that's seeing more than fifteen thousand unscheduled visits a year, and an emergency service seeing less than fifteen thousand unscheduled visits per year.

We were looking at a similar kind of approach for pediatric patients. I don't think anyone disagreed with -- with that approach. The question was whether there -- if we did adopt that approach, there should be separate sections for emergency departments and emergency services with respect to children.

So just as food for thought for that group as we move forward. And unless there are additional comments at this time, I think we can move on to new business here.

DR. HARRIS: Hey Art?

DR. COOPER: Yes.

DR. HARRIS: If I may, it's not -- just two things. One, Amy, I'd love to join this group. I just put into chat.

You know, just a -- just a point which, you know, I brought up, I think, in New York City REMAC. You know, for -- for those who are unaware, pediatric emergency departments and critical care, quote unquote, critical care receiving hospitals in New York City for pediatrics is a self-designation.

So just to get a better understanding are -- are these standards, they're described as statewide right, they're described as built into regulation. But it seems like our colleagues down here don't abide by this.

And I wanted to understand like what our regulatory responsibility is and how we can influence and -- and, you know, use the peds readiness tools and other things to help facilitate those E.R.s that want to be pediatric critical or pediatric receiving hospitals, because I think of the seventy-two hospitals in New York City, I think

sixty-eight of them call themselves pediatric receiving.

So I just wanted to -- if someone can clarify for me how -- how bound are hospitals by these regulations, or are they more of a guideline?

DR. COOPER: Well Matt, that was an issue that was discussed at length last time, as well. And I think that, without taking any more of the committee's time at this point, and without -- without the work group having had an opportunity to do a deeper dive into the document, I'm going to ask that we hold that discussion until next time.

Clearly, you know, it's an issue that needs to be addressed. And it's not something that we reached consensus on, last time. But I think -- as you pointed out, it's high time that we -- you know, that we focused on that issue.

You know, that we've learned through the -- the New York City Pediatric Disaster Coalition project that's sponsored by the New York City Department of Health and Mental Hygiene that -- you know, that in the event of a disaster when all hands must be on deck, that, you know, we have to have a reasonable system in place that -- that identifies

which hospitals are more or -- or less able to care for pediatric patients, recognizing that in the event of a large-scale disaster that involves large numbers of pediatric patients, we simply may not have enough pediatric space in New York City to handle the entire issue.

But it is a very complex issue, as you well know. And I would just suggest we put off further discussion on this until the group has a chance to meet. And maybe, Matt, you and I can have a discussion offline about this in greater detail. Is that okay?

DR. HARRIS: That would be great. Thank you so much.

DR. COOPER: Okay. Sure.

Any other comments or questions on that issue?

Okay. Well, that -- that brings us to -- to a point where we're -- wow, we're right back on time, under new business. And the first issue under new business is the length base measuring tapes and New York collaborative pediatric protocols issue.

We discovered during the last, I believe, SEMAC meeting it was that there was some

discrepancy between what we have in the collaborative protocols and what's on the current version of the length-based color-coded resuscitation tape, which is -- it was initially devised by Jim Broselow and colleagues and is therefore commonly called the Broselow tape, even though there are other tapes out there. And the Broselow tape is just, you know, if you will, one commercially available device.

We need a way to clean this up. And, you know, with, hopefully, your -- your support, I volunteered us as a committee to take this on. So that means I think we need to put together another working group to really look at this in -- in some detail. I imagine that the --.

MS. EISENHAUER: Dr. Cooper?

DR. COOPER: Yes.

MS. EISENHAUER: Hi. I'm sorry to interrupt. I just wanted to let you know that Megan Williams is a paramedic program director and she came up to me during that SEMAC meeting and offered her paramedic students as our researchers to compare all the associated protocols and put together some information for us, essentially doing the legwork with the educators overseeing this, so that we can

then adjust what is necessary. And she is here at the meeting if you'd like to hear from her.

DR. COOPER: Well, I just saw a chat from her and she, I think, may have lost her voice.

MS. EISENHAUER: Okay.

DR. COOPER: If I'm not mistaken, Megan?

But I think we'd be delighted to accept any help we can receive along -- along this -- this pathway. And perhaps if you're unable to speak, you can put something in the chat as to when you think you might have, you know, some information for us, hopefully, by the time of our next meeting.

Sorry, Megan, I don't mean to put you on the spot. Just -- just trying to keep the wheels of progress moving here.

MS. EISENHAUER: For reference, our next meeting is in May. It will be virtual, and I believe it's the 2nd.

Jacob, can you find out what that --?

Jacob is going to look it up.

DR. COOPER: Megan is saying in the chat, they can have it done by then.

Megan, I think -- I think that we

would need to have it done quite some time before that.

MS. EISENHAUER: Yes.

DR. COOPER: Because there's a process that Amy has to go through in order to get documents that are going to be officially on the agenda potentially for approval, you know -- you know, approved by the -- you know, the smarter people up, and us -- than us.

So I know you and Amy can work on that one and -- and where we are.

Jeremy Cushman has raised an issue.

Jeremy, do you want to state that verbally for the record?

DR. CUSHMAN: Yeah. Happy to, thank you -- thank you, Dr. Cooper.

To my knowledge, the only big difference is related to the dosing of midazolam. So our -- our statewide A.L.S. protocols has midazolam dosing at zero point migs per kig for that.

All the -- the length-based tapes that at least I have looked and I -- again, to -- to Megan and the team, please prove me wrong with your thorough review, reference the zero point two migs

per kig, which I -- I think we all know is -- is actually recommended by more of the neurologists than the -- than the lower dose.

And so -- so irrespective of any differences between the collaborative or A.L.S. statewide protocols and the length-based tapes that -- that Megan's team is going to do, it is going to be important for E.M.S.C. to weigh in on the potential protocol change of midazolam being increased to point two migs per kig.

DR. COOPER: Thank you, Jeremy.

Ed Conway, I know you had two comments you made in the chat. Do you want to make them verbally for the group?

DR. CONWAY: Yeah, sure. I mean, this is not my area of expertise, but there are institutions that don't believe that Broselow accurately represents their patient population. And there is some literature out there on it.

So I think when we're looking at items like this, I mean, we'll have to consider diversity as well as sort of before we come out with a blanket recommendation.

DR. HARRIS: I believe at ... but I

actually think the pediatric committee, in their drug dosing resource document that came out of S and P took a similar stance.

DR. COOPER: Thank you, Matt.

So Matt and Ed, if you have any specific literature on that, if you could forward it to Amy to share with the group, that would be very helpful.

DR. HARRIS: Sure thing.

DR. COOPER: Okay. So we'll look forward to -- I think, given the comments that Jeremy and -- and Ed Conway have made, I think it's probably going to be best, Amy, if we try to schedule, you know, a meeting of folks who were interested in this subject well enough before the deadline to submit to the -- I think you call it the E.D.C.C. process, is that right?

You know, before you submit to -- to them, so we -- we've got our ducks in a row in terms of making sure that the document that comes forward in the May meeting is -- is appropriate.

By the way, I'm -- I'm going to go out of order here for a moment. I see a note from Amy Jagareski in the chat regarding the update from

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BOHIP.

Amy, if you'd be willing to make that comment now, just because I see you have to leave the meeting due to a conflict? Forgive me for putting you on the spot.

MS. JAGARESKI: Hi, everyone. No, that's okay. I just wanted to put in the chat because, as Dr. Cooper mentioned, I have to run. But a couple of quick updates from the Bureau of Occupational Health and Injury Prevention.

First, we are working with an intern currently on a project to evaluate providing training to domestic violence shelters around home visiting for their clients.

We put out a survey in early 2020, which revealed there was really a lack of connection and understanding between the programs. So we're looking to kind of fit that niche there.

We're also evaluating a Vehicle and Traffic Law video module that we produced this past grant year for law enforcement agents on spotting misuses in car seat safety. We will be sending a questionnaire to family service providers, WIC, D.S.S., Head Start, Early Head Start, and again, to

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evaluate their capacity and their needs for car seat safety information.

And then, two, kind of, Bureau-wide updates, we have an upcoming injury community implementation group meeting on the 21st. If anyone would like to join or hasn't received that registration link, please send me an email.

And then, we have also revived our quarterly newsletter. BOHIP had previously done this before Covid -19, but kind of fell by the wayside then, so we're reviving it. And it obviously covers three months' worth of injury-specific topics and events and information. So again, if you'd like to receive those newsletters, please send me an email.

That's all. Thank you.

DR. COOPER: Thank you, Amy, so much and thanks for letting us know you -- you had a -- we had a conflict, so we could get your report in, in a timely manner. Thank you.

MS. JAGARESKI: Thank you. Have a great day everyone.

DR. COOPER: Any questions for -- any questions for Amy before she has to leave the call? Well, hearing none, thank you, Amy. Have a great

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evening.

Back to new business, so I think we're just about done with the length-based color-coded recitation tape issue. So unless there any other comments on that, we'll plan on bringing this back to the committee in May with a document to be prepared, based on the search done by -- by Megan, and potential thoughts on the part of -- of the working group, particularly addressing the comments raised by Jeremy Cushman and Matt Harris.

Okay. Is there any -- any further comments on that?

Okay. Well, hearing none, let's move on to the pediatric respiratory, New York State Collaborative protocols review. Amy, I -- and maybe Jeremy, I think you guys were kind of taking the lead on this one.

And I see there's a note in the chat from Elise regarding -- regarding benzodiazepine doses. So Elise, perhaps you could, just before we move into the respiratory, maybe if you just verbally make that comment so everyone here hears it?

DR. VAN DER JAGT: Yeah. Sure. I just -- I was -- I was involved with developing the

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status of ... guidelines here at our institution along with neurology. And for -- we are using intranasal ... patients who do not have an I.D., but that dose is zero point three milligram per kilogram.

And we use it intramuscularly for zero point two milligrams per kilogram for patients who do not have an I.D. And if they have an I.D., the preference ... instead so.

DR. COOPER: Thank you, Elise. I do hope you're going to be part of the group that -- you know, that looks at this issue so we can, you know, get -- get this resolved. I'm sure that you have more than enough conference calls to keep the busy.

But -- but, you know, this one's important for the providers of the state. I know you'll step up as you always do. Thank you.

DR. VAN DER JAGT: Glad to help.

DR. COOPER: Okay. So let's move on to the respiratory issues. So Amy and Jeremy, let's take it away.

MS. EISENHAUER: I will turn it over to Dr. Cushman because he's -- so for reference, during the R.S.V. surge, we had some -- some folks approach -- approached me and E.M.S.C. and I had

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talked with Dr. Cooper because our meeting had already -- our meeting time had already passed by the time that this topic came up.

So we did bring it to Med Standards and SEMAC and SEMSCO for discussion. And during that discussion with Med Standards, the review, Dr. Cushman had found that perhaps the pediatric respiratory protocols could use a review by our group. And so I'll turn it over to him to discuss any specifics that he'd like to reference.

DR. CUSHMAN: Forgive me, because I -- honestly, I don't know where the email is. But I think the -- the context of -- of what was brought forward, if I recall from our colleagues upstate, were excellent. It is absolutely something that I would certainly appreciate the input from -- from E.M.S.C. on.

And there -- there were, I think, two primary components to this. One was the use of high flow nasal cannula in pediatric patients. Both -- and I think that the primary circumstance was -- was in the process of inter-facility transport rather than primary ground nine-one-one response.

And there are -- I will just offer

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there are all sorts of practical limitations that -- that may preclude that from happening with, honestly, any -- any reasonable effect for the pediatric population. But more importantly, from E.M.S.C. perspective of -- you all know the data better than I do, whether it's something that we should, as a state, be exploring the use of high flow nasal cannula for pediatric patients.

And related to that, because it is generally less oxygen consuming, is the use of pediatric CPAP or potentially pediatric BiPAP. And therefore, what would the indications, contraindications, lower age limits, et cetera -- et cetera be for that being added to the scope, again, in two different use cases?

I think primarily in the inner facility transport range, which is questionable whether -- whether under Article 30, we really have that -- that role, but I think you -- you definitely do as you are also an advisory board to the -- to the E.D.s, but also in the nine-one-one transport environment.

So I'll throw that bomb in your laps and you can figure out where you -- where you want to

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take things, if -- if anything, from there.

DR. COOPER: Certainly a topic that is ripe for discussion. Any other -- any -- any -- anybody want to add anything to what Jeremy has said?

DR. HARRIS: Yeah, I'd like to jump in. So I can say that in Northwell, we do use high flow pretty ubiquitously for inter-facility transport. We have Hamilton ventilators, which are very capable of ... which is actually quite dangerous.

So we have a cool mist that we put in, which again is fine for our ... less okay for ... but to Jeremy's point because of the humidification need in the high risk ... without it, it does become a little rate limiting.

And I do have some concerns because we currently use this in the hands of very, very skilled critical care transport nurses who spend all their time with sick kids. And given the limited exposure that most E.M.S. clinicians have to high ... has to be very prescriptive about it.

You know, and then, the CPAP, BiPAP issue, it becomes one of weight, right, so we can't do BiPAP on most ventilators under the age of --

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excuse me -- under the weight to ten kilo. So I think that it's just a little limited.

I do want to just sort of add to Jeremy's point, though, that if there's an ability, especially in line with our conversation of reviewing the regulations on a pediatric facility, I think one of the things that this last R.S.V. surge showed us, and again, this may be out of the purview of E.M.S.C. so please correct me if this is not, is that we found very quickly that the ability of a pediatric hospital, whatever that means at a future version, to have things like high flow on the floor where many of our patients, many -- many of our patients needed to go help reduce the burden on precious pediatric I.C.U. beds.

So again, I don't know whether that's something we can blend to future discussions on this topic and on the topic of redefining pediatric hospitals and emergency departments.

DR. COOPER: That's a great -- that's a great comment, Matt.

I see Elise has his hand up, as well.

DR. VAN DER JAGT: Yeah, thanks very much, Art. This is -- I don't know if it's a bomb --

I don't think it's a bomb. I think it's just that I think I totally get it because we were struggling also with patients at outlying hospitals with severe respiratory distress, and some of them were able to start high flow and some of that were not.

I think it depends an awful lot on the -- as -- as Matt said, the expertise of the folks who are doing this. We find that even in outside hospitals and E.D.s where they don't see many kids with those kinds of difficulties, they're very shaky. They're not sure that they can assess patients very well. They have to have a really good respiratory therapist to make sure that the equipment they used, you know, isn't too big and obstructs entire nose kind of thing and resulting with a potential complication of a pneumothorax.

So there are -- there are really a lot of nuances here that would have to be looked at extremely carefully. Right now, at least in our area high flow nasal cannula patients were all transported between hospitals by our pediatric transport team, because they end up in our PICU, by and large, if they're that sick, although we certainly have high flow nasal cannula on the floor.

The other thing is -- is that any discussion needs to clearly be done, I think, with pediatric emergency medicine providers, because what we are also finding is that people -- kids get put in high flow, this is a sort of a panacea. Well, now, you've got all these kids in high flow, and now, they're on all on oximetry and there's prolong length of stay. And now, decisions have to be made in the E.D. potentially do they go in high flow, not on high flow, PICU, no PICU depends on that.

So it is a very thorny issue, I think, that would have to be approached very carefully. And I guess personally, I -- I think that to say start high -- this would be inter-facility, I do understand that, but because there are nuances of this mode of doing it, they -- it has to be humidified, it has to be warmed, it has to be the right size in terms of the nasal cannulas that are used. This may be more than can be handled by most E.M.S. agencies independently.

Certainly would need to be under very careful medical control during the transport. If there was no pediatric specific team, there would have to be some sort of a -- you know, a connection

with a critical care center -- children's hospital kind of thing, so that the core E.M.S. folks, you know, they develop a problem, you know, that they immediately have access to someone who is quite expert in dealing with this.

And BiPAP and CPAP is another whole venture of a little different kind of scenario. I was thinking -- I relayed the sort of question is -- is BiPAP for pediatric asthma, which we also do, it sort of falls in that same category, can you maintain competencies in your E.M.S. providers to really do this when it's already very challenging for emergency medicine physicians. So -- anyway, enough said.

DR. COOPER: Elise, I think you have just, you know, described the situation in your usual eloquent and intensive manner. I mean, that's it, in a nutshell. You know -- you know, it's -- it's difficult enough for a pediatric emergency medicine physician, even in some cases pediatric I.C.U. physician, you know, to deal with this issue, you know, in a consistent manner.

And certainly to ask our emergency medical technicians who have, you know, very limited training in terms of the numbers of hours, paramedics

have more, of course, you know, to take this on, may be -- may be, you know, a bit more than we can -- we can take on as a committee here.

But let me raise the larger issue, at least what I see as the larger issue. The issue of inter-facility transport has been a broad issue in the E.M.S. world and in the critical care world for years.

Deb Funk was a prominent emergency medicine physician at the Albany Medical Center, many -- many years ago, led a task force. Jeremy's smiling, I can see that, hiding behind his hand there. Led a taskforce for the -- for -- for SEMAC and state council, many -- many years ago on this issue, you know, which laid out some of the issues of inter-facility transport that needed to be addressed.

But you know, we never really have adopted a set of, if you will, inter-facility transport protocols, you know, for anybody. Whether we should or not is another matter. But you know, let me summarize the issue by saying that inter-facility transport turns out to be, you know -- you know, Article 28 care on an Article 30 platform.

You know, if there are nurses and

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physicians transporting the patient, as with -- as with a critical care transport -- transport team, that's one issue. But if we're involving A.L.S. providers, paramedics in the mix of doing the transport, you know, what are their responsibilities and the limitations of those responsibilities? And, of course, what's permissible? And what is in their scope of practice under those circumstances? That's never been defined at any level, really, you know.

There are certainly many critical care transport agencies out there, many curricula out there, many of them homegrown, you know, nothing that I'm aware of that has really received national -- sort of a national stamp of approval.

Guys, correct me, I'm not -- if I'm wrong. I haven't thought about this issue, you know, in depth in -- in a few years. But -- but I think if we're going to start getting into issues of the -- of what E.M.S. providers, let alone E.M.S. providers dealing with children should be doing in the inter-facility transport arena, I think we really need to have a little bit better understanding of -- you know, of what's going on in that arena and you know, where, if any -- where, if any -- anywhere in that

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arena, we can -- we can make a difference.

So sorry, Amy, time for another taskforce. We got to put together a group that's really interested in this. I know Jeremy and Elise will be delighted to participate. I will, too.

Pam Feuer, you have a boatload of experience dealing with issues like this. I'd like to ask you to be part of that.

Matt, of course, and anybody else who wants to participate because this is something that's going to happen -- that's going to require a good deal of thought on all our parts. And I think, as Elise and Jeremy have both indicated, is an area where -- in which we really need to tread very carefully. But at the same time, we all know that there is value, you know, in -- in things such as high flow nasal cannula under select circumstances, with appropriately trained providers, you know, under appropriate -- with appropriate medical support.

So any other comments before we move on to pediatric quality measures?

DR. CUSHMAN: Yeah, Art, just -- just two real quick things. One is I -- I hope that, you know, perhaps Dr. Doynow or Director Greenberg can

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facilitate. You know, this -- this is more than just kids. The -- the -- the issues transcend all ages.

So I think it -- it is absolutely critical that we have a diverse -- a diverse group because we have some things that might work in the adult population that absolutely will not work in the pediatric population and -- and potentially vice versa.

So I completely agree with -- with the need for that and to expand that. You know, also just -- just to be clear, I'm actually, for a change, not advocating to add this stuff to the E.M.S. scope of practice. The question came up. Amy was kind enough to throw the update on my lap. I bit because I don't stay quiet sometimes.

I -- Elise, I completely agree with you. I -- I -- I don't think this has, quite frankly, any -- any role in the nine-one-one world and in the inter-facility transport world. But it's -- it's folks like Matt that are extraordinarily well trained.

It's folks like yours that are extraordinarily well trained, where you know what you're getting into before you even get there and can

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match the -- the patient with -- with those things.

But we also do have to recognize that we have, particularly in some of our more rural areas, some tremendous challenges in moving these kids with teams that are capable of moving them.

And -- and ultimately, Art, to your point, that that's a system issue, not necessarily a peds issue, but we still have to address it either way.

DR. COOPER: Hear hear. Thank you, Jeremy.

Matt, did you raise your hand or is that from before, Matt?

DR. HARRIS: Forgive -- forgive me. That was from before. I'll lower it.

DR. COOPER: Okay. Elise, please.

DR. VAN DER JAGT: Yeah, I just -- I just put something in the chat here because it makes me think of, you know, first of all the E.M.S.C is more than E.M.S. You know, it's E.D.s, it's hospitals, it's I.C.U.s --

DR. COOPER: Yeah.

DR. VAN DER JAGT: -- inpatient. And I think that it, really with the push, as Amy had

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suggested looking -- giving us a little bit of information about nationally the emphasis on disaster response, this really falls open, in many ways, across -- into disaster response with a particular area. And in pediatrics respiratory issues, we were hit with basically a disaster. And how do we triage, how do we do this, can E.M.S. do more than they usually do?

Many of you know that we're in a rural -- I'm in a rural area, that we had -- we asked hospitals to do a lot more than they were comfortable doing in terms of even physicians' scope of practice, because there was just simply no beds.

And so it really becomes a way of looking at this. And maybe Jeremy, what you were saying about is respiratory, it's -- it's a big issue, but it could be used as a model, perhaps, of how we might orchestrate this.

And so -- so that may be the overarching umbrella disaster response in a situation, whether it's Covid for adults, whether it's respiratory issues for kids, I -- I think this might be a context that we might want to consider.

DR. COOPER: Absolutely.

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So Amy, I will make it my business to reach out to Dan Doynow. Okay? And, you know, see how he wants to proceed with this issue. And, as Jeremy has pointed out, it's a much bigger issue than simply peds. But I do want to make sure that the appropriate pediatric voices are included in -- in the discussion.

And we've identified several pediatric voices during this call, all of whom have either volunteered or have been voluntold to participate. And you know, I -- I -- I think we can probably get together a reasonable group to -- to discuss this.

I don't know if any of us -- if it would be possible for us maybe to -- to put together, at least at a very, very, very preliminary stage setting discussion at the -- at the SEMAC meeting next week, you know, informally, totally.

But let's see what we can do to come up with -- with an appropriate response to this. I just noted Elise's comment that there are people with expertise in this area who are not part of either group.

And Elise, if you have any special names that you want to forward to the group,

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especially Amy, please let us know. Okay? And I'll reach out to Doynow and -- Dr. Doynow and we'll -- we'll see how he wants to proceed in this -- in this area.

Well, that was exhausting. Any other comment on the peds respiratory issue which expanded well into critical care and inter-facility transport and E.M.S. as a whole? We're going to -- we're going to try to -- maybe we won't boil the ocean, but maybe -- maybe a small lake. I don't know. We'll see.

Okay. Pediatric quality measures, Amy, where are we on this one?

MS. EISENHAUER: All right. So we have some guests with us, David Violante and Dr. Michael Redlener are here. I had a meeting with them to discuss pediatric quality measures and the quality measures program at the state. So I invited them here because, obviously, some things are -- we already have one pediatric quality measure and the set that are out currently that deals with pediatric respiratory, we discussed that. But they are looking for other things that we might be interested in.

So if David or Dr. Redlener would like to kind of give some background information on the

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project and where it's going and how we can help in the future, that would be great.

DR. COOPER: I see Michael on the call. I don't see -- David -- oh, yes.

MR. VIOLANTE: Thank you so -- so much. Dr. Redlener, do you -- is there -- do you want to take this away?

DR. REDLENER: I'm happy -- you want to give a broad overview, and then I'll -- I'll pick up after you?

MR. VIOLANTE: Okay. Sounds good. The quality metrics committee is -- is currently working on the number of measures at the state level and want to expand it out to some other measures. And so we're looking at a -- a number of different quality sources, nationally, to vet some of these measures from the American Heart Association, et cetera.

And wanted to broaden it out from where we currently stand now to a short group of measures. And it'd be inclusive by the different kinds of agencies that would be involved in it, so trauma, pediatrics, et cetera, on from there.

And so to that end, we had a great

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meeting with Amy and talked about a number of measures that we want to look at. And I'll ask Dr. Redlener to take a -- take a run through those with the group if that's okay.

DR. REDLENER: Thanks, David. And just to add a little bit of -- of context, you know, so that the availability of E.M.S. quality measures has grown and --.

DR. COOPER: Michael -- Michael, would you be kind enough to try to get a little closer to your microphone, please? I think --

DR. REDLENER: Is that better now?

DR. COOPER: -- we're having trouble hearing you.

DR. REDLENER: Can you hear me?

DR. COOPER: Yes, we can hear you, but can you come a little closer to your microphone? Thank you.

DR. REDLENER: I can't get much closer than this.

DR. COOPER: That's better; thanks.

DR. REDLENER: All right. I'll do my best. I hope I'm not yelling for everyone else, so I don't mean to yell.

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So my -- what I was saying is that there are -- there's an increasing opportunity for us for standardized measures in E.M.S. related to using them. And that is being developed as we speak.

I'm -- I'm a part of the national E.M.S. Quality Alliance, which is -- which is an organization that is doing that work to create measures within the NEMSIS dataset. And the opportunity presents itself now for states like New York to really embrace that and look for opportunities where we can overlap with our colleagues around specific specialties and -- and systems of care and priorities to different groups.

And so the conversation with Amy and team was really around how do we take that work and translate it for New York State into the pediatric environment.

So there are things that -- there are specific measures that we have -- that we have at our fingertips that we could implement, should we choose, in terms of the pediatric environment and area. So things like using weight-based -- weight-based augmentation in kilograms, looking at the assessment of pediatric patients and -- and the respiratory --

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you know, the respiratory assessment for pediatrics.

You know, some of these things align exactly with what E.M.S.C. is interested. Others, there's probably a discussion to be had around the specifics of what we're trying to measure to make sure that it's aligned with the projects that E.M.S.C. is supporting and the priorities of the E.M.S.C.

So I think that we've initiated those conversations. And over the next six months, we're really going to be looking to -- to kind of really put pen to paper when it comes to this -- what the state is interested in looking at and thinking about.

So I -- I don't know. Maybe it's best to respond to any questions, or Amy, if there's anything that you wanted to make sure to cover during this conversation?

MS. EISENHAUER: I don't have anything specific. I think we kind of discussed the -- just reviewing the respiratory assessment, and that I would bring this to the group to see, because I know that people had varied interests and that some of those do depend on our ability to collect the data based on the platform that we have.

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So that's why I wanted to include both of you in those discussions because you know more about what's possible and what isn't so we're not chasing our tails but actually getting good data that we can use to inform our care.

DR. REDLENER: Yeah. So one -- one example that we discussed during our conversation that I think is -- kind of illustrates that point is the -- the pediatric respiratory assessment. Right? And it's hard looking at big data in E.M.S. to say did somebody follow the pediatric assessment triangle -- the pediatric assessment, kind of the -- the qualitative nature of that.

But, you know, the way that the net score measure is written for respiratory assessment for -- for kids is really around did they document the respiratory rate? Did they document the O2 sat?

And so, you know, things might not be exactly perfect. And -- and what I always encourage people to think about is, maybe we should start with what's practical and possible within the existing dataset and think about how we can improve and broaden it as we get to -- you know, again, closer to exactly what we want to measure. Right?

And I -- I try not to let the -- the common saying of the perfect being the enemy of the good get in the way of -- of some -- doing something, something that's valuable to us as -- you know, as practitioners -- as E.M.S. providers, practitioners, and leaders. I think that -- I think it's really important to do something. And getting the input of this group on that is -- is very valuable.

What I would say is that there's a lot of existing measures that can be stratified by pediatric, by -- by age, so that it's pediatric-focused. So for example, if we wanted to do the pediatric trauma to trauma centers, that's a possibility.

NEMSCO worked with the American College of Surgeons to create quality measures for the new trauma triage guidelines. So that's also an opportunity to think about how it fits in with the -- that work. I think that there's really practical ways to implement those things, as well.

There's -- you know, if you're looking at airway and capnography utilization, that's also, you know, potentially a good opportunity. So there's lots of directions to go. And if there's a

particular priority of this group, I think that it's important to hear it and to -- you know, to integrate it into what we're going to do.

Right, David?

MR. VIOLANTE: Absolutely. Yeah, there's a -- there's a lot of data that -- that -- that we could get. And we're working with the state, that informatics team, to look at some of the -- the data dictionaries that are out there, especially from NEMSIS, so that we can get that data, analyze it appropriately, stratify it by age, also, to use for pediatrics. And there's a new dataset that's going to be coming up fairly soon from NEMSIS that's going to be very helpful in looking at improved data and better data overall in documentation. So we're looking forward to those -- those components, as well.

MS. EISENHAUER: I think you're muted, Dr. Cooper.

DR. COOPER: Thank you, Amy.

Before I recognize Dr. Van der Jagt, I just want to ask David and Michael if, you know, for our next meeting, you know, I think while it's -- it's absolutely true that we can, as a group, provide

you with good input, I think that what would be most helpful, as you had indicated, Michael, is to find some issues that, you know, are relatively straightforward and relatively low-hanging fruit, if you will, that we can focus on early.

And, you know, I think a -- you know, a specific proposal from your group, you know, that we could, you know, discuss at the next meeting might be helpful. If that's something that --.

I see Jeremy has to go. Thank you, Jeremy.

I -- I do think that if you could get that to Amy in time for us to be able to run it up the flagpole through the E.D.C.C. process, so it can be officially discussed at our -- at our next meeting on the agenda, it would be very helpful.

But, you know, I think there's no one on this call that disagrees with anything either of you has said. We're -- we're totally into ensuring that we're measuring quality as best we can, given the resources we have available to us.

And the expertise you both bring to this process is immeasurable and we're extremely grateful for it.

Elise, please, didn't mean to be so long winded but so please -- please chime in.

DR. VAN DER JAGT: I think -- no -- thanks very much, Dr. Cooper. No, this is extremely exciting, I think. I think -- I just had a couple of questions about the little bit of logistics and things.

So when you are looking at that data, you basically look at data of New York State residents from the national database. Is that correct? That's number one.

Secondly, is there a way to assess how complete each of those data elements are because if you have a data element you want, but, you know, most of the values are missing, that is not going to be very helpful. So that -- that's one thing that would be helpful, I think.

And then, the third thing in the data dictionary, itself, is -- I mean, for me, I'm not exactly sure what the dataset contains and so it makes it a little bit harder to say, oh, you know, we'll just get this, but then it turns out that the data dictionary doesn't have that data.

So I don't know if there's a way to,

you know, have access, or to have -- to look at a little bit of what's happening, a little bit like, you know, we -- I'm in the sepsis group, as well, for New York State. And you know, we have the sepsis data dictionary, so you can look at that and you can get a pretty good sense of what's being collected. But I don't have any good idea of what might be in this -- in this database.

MR. VIOLANTE: Yeah.

DR. VAN DER JAGT: And then, finally, you know, once we have a little bit better sense for that, I think, as a committee, we should probably identify at least some areas that we think that we should be looking at across the board. And I would say, not only E.M.S. but certainly, this is the E.M.S. database, but areas that cross over into E.D. and inpatient because, you know, E.M.S. kind of illnesses and injuries, inevitably crossover there hopefully. And then the outcomes depend on all those areas. So it could be looked at as a place to start, at least, and go from there.

Anyway, that's my --.

DR. REDLENER: If I -- if I could, I'll -- then I'll make a few comments about NEMSIS in

general. So -- so NEMSIS is the national E.M.S. dataset. It actually lives at the state level. And when E.M.S. -- when an E.M.S. provider or agency goes on an E.M.S. call, they fill out an electronic P.C.R. medical record and that data goes directly to the state dataset.

And then there's a national dataset that has common elements from every state, and then it goes up to the -- so it's not a -- it's really a state-based dataset that goes up to the national level and gets combined.

And so there's a lot of work done related to what's called pseudocode, which is -- you know, the good thing about E.M.S. data is that it's pretty common. Like there's -- I mean, there's -- it's pretty organized and set out to what exactly needs to be in it, as electronic medical records for E.M.S.

And using that dataset, I think that Dan -- Dan put in there that the trauma data dictionary, but also there's the NEMSIS data dictionary that is used and populates, you know, every -- every electronic medical record that gets uploaded into New York State database has some common

elements.

And that -- those are the elements that have been used to kind of think about what's available currently. So I guess, David, I'll -- I'll -- maybe stick to our -- our thoughts about process. Right? So I think what will happen is that we will pull from the existing measures that have been, you know, kind of created out of the -- the NEMSIS data.

And we will have a core group of -- of things that we think are important from -- from a pediatric perspective that will come -- that will be included in kind of our -- our middle range, you know, databases or we'll make a few recommendations and then we would ask for your advice about the specific core ones.

And then, as you kind of learn about that and we have an opportunity to speak about it more, then we would, you know, again, kind of think about how to create the measures that cross from the E.M.S. to the hospital, that cross from, you know, like these outcome measures that are important, how they're related to E.M.S. data.

All of those things are a much larger and probably longer discussion and would have to be -

- you know, take some work to get to -- to those points.

So -- so I guess, I think we're in line with the -- your -- your thinking. I think let's do the easy things first, that make sense, that are evidence-based, that fit into the E.M.S. existing dataset. And then we'll move from there into the realm of, hey, what are the higher-level things that we need to -- to do. How can we include those in what we think about. But love that -- love those discussions and -- and how to think about, and value everyone's input.

DR. COOPER: But more -- more to come on this, no doubt.

Oh, David, you had a point?

MR. VIOLANTE: Yeah. I'm sorry. Dr. Cooper, I just wanted to say we did get a presentation out to the state so that we could present at SEMAC/SEMSCO in February of exactly what we're doing, where we're going, what we'd like to get from -- from each representative group of folks in terms of data, in terms of what they would like to see, their needs, their wants, et cetera.

And also, to answer a question about

areas that cross over, there are some areas that might cross over into the hospital. In summary, we're happy to take a look at those as long as those are things that are reported. And we have two programs that we're looking at, ... biospatial, and make it a lot nicer for folks to look at and -- and easier in terms of functionality.

And that -- in pieces of this, as well, the outcomes coming out from the hospitals back to the agencies can help the datasets that we look at to find that crossover that you're looking for, as well. And so we're looking forward to that.

Some of these things are coming down the line. It's a lot of work by the D.I. team of the state. They're doing a tremendous job at it. And the -- the committee here is doing a ton of work. So much appreciation to them.

And thank you very much for being a part of what we're looking at doing. It's super helpful for us to get this feedback so that we can provide you the things that you're -- that you want and are looking for and need.

DR. COOPER: Elise, you had a comment?

DR. VAN DER JAGT: I put it in the

chat, actually, just some, I think, areas that would be really great. So one is cardiac arrest because of the high mortality of that across the state, I think we've talked about this a little bit in the last meeting, and then also the status epilepticus issue, the context of course, today was the midazolam issue, but the increasingly important role of speed to treatment, I think, and the very high incidence of pediatric epilepsy lend itself as two areas we may want to consider.

DR. COOPER: Thank you, Elise.

David and Michael, we'll look forward to additional information in our May meeting. And if there is a slideshow that you're going to be presenting next week at SEMAC, once that has been approved, Amy, perhaps you could share that with us so we can see what David and Michael have been saying verbally for the last twenty minutes or so, a little bit more in a -- you know, on -- on paper, so to speak.

MR. VIOLANTE: Okay.

DR. COOPER: Thank you so much.

All right. It is almost three ten. We now have an opportunity to move in to updates from

our -- our D.O.H. partners and -- and others. And we'll begin with Darlene Reda. I hope I'm saying that correctly, Ms. Reda. From the Westchester County Domestic Violence High Risk Team.

MS. REDA: Thank you so much. I appreciate it. Thank you for having me.

Thank you, Amy, for arranging to have this presentation today. If you just give me a second, I'll share what I have. Can everyone see that? We're good?

I just want to give you a brief background on myself before I get started. I -- I know most of you are in the medical field or at least affiliated in some way with the medical field. I actually took a different path. I'm an attorney. So I have a somewhat different perspective, but we have worked extensively with those in the medical field.

What I'll be talking about today, in a very brief presentation, is a high-risk team that we put together about five years ago based upon situations that we saw occurring and here in Westchester County where we had a very high number of domestic violence homicides. And I'll -- I'll talk about -- a little bit about domestic violence and how

we came about creating our team, assuming my computer cooperates with me today.

So just initially, I will be using the term, she, when I refer to victims, he when referring to abusers. And even though our Westchester statistics show that women are victims approximately ninety to ninety-five percent of the time and nationally that appears to be about the same, we know that men can be victims as well.

Members of the L.G.B.T.Q.I.A. community are also victims and abusers. And our team is fully committed to serving everybody.

So in addition to being an attorney, I was also an accountant, an accounting major. So I kind of like numbers. I know a lot of people are not as fascinated as I am. So I'll just keep it very brief just to give some perspective to this presentation.

Women murdered by intimate partners, we know that of all women killed in the U.S. each year, forty to fifty-four percent of them were killed by an intimate partner. And women are killed by intimate partner nine times more often than by a stranger.

So when we have children and we're teaching them about stranger danger and to be aware of, you know, that person on the street, you know, everyone is very careful, especially when walking in big cities, they're afraid they'll be assaulted by a stranger and -- and for sure that is ...

But women are more likely to be injured by an intimate partner, by someone they're close with, than by a stranger. Two-thirds of women killed by an intimate partner have been physically abused by that partner prior to the murder. That statistic is likely higher because the incidence of physical abuse and domestic violence are very underreported, probably the most underreported crime, actually. And so that's -- that's an estimate, a rough estimate but again, probably a little on the low side.

We do know, and this is probably most relevant to all of you here, that forty to forty-seven percent of the women who were murdered by an intimate partner were seen by a healthcare provider prior to the murder occurring. The reason for that is many women who are victims are reluctant to reach out to the police, reluctant to confide in family,

friends, colleagues, but they will go for medical attention.

And this gives you, as E.M.T.s and as doctors and nurses and -- and medical professionals, a very unique opportunity to be open and responsive to people that come forward and want to confide in you about a situation that they're experiencing at home.

For every one woman killed by an intimate partner, there are eight to nine attempted murders. And someone strangled just once by an intimate partner is eight hundred percent times more likely to be killed in a future attack by that partner. A probation officer who was part of our domestic violence high risk team once referred to strangulation victims as homicide victims who survived. That's how dangerous strangulation is for victims of domestic violence.

To be fair, we'll look at men who are murdered by an intimate partner. Of all the men killed in the U.S. each year, the statistics are much lower, as you can see. Five to eight percent of men are killed by an intimate partner. And in those cases, about three-quarters of them included prior

domestic violence that the male partner had perpetrated against the female.

One-third of male perpetrators who killed their intimate partners then commit suicide. In Westchester County, we have a very -- I would say, it's probably higher than one third. We have a very high correlation between suicidality and homicidality. I'll talk about that in a little bit.

Just to, again, bring it down and give perspective, New York State and Westchester County stats, the prevalence, again, is difficult to quantify because domestic violence is one of the most, if not, the most underreported crime.

Domestic incident reports which are a measure of domestic violence, they are required to be filled out by police officers every single time they respond to the scene of a domestic. In Westchester County, in 2020, there were just ten thousand, nine hundred and seventy-seven reports filed. And that's for a population that's roughly a million. So you can see how low those statistics are.

In 2018, our family courts here issued just under twenty-six hundred orders of protection. That sounds like a lot, but again, when you look at

the population, it's a really low number of people who are reaching out to get orders of protection and really coming forward with the domestic violence that they're experiencing.

The most horrible and egregious statistic that we've -- that we came across during our research was that, outside of New York City, Westchester County had the horrible distinction of ranking number two in the number of children killed in domestic violence homicides between 2008 and 2017.

We are trying to get updated statistics on that. We're hoping, obviously, that our numbers have gone down, but that was a horrific number that we came across and it was one of the pieces of information that we found out that really spurred us to create this high-risk team.

So briefly, what is domestic violence? The New York State Office for the Prevention of Domestic Violence defines it as a pattern of coercive tactics that can include a variety of forms of abuse such as physical, psychological, sexual, financial, emotional, that's perpetrated by one person against an adult intimate partner. And the goal of that is to establish and maintain power and control over the

victim.

So when we're looking at domestic violence, we're really looking at something that happens over a period of time. It's not a one-and-done. It's not something that happens within a week. It's a pattern of tactics that an abuser will employ over that period of time. And at the heart of it is power and control. He wants to gain and maintain power and control over the victim.

So many people think of physical abuse when thinking of domestic violence. That's probably the first thing that comes to mind. There are many of other -- many other types of abuse, as I just laid out. And in addition to the ones I just mentioned, I wanted to add technological and litigation abuse.

Very briefly, I'll give a very brief overview on these types of abuse. Sexual abuse is forced sex that you may think of, and it also includes cybersex such as sextortion and other sorts of cybercrimes that people are induced into doing, such as other forms of sexual abuse can include sharing images, like very explicit images of someone.

I had one client come in, who left her husband. She moved to a different country, wanted to

have a fresh start. And when she got to the new country, she was a teacher. When she got there, she found out that her ex-husband had sent across some very explicit videos that she consented to having taken during their marriage, but obviously, she never consented to him distributing them. So you can imagine like the psychological, you know, damage that was done when she got there, thinking she was going to be starting over and these images followed her across the seas even.

We can have physical harm without violence. We see this a lot with our disabled clients, our elderly clients, where the caretaker will leave the medication, food, and water just far enough away from the patient so that they can't get to it during the day. So that patient is sitting there. They're not -- the abuser is not physically harming them with violence, but yet he is causing harm because he is not enabling the victim to reach the water that she may need or the food that she may need or the medication that she may have to take throughout the day.

Financial abuse is one of the main reasons that victims tell us they stayed in a

domestic violence situation because they couldn't afford to leave. They -- they were just, you know, trapped financially.

Emotional psychological abuse. Psychological can be extremely controlling, I would say. We had one client whose husband was not necessarily physically abusive, but extremely psychologically abusive. So he would take her -- they had an argument one time. She was about five feet tall, and ninety pounds soaking wet. He grabbed her by the ankles, hung her out the window of their second-floor bedroom, and said accidents happen. So it kind of put her on notice, so to speak, that if she didn't comply with all his demands and, you know, appease him at all times, she knew what he was threatening to do. And she knew that he was capable of doing it.

Litigation abuse. We see that abusers are using the court system to perpetuate abuse long after the -- the relationship ends. And this is really a problem in cases where there are children involved, so the children are used as pawns. And the courts -- the abusers will engage the courts repeatedly, costing the victim a lot of time. She

may, you know, be in jeopardy of losing her job and a lot of money.

Technological abuse, again, cyber abuse is really prevalent now. It just gave abusers one more platform that they can work from. And stalking, sexual abuse, all these other type -- different types of tactics and abuse can fall within the technological spectrum. Victims often tell us that these other forms of abuse can be much more damaging than physical violence.

So you might think with all this going on, why are these two still together, why doesn't she just get out of the situation. And in the interest of time, I'll just go over a few of these. And this is, by no means, an exhaustive list.

But children is one of the top reasons that victims will tell us they stayed. They did not want their children to be alone with their abusive partners during visitation, whether it was court ordered, or you know, or -- you know, even with supervised visitation, they didn't want the husband alone with the kids. So they stayed way longer than they would have under normal circumstances.

People are often heavily influenced by

culture, their families and religious beliefs. If -- we had one client come in one time whose arm was black and blue from the shoulder down to the wrist. And we talked to her about, you know, what her plans were. And she said -- she was engaged at the time. She and her husband were both -- her future husband -- were both doctors and their families had talked it out and her parents were very influential and they said they wanted them to have a discussion. Everyone would have a discussion to work this problem out and the marriage would still go forward.

So this woman was, you know, even as a professional and as someone who was very capable of, you know, making very independent decisions, heavily influenced by her family and their cultural beliefs.

Immigration is a -- a tremendous influence on why women will stay. Love, sometimes they just want the abuser to go back to what they were when the relationship started.

So the Westchester County Domestic Violence High Risk Team really was spurred by an event that occurred in 2017 when Loretta Dym was killed by her husband. He also killed their daughter, Caroline.

Loretta had just gotten back from dropping their son, William, off at college in California, the day before Steven Dym, again, Loretta Caroline, before turning the gun on himself.

And the reason this case was so influential to us is that the police chief of the town in which it occurred, which was Pound Ridge, New York, was very proactive in the D.V. community. He was on our domestic violence counsel. He headed the domestic violence chapter for the P.B.A. and he was very responsive to victims. He knew the family. He never really anticipated this and never knew that anything was going on behind closed doors.

So we knew that if this horrific crime could happen in a family like that, in a town like that, where the police chief was so responsive and where so many resources were available, that it could happen anywhere.

And so as a county, we created a multidisciplinary team. We -- literally this happened on a Friday. We sat down on Monday morning together after, of course, being on the phone all weekend. We pulled a bunch of us together from the D.A.'s office, Probation, our office, the Office for

Women, civil legal attorneys, and we said, we need to do something here to prevent this from happening again.

So we put together an evidence -- we looked into these various options and we now utilize an evidence-based model called the lethality assessment program. And the purpose of that is to reduce the risk of death and serious physical harm for victims of intimate partner violence and their families.

So this was initially created as a pilot program. We -- around the same time this happened, we were able to get some funding for -- from New York State to implement a two-year pilot program and we put that in five of the counties in Upper Westchester.

But we knew we had to do better. Right? We can't have victims' safety depend upon their ZIP code, and we wanted to roll this out countywide. So right around 2020, January of 2020, before the world fell apart, we trained our first police department. We have forty-two police jurisdictions in Westchester County. So this was quite a huge undertaking.

We trained our first police department. And then COVID hit. And so we obviously had to, you know, pedal back for a little bit. We then moved forward. We started training virtually at first and then we put our masks on. We went out there and we continued training the police departments.

Around that time, I just want to note, we were awarded, in 2021, a one-million-dollar grant from the United States Department of Justice to expand this team. But this money was not needed for these police departments to train. We -- we were fortunate to get this money. We were able to hire a program director, additional advocates, more training, but the police departments were entirely on board.

Everybody that's participating in this team was entirely on board and was not looking for more money, which is really, really important when you're rolling out a team like this.

As of today, we've trained all forty-two police jurisdictions, including New York State Police, county police, and local police. Actually, tonight I'm going to do a refresher training for one

of the first towns that was implemented, Somers, in this program and we are actually underway, undertaking efforts right now to expand this program, statewide. So we're really excited about that. We think everyone should have access to this program.

As I said, the team includes County New York State Police Departments, along with our local police departments, service providers -- providers, D.A.'s office, civil legal, different county agencies, and the Westchester Medical Center which houses our twenty-four-seven hotline, where the police when they respond to a domestic incident, after asking the victim a series of questions, which I'll show you in a minute, if the victim screens in as a yes, as a high risk client, they will call the medical center.

The advocate who answers the phone there will then talk to the victim if she'd like to get on the phone, get some information from her, educate her on -- on what her availability of services is within the county, do some safety planning, and then that's the end of the call.

And then that case will be referred to the domestic violence service providers throughout

the county, who then provide ongoing services for the victim and her family.

So as of 2022, we had over twelve hundred high-risk cases. In 2021, when the team was not fully rolled out, when the police departments had not been fully trained, we had just three hundred and twelve. So we've already quadrupled the number of victims that we've reached since, you know, 2021.

And at the core of this program is the Jackie Campbell Danger Assessment. You may have heard of Dr. Jacqueline Campbell. She was a nurse in Maryland who, way back in 1985, developed this program. It's an evidence-based tool, provides validated information to predict the risk of serious harm or lethality.

And the benefit of this to those of us who are an attorney or is that this document can be used in court. And essentially, it's a questionnaire that's designed to assess a woman's risk of being killed by her abusive partner. And when you're going through the questionnaire with the victim, it also gives her an idea of a better sense of the type of danger that she is facing for her and her kids.

We know that the risk to mom is equal

to the risk to children. If the children are in that situation, they're equally at risk of being injured or killed.

So the main objectives of our team are understanding and identifying the risk factors for victims of intimate partner violence, launching an action-oriented collaboration of a multidisciplinary team that supports the survivor and her family from every discipline.

So again, we have police. We've got law enforcement, District Attorney's office, civil legal, counseling services, mental health. We -- we help them from every possible angle.

Develop and strengthen good communication among the partners. And we look at offender behavior as well. It's a very, very important piece to us, offender accountability, because if we're not addressing that piece, then the victimization is going to continue.

We know often that the non-offending parent may make decisions that seem counterintuitive, such as staying with them, you know, when -- for a longer period than you might think is necessary, but they're actually based on the children's safety, as I

described earlier.

So I'll give you a look at the lethality screen. It's a twelve-question questionnaire. In this case, it's used by law enforcement. There is a longer model that's used by advocates. You can see the top three questions. Has he ever used a weapon against you? Has he ever threatened to kill you or the children and you think he might try to kill you?

And if the victim answers yes to any one of those questions, it immediately triggers a phone call to the LAP line, which is at the medical center. If she answers yes, or he of course, to four of the next four -- of questions four through twelve, that would also trigger a phone call.

Does he have a gun or can he get one easily? We know that the presence of a gun in a household or the ability to get a gun increases the risk of being killed by that gun by four to five times.

Has he ever tried to choke you or obstructed your breathing? Notice the use of the word, choke, because that's how many victims will describe it. They won't say strangled. They'll say

choked and so this was put in language that was understandable and used by victims.

Is he or she violently or constantly jealous? Has he -- have you left him or separated after living together or being legally married? We know that separation is the most dangerous time because that's when the victim is leaving and the abuser is losing his power over her and he becomes desperate.

Is he unemployed? Has he ever tried to kill himself? Again, suicidality and the way that ties in.

Do you have a child that he or she knows is not hers? And does he follow or spy on you? We know that stalking, again, is very high on the list of lethality factors.

So what have we learned from these cases? We've seen, as I mentioned earlier, and it bears repeating, that common denominator in Westchester cases is that in almost every single case, the perpetrator had articulated suicidality, attempted suicide, or completed suicide when he killed the victims.

We often warn our clients do not

underestimate the risk. If he comes in and says to us -- if she comes in and says he won't hurt me or the kids, he will just hurt himself, we're not seeing that here. We tell them that that's not borne out by the facts of these cases.

If some is suicidal, they're willing to basically take anyone down with them, unfortunately. So in addition to -- or I should say in conjunction with the LAP screen, we've kind of developed our own shorthand that we call the six S's to help us kind of spot lethality factors very briefly.

Separation, always the most dangerous time. Suicide includes threats or attempts to kill himself or children, strangulation, stalking, sexual assault, and then a change in socio or economic or other status. Even though that's not on the LAP screen, we are seeing that here in Westchester County.

So I'm just going to -- Amy, I think you said to step it up a little bit up. I'll speed through these next couple of slides.

How can you, as medical professionals, help? Many victims are reluctant to reach out, but

we know they're going to reach out for medical assistance and that puts you in a great spot to help people who might not otherwise get assistance.

Keep in mind the mandated reporting laws, and they're not applicable to domestic violence. So there are no mandatory reporting laws for D.V. Make no assumptions; anyone can be an abuser, anyone can be a victim. It doesn't matter.

As I told you earlier, we had a victim and an abuser who were both doctors and I wasn't using that example because I'm here in the -- it would -- with a bunch of medical professionals. It was just really to show cultural differences. But just because someone is highly educated and appears very, you know, put together on the outside doesn't mean they're not an abuser, doesn't mean they're not a victim.

Speak to them alone. We had one client tell us she was in a hospital and her -- with a police officer in full uniform. And the medical team at that time came in and spoke to them while the cop was in the room with them. What they didn't know was that that cop in uniform was her abusive husband and he was standing there to make sure she didn't

divulge any details of what actually happened, what put her in the hospital.

Speak to the patient alone. Rely on protocol, if you have to. Ask someone every time, are you being abused at home? Do you feel safe? Are you afraid? Use good eye contact. Understand victims may not self-identify. They may not -- they may not know they're in a D.V. situation if it's only psychological. And take note of any physiological responses to stress and trauma, sadness, P.T.S.D., panic attacks.

And most importantly, connect them to local resources for safety planning.

So I think that's about it. Here are some resources for you. This is my office number here at the Westchester County Office for Women, New York State Domestic and Sexual Violence Hotline, the National D.V. hotline, sexual assault hotline, and National Suicide Prevention Lifeline which really ties in with, unfortunately, the homicides that we've worked with.

So thank you again for having me today. Hopefully, I didn't go too over time. And I don't know if we have time for questions. Amy,

that's entirely up to you.

DR. COOPER: Thank you so much, Ms. Reda, for your presentation. You know, this is such important information for all of us who are concerned about the welfare of children, which means that we have to be concerned about the welfare of their caretakers, no less urgently or importantly.

Let me just ask. Is there a specific ask that you have for us as a committee, other than to be aware of this issue at this time, and aware of particularly of the program that you have, you know, presented to us? I think it's very clearly a model for others if they wish -- if they wish to adopt such programs in their own locality.

But is there something we can do as a committee to, you know, assist you and others in -- in -- you know, in addressing this very important public health problem?

MS. REDA: Well, we were always happy to talk to anybody about working together. I think D.O.H. and -- and really the medical professional, as a whole, we're happy to train them. We've trained med students. We think it's important to get in, you know, while they're still in school as -- you know,

as they're developing their practices and moving forward.

I'm always available to talk in more detail with anyone who is, you know, in a different county and wants to roll this program out. We're actually training right now in -- in Broome County, as well, because they're interested in rolling it out, scheduled to talk to people in Suffolk County in the spring.

So you know, if anyone -- any training that we can do and however we can collaborate with any of you, we're happy to do it.

DR. COOPER: Thank you so much.

MS. REDA: Thank you.

DR. COOPER: Elise, you had your hand up, earlier. Did you have a comment about this presentation?

DR. VAN DER JAGT: I really don't. But I thank you very much. It's very informative. I appreciate it very much. Good work.

MS. REDA: Thank you very much.

DR. COOPER: Any other questions or comments for Ms. Reda?

Did I say it properly?

MS. REDA: Yes, perfect.

DR. COOPER: Thank you. Okay. Well, thank you again so very much.

Maybe, Amy, you could make the slides available for us, so that, you know, we can all review the information on our own? That would be, you know, I think good education for all of us.

I was particularly unaware of some of the finer points that you -- that you brought to us, brought to our attention. So thank you again for your --

MS. REDA: Thank you.

DR. COOPER: -- your time and -- and your work in this area.

Okay. Jennifer Salomon, if you can tell us about behavioral health and, you know, substance abuse disorder considerations for the E.M.S. course?

MS. SALOMON: Good afternoon, folks. Thank you so much for being here. I know you've been here for a while. I'll try not to keep you too long. I'm also aware that Ryan already spoke a bit about what I'm doing.

We have trained, so far, over two

hundred providers in New York State. We've had over a dozen classes. We are continuing on with this, all things behavioral health, substance use disorder, mental health, the intersection, and the fact that everything is connected.

So if someone were to be sitting here today and wonder why that would be relevant to children, it would be easily understood when we talk about adverse childhood experiences and those contributions to substance use disorder and all things behavioral health.

We are also continuing on with some other outcroppings of this program. I don't know a better word for that. I don't know if I just made that one up, but it's great because we're going -- we're leveraging some subject matter experts to come speak on some of these topics in deeper dive.

So we will have upcoming -- actually, you'll be happy to hear --.

Oh, sorry, I'm being prompted and I'm grateful for the prompts, and now I just got thrown off my track.

So we're leveraging our Vital Signs academy, as well as, for some subject matter experts.

I have a meeting set up when we're done here with someone who is going to speak towards sexual violence, responding to victims and institutional sexual violence, as well.

So that will be great to help further our causes and especially what Westchester, what Darlene just was able to speak to as well. You can find more out about this at our website. Amy is already making slides available, so I'm going to volunteer her for also making available the signup form for providers. And she'll also be able to provide you with my email address.

If your hospital has hospital-based E.M.S. and you'd like to host one of these classes, I would love to do that for you, as well. We don't just need to go to firehouses; we can go to hospitals that would want to host us for their providers as well.

I'd love to answer any questions anyone has. I know everyone's time is very valuable and I promised I would try to keep this under five minutes. So I'm at three minutes, which leaves us two minutes for questions.

DR. COOPER: Well, I will weigh in

briefly, Ms. Salomon. Would it be -- do you think it would be possible for you to provide us with -- as a committee, with -- if you're -- you know, sort of a brief overview of the course in writing or perhaps, you know -- you know, a PowerPoint summary, something along those lines that would give those of us who have a particular interest in this an opportunity to review the -- to review the program in greater detail, particularly given our focus of late in pediatric education issues?

Hello?

MS. SALOMON: I don't have a PowerPoint that's prepared to put up here for you today. I'm happy to give Amy an outline of the course that she can also disseminate.

The course is broken down into four sections in which we speak about substance use disorder, mental health, the intersection of the two best practices, suicide and provider wellness.

So if you're looking for specifically pediatric agitation, I don't have somewhere where that is its own topic. But if that is a critical feedback, then what I think I'd like to do with that is seek out a subject matter expert to be able to

speak to that on one of these deeper dives, leveraging our -- our learning management system.

So it sounds like you might be the perfect person to talk to about that, anyways, after today.

DR. COOPER: That'd be great. Amy will get us in touch and we can -- then we can chat a bit. Thank you.

Any other comments or questions?

And Amy, perhaps, you could disseminate that outline to us, so we can get a better sense of what's in the course. Thank you.

And of course, the forms that you mentioned, Ms. Salomon, so anybody who wants it, to the eight-hour program, can do that. Thank you so much.

Oh, there's --.

MS. EISENHAUER: The links -- the link for -- to register for any of the classes that are currently available should be in the chat. Jacob popped it up for us. And also Jenny's email, so you can reach her if you wanted to host a course at your agency for -- for your hospital-based E.M.S., she would be the one to help you set that up.

DR. COOPER: Okay. Sounds great.

MS. EISENHAUER: Thank you.

DR. COOPER: Okay. So we're up to the PECARN report. Brooke and Peter, we're so glad you were able to stick with us this whole time. So welcome and please give us an update.

MS. LEARNER: Thank you.

Actually, today, I'm here to share a new study that we're hoping, like we did before, that this committee would formally approve it, but to make sure you have no objections to it before we take it to the State.

This one has the best name ever. It's called TRECs. It's Treating Respiratory Emergencies in Children. And it's very similar to the seizure study that I brought to you before. I will say that that seizure study continues to enroll -- I think we've enrolled ten people in Buffalo. Study-wide, they've enrolled three hundred kids with seizures. So that is going very well and very promising.

In terms of asthma or respiratory distress, we know this is about twenty-two percent of the reason that we transport children.

Amy, I lost your share.

MS. EISENHAUER: Yes, it was automatically going forward. I don't know if you want me to stop that or --?

MS. LEARNER: Yeah, if you start at two, it won't -- it won't go forward, I think. This is the hazard of not using your own slides.

Anyway, as you know, during a respiratory distress or with an asthmatic, there's really three drugs that we use. Next slide. Albuterol, Ipratropium, sorry for the spelling, and dexamethasone, each having their own time of onset immediate to two hours first and hours of effect.

Next slide. And traditionally, albuterol and oxygen have been the common E.M.S. treatments. And then in the hospital oxygen, albuterol, Ipratropium, and dexamethasone are given. Next slide. But we know, per emergency department data, that when triage nurses give steroids, this reduces the admission rate, as well as any early beta agonist -- agonist reduces the admission rate.

So from a pre-hospital standpoint, there is some data to show that pre-hospital steroids can remove -- reduce admission by thirty to twenty percent. This was done in Houston.

Next slide. So the concept of this study is to basically take these treatments that normally they wait to get in the hospital and bring them out to the patient. So in the hopes that taking all of them out will reduce symptoms more quickly, reduce hospital admissions, reduce I.C.U. admissions, reduce invasive treatments, and hopefully, in general, improve quality of life by getting these kids back to normal and out of the hospital.

Next slide. So what we're proposing is to create a bundle of treatments that would -- treatment bundle that would be implemented within the E.M.S. agencies. The study would focus on severe life-threatening wheezing, so not just any old asthma attack but a severe one.

It would require a small protocol change. It would be implemented agency-wide, and it would use ... for all patients. It would also give early dexamethasone, hopefully oral, if possible.

And so the picture is really the thing you want to look at. That's the bundle that would be applied, so they would get vitals, administer albuterol -- sorry, it got really small in my screen -- then give the dexamethasone, repeat the albuterol

if needed, and then consider epi with key considerations about just the general study things.

So that is -- looks like -- next slide. This study, unlike the seizure study that I came to with, is going to start out as a pilot, but the aim is to finalize this checklist and make sure it's, you know, correct and then to ensure protocol adherence, so how can we implement this with good adherence.

Next slide. And then the second thing that we'll be looking at is how can we evaluate the feasibility collecting the outcomes and making sure that we collect at least ninety percent of the patient outcomes without missing them.

So this is kind of a new N.I.H. thing, which, I think makes good sense for your tax dollars. It's basically, instead of investing in a huge trial and hoping it works, they start with these pilot studies and then show that -- that it can be done and then move on to the bigger trial, so that they're being good stewards of the research dollar.

So for us being a part of this pilot, next slide, we would include all nine-one-one E.M.S. -- E.M.S. activations for anyone ages two to

seventeen that had a prior history of wheezing or asthma and current asthma symptoms, at least for the following to make them severe. So visible retractions or accessory muscles, inspiratory or expiratory wheeze or silent chest, abnormal respiratory rate for age, agitation, drowsiness or confusion, and low oxygen saturation.

Next slide. We wouldn't put anybody in the study who had a medication allergy, was pregnant, a prisoner, had croup, suspected airway foreign body, or respiratory distress not due to wheezing or a patient who objected to prior treatment.

Next slide. So like I said, this is a pilot. There's only three sites that would be participating, Buffalo, Charlotte, and Utah. Sorry, it's a city in Utah, now I can't think of it. The -- the primary thing would be to make sure for these patients that get enrolled, we can get their hospital I.C.U. ventilation status, as well as their asthma impact score at seven days to look at their quality of life.

Next slide. So what would happen is all three sites start the study at the same time.

They would give usual care, so they would do what we're doing now. We do that for five months. We take three months to train the providers, and then convert over to the bundle, and look at that data, and then see if it had an impact, how long we got the outcomes and those things, and hopefully move on to a larger randomized trial that randomized the start time.

Next slide. Prior to ...

Next slide. Much like the seizure study we talked about before, obviously a kid in severe respiratory distress isn't going to be able to ... parent to be able to consent. So this would again use the emergency exception for informed consent. This has been approved by the F.D.A. to move forward with an I.N.D. and that -- using the emergency exception. It's using a single I.R.B. through Utah. And we'll just follow the same kind of formula as the seizure study did.

Next slide. It would have a data safety monitoring board that would take periodic looks at the data to make sure, you know, something wasn't happening that we weren't seeing. So there would be those extra safety measures in place.

Next slide. I hope that wasn't too super fast, but I'm happy to ask -- answer any questions.

DR. COOPER: Brooke, this is, no question, your usual outstanding presentation of a very well-designed study. Thank you so much. I'm presuming that, you know, you're seeking, you know, an endorsement from the -- from the committee as was the case and with the seizure study, I think you bought us earlier?

MS. LEARNER: Yes.

DR. COOPER: Yes. Before -- Pam Feuer?

DR. FEUER: Hi. Thanks for the presentation. I just had a question about your dosing of the DuoNeb. The standard DuoNebs are usually two point five milligrams of albuterol and point five milligrams of the ipratropium.

So how does -- and -- and that's still what many E.R.s are using. You know, I know it could be higher. So how did you choose that and how might it impact your results?

MS. LEARNER: I think they'd show that based on the evidence they had and the -- the

guideline recommendations, you know, that would be a change for us is to go to the -- to the five milligrams. So you'd have to put two -- two vials in.

DR. FEUER: Right. Which would make the Atrovent higher, as well. So there might be -- if you're doing safety things, there might be increased heart rate, et cetera, even though you might need that -- that treatment. I don't know if anyone else has comments about it who uses it in the emergency room?

So that's -- that's the only concern I have that I don't think that's fully the standard across most E.R.s to give the double DuoNeb.

DR. COOPER: Any other comments?

Brooke, do you want to respond to Pamela's thought?

MS. LEARNER: Yeah. So I'm -- I know they selected it based on the evidence that was available is really all I can say. I could get more information on it. But -- and the F.D.A. did approve the dosages and the drugs. So people smarter than me picked it. It's not a great answer, but it's the answer.

DR. COOPER: Well, who's the lead investigator on this?

MS. LEARNER: Matt Hanson from the University of Oregon.

DR. COOPER: Got it.

Perhaps, Pamela, you could reach out to him? I don't know? That might be something worth asking.

DR. FEUER: Okay. Does anyone else from the E.R. or the I.C.U. world have any comments about that?

DR. HARRIS: It's -- it's Matt. I'm sure Peter can comment the same. It's -- I think it's pretty ubiquitous. Most of us are not following weight. I mean, there is a weight-based approach to albuterol that -- that no one uses except, perhaps, for continuous. But I think almost ubiquitously if you're two years old or twenty years old, you're getting probably two point five and -- and point five. I'd say that it's pretty ubiquitous. Just my two cents.

DR. FEUER: Right. But the study -- study is five milligrams of albuterol.

DR. HARRIS: Right, so that's why I

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think it's an issue to raise -- to be raised. I agree.

DR. FEUER: Yeah, uh-huh. Thanks.

DR. COOPER: Any other comments? All right. Hearing none --.

MS. CHIUMENTO: Just one question.

DR. COOPER: Go ahead. Go ahead.

MS. CHIUMENTO: What about those -- those drugs all approved for paramedics in New York State, the problem is I think that the E.M.T.s can give the albuterol portion. What are you going to do in your study to -- are they not going to be allowed to give albuterol to start off with, so the paramedic complies? Or is there anything around that?

MS. LEARNER: The basic protocol wouldn't change. This would just be for paramedics.

MS. CHIUMENTO: Okay.

DR. COOPER: Thank you, Sharon.

And thank you, Brooke.

I'm -- I think at this time it's -- it's appropriate for us to entertain a motion to endorse the study for those who Brooke is able to recruit.

MS. CHIUMENTO: I'll make the motion.

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DR. COOPER: Thank you, Sharon.

Second, please?

DR. HARRIS: I'll second.

DR. COOPER: Thank you. That was Matt or --?

DR. HARRIS: This is Matt.

DR. COOPER: Thank you. Thank you.

Discussion? Okay. Hearing none, all in favor of -- of endorsing the study, please signify by saying aye.

ALL: Aye.

DR. COOPER: Any opposed? Okay. Done. Thank you.

Thank you, Brooke and -- and Peter so much for your -- your presentation today and another terrific piece of work and to be -- terrific piece of work to be -- to become terrific as the study goes forward. Thank you so much.

We already heard from Amy Jagareski for injury prevention.

Dr. Marilyn Kacica, do you have anything from family health that you wish to share with us today?

DR. KACICA: Yeah, I'll just give you

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one real brief update. I know we're running late. We -- the Division of Family Health is working with the Office of Primary Care and Health Systems Management. We are finalizing draft regulations with the chamber on perinatal services and --.

(The meeting was interrupted.)

DR. KACICA: So we're working on these regulations on perinatal services and perinatal regionalization and also freestanding and midwifery birth centers. And this regulation package is scheduled to be presented to the Public Health and Health Planning Council on February 9th, and then it will be put out for public comment.

Once these regulations are adopted, the Department will begin the process of re-designating each birthing hospital center for their level of care based on the new regulations.

And some of the changes most relevant to E.M.S. include the addition of regional perinatal centers, coordinating neonatal transfers between birthing hospital affiliates, and also obstetrical transfers. The current regulations only require neonatal transfer coordination.

There's also updated requirements for

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transfer agreements, including such agreements between freestanding and midwifery birth centers, and their geographically close birthing hospitals and regional perinatal center.

So -- so that -- that's to come.

MS. EISENHAUER: Okay. So does anybody have any questions for Dr. Kacica?

DR. COOPER: Thank you. And -- and yeah, I didn't realize I was on -- I was muted.

Okay. Hearing none. Okay. Let's move on to Kate Butler, followed by Drew Fried on the -- the Health Emergency Preparedness programs, both centrally and regionally.

Kate first.

MS. BUTLER-AZZOPARDI: Thank you, Dr. Cooper. I just have a couple of quick updates that are germane to this group. We are currently wrapping up the -- the state-level. And I did want to extend a thank you because I know that there are some folks that sit on this committee that have participated in our expert input -- input group as it related to the -- the crafting and -- and revisions of that -- that plan.

And then that will then ship down to

the regional level across all of the state to do some work.

We then will -- so our next grant year, so to speak, is that we will have to do a chemical search functional annex. We'll probably will be reaching out to partners, similarly, as we did for that radiation annex next year for some input.

We are currently -- even though we're only about halfway through our current budget period, we are now looking for -- doing a lot of our planning as it relates to our grant-related initiatives for the next grant year which is our -- our final grant year of a five-year cooperative agreement.

So we are working on some -- on the deliverables for all of our sub awardees. Currently, we are anticipating our continuation guidance to come out imminently as it relates to that so there may be some more information if anything changes to that.

And I did want to thank Amy. We've been having some preliminary chats for some potential crossover activities as it relates to those budget period ... deliverables for our contract hospitals. And that is specific to the contract of hospitals

outside of New York City, but I have been in communication with our D.O.H. M.H. partners that also contract with some of the city facilities regarding some potential crossover deliverables.

And hopefully, we'll have some good news on that as we move forward in our planning. But we are -- are trying to kind to -- to kind of do some additional crossover activities that I'm -- I'm really eager to -- to see in fruition. But nothing's approved. Nothing's set yet, but we are having those initial conversations.

Barring anything else, end of report.

DR. COOPER: Thank you so much.

Any questions for -- for Kate?

Hearing none, Drew, how about you?

MR. FRIED: Yeah, just a couple of quick things to add to -- to Kate. So locally, some of the things we're working in the MARO region, which of course is Long Island, the lower Hudson Valley area, and similarly some of the other regional reps are working in the same type of programs.

I know down here, we're looking to augment the radiological annex. We're looking at pediatric decon, decontamination both for chemical

and radiological. So we're working with the hospitals on that.

We continue to work with our Regional Training Center on pediatric-related education for both hospitals and E.M.S. folks, how E.N.P.C. has and other pediatric-related classes that we can sponsor with that group.

And finally, our hazard vulnerability analysis, we look to augment our pediatric-related risks and risk areas to bring that more to light. And that is something we'll be working on for the rest of the third and fourth quarter, which ends in June. End of report.

DR. COOPER: Thank you, Drew.

Any questions for Kate or Drew?

Hearing none, moving on to Quality and Patient Safety/Sepsis Initiative, I see that George Stathidis is here, representing the group.

George, do you have any brief comments for us today?

MR. STATHIDIS: Yes, I do. Thank you, Dr. Cooper. Thank you for having me today.

I'll give a brief update on the data collection and -- and what we're working on

currently. At this point, the Sepsis Care Improvement Initiative is currently analyzing pediatric data for -- from hospitals for calendar year 2021.

I know that several -- I see several attendees here who are on our pediatric advisory group. So this will be somewhat familiar. But right now in 2021 data, we are focusing on the following cohorts that have been identified and reported to us by I.C.D. 10 -- I.C.D. 10 c.m. code.

We're currently looking at severe sepsis and septic shock, severe sepsis and/or septic shock with Covid-19, severe sepsis/septic shock with M.I.S.C. or Multisystem Inflammatory Syndrome in Children, and then we do have some -- one cohort with severe sepsis/septic shock with Covid and M.I.S.C. which we're investigating further. We're not certain that that's an actual cohort that -- that is possible being that Covid-19 and M.I.S.C. are concurrent as diagnoses.

But really, we're currently investigating this data as we received it from -- from our partners and from the hospitals in New York State. In calendar year 2021, we received more than

eight thousand pediatric cases, encompassing all the cohorts I just mentioned that were -- that were submitted to the New York State Department of Health's Sepsis Care Improvement Initiative.

Of those, more than seven thousand cases were identified as Covid-only diagnosis. So really, nearly eight hundred cases are carrying a severe sepsis or septic shock diagnosis without Covid or M.I.S.C. And that's really the -- the cohort that we're focusing on. That's our mandate, the eight hundred cases of severe sepsis and/or septic shock.

For reference, in 2019, the Department collected six hundred and twenty-four cases of severe sepsis or septic shock for pediatric patients. So our -- our 2021 numbers are relatively close to what we collected in 2019.

At the time, in 2019, the inclusion criteria for patients -- for pediatric patients was up to age eighteen, whereas in 2021 pediatric patients were included up to age twenty-one. So there is a slight change in -- in our inclusion criteria there, which also may account for the increase in cases that we saw during that timeframe.

Lastly, the clinical center where the

sepsis program is located, continuing to work towards executing a data use agreement or the bureau of E.M.S. recently was in touch with Amy, and we're looking for a date to -- to get together to see if we can continue working to secure access to NEMSIS data for the purposes of investigating any pre-hospital care that was received by pediatric patients with severe sepsis or septic shock when they're transported to the hospital via -- via E.M.S.

So that is something that we're continuing to work towards. It's something that I know this committee was interested in us investigating. And we do think that, over time, we will secure access to that data and be happy to come back to the committee and look for recommendations on how to analyze that data or, you know, additional comments on analyzing that data once we've had the chance to -- to put some results together.

So that's the end of my report.

DR. COOPER: Thank you, George, very much. I know we're all looking forward to, you know, the latest iteration of a pediatric report. Do you think that will be available by the time of the May meeting?

MR. STATHIDIS: I'm not certain that we'll have a public report available by the May meeting, but I am confident that we'll have a lot more information on 2021 data, as well as likely 2022 data. So we'd be happy to come back and give an update on what we're seeing in those two years.

Hopefully, we can provide at least some trends and some -- some information on the demographics. And again, you know, hopefully we -- we will be a little bit earlier this time with the E.D.C.C. process and we'll be able to share some slides at the next meeting.

DR. COOPER: Great. Thank you so much.

Mike McEvoy, Chair from the State E.M.S. Council, unfortunately, had to leave the meeting today. But as he mentioned in the chat, all of his issues were covered earlier in the report, I'm presuming, by Ryan Greenberg and others.

And that brings us to the final item on the agenda, which is the STAC and Pediatric Trauma Subcommittee report from myself and Jose Prince.

I would have to say that we have -- I don't think a whole lot to share with you today

because the meeting, which was supposed to have been held within the last week or so had to be -- had to be postponed until March 1st due to inclement weather across the state, and the inability of many people to travel during that -- that period of time.

So I don't have anything new for you at this particular time. Jose, do you want to chime in at this point? If you -- to add anything to what I've just reported? Jose, I can -- I can see you're still with us. I -- you may be tied up with something else back home.

DR. JOSE: I do. I'm sorry, I was having a hard time there for a second.

DR. COOPER: No problem.

DR. JOSE: I don't have much to add. It's been a long meeting. And I -- I think we had a delay, obviously, in our -- our staff meeting. So the next meeting will be in March and -- and I'm happy to report after that.

DR. COOPER: Okay. That sounds great.

One additional item I might mention is that Tim Wallenstein from Syracuse, who has been working together with Dr. Prince on the STAC Pediatric Subcommittee, may be playing a greater role

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in -- with us going -- going forward, but we'll see how -- how that plays out.

Okay. So that having been said --.

DR. JOSE: I think those -- I think him and Derek Wakeman, as well. I would just say the two of them are really going to help transition over some of the leadership for the pediatric subcommittee.

DR. COOPER: Okay. I wasn't aware Derek was going to be involved in that, as well.

DR. JOSE: Yeah.

DR. COOPER: That's great. Okay. Terrific. Thanks, Jose.

So that brings us to the end of our formal agenda. We started a couple of minutes late and we're finishing, you know, finishing a couple of minutes late, but we did pick up three or four minutes in the process.

So unless anybody has anything to say, at this point, I will, you know, first say I am super grateful for everyone being so involved in the meeting today. We got an enormous amount of work done. This is one of the busiest agendas we've had in recent months.

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We've got a lot of work to -- to do ahead of it, but I have no doubt that, particularly with Amy Eisenhauer's incredibly strong support, that we'll get it all done. So thank you again.

Any final comments from Elise van der Jagt or -- or Amy?

And if not, Amy, please remind us of the date of the next meeting?

MS. EISENHAUER: Our next meeting will be May 2nd and it will be virtual via WebEx. I am working on the last two meetings of the year. I'm working with Val and Teresa since they have all the contacts for the hotels.

The last two meetings of the year will be in person in Albany. I'm working on finalizing contracts so that I can get you the official dates. And they will be somewhere here in the -- in the Albany area once we get all of that concluded.

So I hope in the next few weeks, I'll be able to have all the dates for you, but the very next meeting will be May 2nd and it will be virtual.

DR. COOPER: Thank you, Amy. Is -- is Ryan still on?

MS. EISENHAUER: No. I think he -- he

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had to jump off for another conference call.

DR. COOPER: Okay. Elise, any final thoughts or -- or are we good to go?

DR. VAN DER JAGT: No, I have no comments. Have a great day. Thank you very much.

DR. COOPER: Thanks and -- thank you, Elise, for all your incredible commentary and participation and co-leadership as always.

So all right, everyone. Have a wonderful rest of the later winter and early spring and hope that, you know, the weather remains reasonable for you and you're able -- we're to travel wherever we need to go. And we'll -- we will try to see in May when the -- the flowers just starting to grow. So take care, everyone, and let's keep up the strong work.

Thank you so much, again, Amy, for all you're doing for us. We really appreciate it.

Take care, everyone. Thank you.

(The meeting concluded at 4:11 p.m.)

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STATE OF NEW YORK

I, HOWARD HUBBARD, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription consisting of pages 1 through 151, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 9th day of February, 2023.

HOWARD HUBBARD, Reporter

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