5-2-2023 - EMS for Children Meeting May 2023

STATE OF NEW YORK
E.M.S. FOR CHILDREN ADVISORY
COMMITTEE MEETING MAY 2023

Tuesday, May 2, 2023
1:03 p.m. until 3:38 p.m.
WebEx

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(On the record 1:03 p.m.)

MR. COOPER: Hi, Amy. Can you hear me?

MS. EISENHAUER: I can hear you, Dr. Cooper.

MR. COOPER: Okay. I can only see Ed Conway, you and me on the screen.

MS. EISENHAUER: I think people -- some people are sharing and some people are not.

MR. COOPER: I see. Okay.

MS. EISENHAUER: Alright. I just want to make sure. Alright, you are not seeing what -- hang on one second. The multiple monitors always mixes up all the things. Alright. So if you want to start Dr. Cooper?

MR. COOPER: Sure. Do we have a -- do we have a quorum? Do you need to take that?

MS. EISENHAUER: You have a quorum? I can take attendance, yes. Let me do that.

MR. COOPER: Let's do that.

MS. EISENHAUER: Alright.

MR. COOPER: Okay. Let's welcome everybody to the meeting today, Tuesday, May 2, Emergency Medical Services for Children Advisory

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Committee via Zoom. Amy, can you please take attendance?

MS. EISENHAUER: Yes. When I call your name, please state your name and say yes, so that the court reporter can record it. Dr. Cooper?

MR. COOPER: Here.

MR. CLAYTON: Amy, before you start --

MR. COOPER: Dr. Cooper here.

MR. CLAYTON: Hit record.

MS. EISENHAUER: I did hit record.

MR. CLAYTON: Okay. Thank you.

MS. EISENHAUER: Yeah.

MR. COOPER: Dr. Cooper is here.

MS. EISENHAUER: Excellent. Dr. VanderJagt? Dr. Albert?

MR. ALBERT: Present.

MS. EISENHAUER: Bruce Barry?

MR. BARRY: Bruce Barry is here.

MS. EISENHAUER: Sharon Chiumento?

MS. CHIUMENTO: Sharon Chiumento is here.

MS. EISENHAUER: Dr. Conway?

MR. Conway: Ed Conway. I'm here.

MS. EISENHAUER: Dr. Pamela Feuer?

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MR. FEUER: Present.

MS. EISENHAUER: Dr. Vincent Coyle? He did e-mail me that he was going to have a conference and might not be able to attend.

Douglas Hexel?

MR. CLAYTON: Dr. Cooper, can you go on mute please if you're not talking.

MR. HEXEL: Douglas Hexel, I'm here.

MS. EISENHAUER: Thank you. Nickol O'Toole? Dr. Bombard?

MR. BOMBARD: Dr. Bombard here, sorry.

MS. EISENHAUER: That's okay. Thank you. Dr. Harris?

MR. HARRIS: Dr. Harris, I'm here.

MS. EISENHAUER: Excellent. Chief Pataky?

MR. PATAKY: Joe Pataky here.

MS. EISENHAUER: Thank you. Jason Haag?

MR. HAAG: Jason Haag is here.

MS. EISENHAUER: Excellent. Ben Kasper?

MR. KASPER: Ben Kasper here.

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MS. EISENHAUER: Great. So that is the attendance. We do have a quorum. I did want to note that Dr. Haggins sent in her resignation. She got a promotion and would not be able to meet all the requirements. We are in the process. She suggested Dr. Vera Feuer, which many of you are familiar with, as she has helped us and has also done some work with the E.I.I.C. at the federal level. So she is -- we have started the vetting process and then also Dr. Prince is going to take a step back. And Dr. Kim Wallenstein is going to be vetted as his replacement as she's done extensive work with the Ped Sub-Committee at STAC and worked with us on a variety of projects. So they are both entering the vetting process. And I'll turn it back over to you, Dr. Cooper.

MR. COOPER: Thank you so much. So welcome again, and we have a full agenda. We're going to hear from Ryan Greenberg, from Amy Eisenhauer. And then, as you can see, we have all business to cover regarding pediatric agitation, the PET program, pediatric triage recommendations, and the length-based measuring tape issue. And then of course, we're going to hear from our other things on

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system committee. And so hopefully we'll keep you all busy for the next two hours. Ryan, would you lead it off, please?

MR. GREENBERG: I have to get off mute. I'm going to try and make it fairly brief today; in case it works. And then obviously have you take any comments or questions. So, a lot going on the Bureau most notably is that I've actually been hiring a number of new staff members, so we're excited to see that one in a number of different categories. In relation to E.M.S for children, operations continued down in all of our field operations and doing investigations and full-service inspections. One of the things that we are looking at is a revamp of our full-service inspections. And one of the things, my peak consideration is more focused also on our pediatrics. We know that they're both regulatory changes that are in the process right now for updated equipment standards as well as educational standards.

Educational standards don't change much related to pediatrics; however, the equipment standards do. And that will, open the door for our field investigators to be looking for more of the

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pediatric things as well as to make sure that people know how to use the pediatric equipment that's out there and make sure that they are well treated and have the equipment that they need in order to kind of move things forward. Our program agencies and our REMSCO continue to execute their contracts and perform their regional responsibilities. Our education unit has had some changes in it. The branch chief operations, Mike Bagozzi is now the acting educational branch chief. And he is working with the unit chiefs within the education department to keep things moving over on that side of things.

We're also moving to a new way of testing for our E.M.T.s on the skills that they have and the skills that they learn. And we're moving from a specific skill-based exam to a scenario based exam that we take a series of scenarios and have to treat the patient from the time that they walk in until till the end and transferring care to essentially you're treating the patient in the ambulance. We say this on our paramedic exams right now, but it's now from -- side. So we are working on having more of that real life scenario moving forward. So we're very excited about that one,

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seeing that come forward. We've had our second beta run of that and we're just tweaking what that process will be, but that most likely will be north of twelve to eighteen months out before you actually see that implemented. Our data and informatics unit is remaining busy.

We continue to collect data. That's a big thing, particularly for E.M.S. for children is our biospatial agreements and being able to collect data and put it into an analytical form for our agencies. Some of those data points that we'll be looking at is directly related to pediatrics. The top part that comes for some of our smaller agencies, which we have a thousand agencies, many of them have a fairly small subset of patient population or incidents in a given year. And so when they start to look at pediatric patients, regardless of, if you consider that's under the age of eighteen, or under the age of fourteen, there are many of our agencies that just don't have a large pediatric population that they treat. And so then looking at statistically how they're doing on certain things become a little bit more challenging. So that's one of the things that we've noticed in trying to collect

some of the data and looking for ways that we'll be addressing that one. And as for children, obviously, now that Amy talk about all her key points as well as her growth in the team, and but I'm going put a shout out the congratulations on the extension of the contract for several more years. I'm very excited about that one. And absolutely do the hard work and commitment of all of you here, as well as, -- going to come back on the camera for that one. But your work here as well is but everything that Amy's doing behind the scenes and in front to make things happen, Vital Signs next year is October 17 to 22. Again, I bring that up as we finalize the schedule for things, we are making sure that we have a focus on our pediatric components and pediatric courses. Everybody taught there. Our annual memorial, our E.M.S. memorial is May 23. That's right around the corner at the State Plaza, our next council operations, our next council meeting, our SEMSCO and C.A.C. meeting are and actually STAC is also next week. So Tuesday, Wednesday, Thursday is all of those meetings. So Art will be spending the entire week up in the Albany area. Thanks. And we are trying to align these meetings to happen in the

future, right before or very close to, in order to bring any information forward. So just keeping in mind of what that future looks like. But some of those, and you wonder why we're on certain dates. It's normally to align with those.

We spoke about the regulations. They are moving through. We were hoping to have them out by public -- for public comment, by the SEMSCO meetings. You don't see that happening, but they are moving through the process upwards as we go, so I'm hoping in the next probably four to the six weeks, maybe eight weeks, we'll see those out. And we'd encourage everybody here to provide some public comments, including positive public comments. So it's always something that some people kind of sometimes stay quiet on, but positive feedback on regulations is also a good thing. So when you see the pediatric standards and things coming out, if you are supportive of those putting a public comment in related to that is always a wonderful thing to hear as well.

Executive orders, safe mapping ... is still in place at this moment. The Rural Health Task Force has their next meeting tomorrow. And just a

reminder to everybody here, we have moved the bulk of our forms and things, including the PET program, which truly has been since the beginning, all the one page on our homepage, which is the forms page, and it's a dropdown. So if you do need any forms or any -- or agencies need any forms we've made almost everything electronic. A few things are still P.D.F., but they're still submitted electronically. We do not accept mail for the most part. And actually, you've even gotten to the point of certain things. We will start to return the mail to you until you submit it electronically, just to make sure that people are following that process.

It helps us process things faster, it helps make sure nothing gets lost and really is a positive thing and moving forward. Last but not least, really have some great collaboration amongst different councils. We know this council works with our SEMSCO Council on a very regular basis, but we're also now working with the council on a pretty regular basis, in particular related to offload times. And so just seeing that synergy and working through allows us really to put a positive step forward and some great things especially as we start moving

forward on some of the new federal expectations for E.M.S. for children grant and now moving into hospitals even more, so I think this partnership and working with other councils will become more and more apparent is something we're going to need to even further stand.

So outside of that, the last thing, the biggest thing's probably been going on the past couple of months is, is the budget, there's a proposal in the budget for E.M.S. and to advance different things in E.M.S. and different opportunities to help lead the E.M.S. sustainability study. The E.M.S. sustainability study, E.M.S. agenda for the future was released back in January if you haven't seen it. If you just Google New York State E.M.S. agenda for the future, E.M.S. sustainability should be one of the top Google that pops up there. And if not, you can go to our webpage and find it there. But very excited about that, that was a year and a half in the making with ... who really led that team, they came up with twenty-five recommendations in order to create E.M.S. sustainability around the state.

Nineteen of those twenty-five recommendations were, have solutions to them either in full or in part in this year's submission with the Part F proposal that this is a budget. We're still waiting for the final side of where the budget kind of does fall and what's included or not included with that one. But very excited to see things move forward on every front in E.M.S., including our pediatric patients, and making sure that we do our best as we can, that's all that I got. Happy to take any comments, questions, or concerns?

MR. COOPER: Thank you so much, Ryan Greenberg. Do we have any questions for Ryan or issues regarding the report that he's given us? Well, hearing none. Ryan, it sounds like it's all good, so what could be better than that? So at this point, we are aware that Jeremy Cushman is unable to be with us after two o'clock. So I'm hoping that Jeremy is able at this point to deal with the protocol updates, which are currently listed under the new business. Jeremy, does that work for you?

MR. CUSHMAN: It does Dr. Cooper.

MS. EISENHAUER: Give me one second just to get on the screen.

MR. COOPER: What? Did you say it does? Thank you.

MR. CUSHMAN: Yep. Can you hear me okay?

MR. COOPER: Yeah, maybe a little closer to microphone if you can.

MR. CUSHMAN: [Crosstalk] -- getting the right one up.

MS. EISENHAUER: I will get the seizure one up first.

MR. CUSHMAN: Okay. Let me take a quick second to kind of summarize those if you will the substantive changes to the seizure revisions. On the PEDs end of things it is primarily to clarify and address the dosing regimen to reflect zero point two milligrams per kilo I.M. or intranasal to a max dose of ten milligrams.

And then if I.V., the zero point one milligrams per kilo I.V. to be consistent with most practices, as well as the National Model E.M.S. guidelines. The remainder of the protocol itself is pretty much unchanged. So Amy, if you just scroll down to the PED section so the group can see those

recommended changes. Any questions, concerns related to that recommendation for change?

MR. COOPER: Amy, perhaps we could slide down just a bit more so we can see the paramedic level as well. Thank you.

MR. CUSHMAN: There you go. So, again, at the C.C. level they're only giving it I.M. or intranasal at the paramedic level, they do have the option for I.V., and again, consistent with the National Model EMS guidelines having the zero point two mg/kg I.M. or intranasal and then the zero point one mg/kg if an I.V. is established.

As always, best practice remains. The first line is really intramuscular administration for your first round, and not to delay obtaining vascular access, particularly in a child who is typically a little bit more challenging for most of our practitioners. And then again, the remainder of the protocol remains pretty much unchanged.

MR. COOPER: Any questions for Jeremy about this? Okay, next protocol, then. Thank you, Jeremy.

MR. CUSHMAN: Alright. So the next protocol looks like, so this is a pain management

protocol, looks like, holy cow, there's a lot of red. Hopefully, we won't have that one. But what we did in pediatric is frankly cleaned up a lot of stuff because a lot of things has been injected in many of the revisions during that time.

What we also did was really try to simplify some of the -- not the dosing regimens, but simplify the language on it, so the protocol frankly, was not as busy. So to that end, really when we look at -- at it we are clarifying the concentration. We're making sure that the -- if equipped and trained asterisks are in the right location and then providing some standardization as you -- so again, these are the same dosing tables that you had before, but before there was a whole another column within the concentration. And so we just move that concentration to where it says acetaminophen and so forth.

Amy, just scroll down to the C.C. level in terms of pain management, again, this is all aligning things with the adult in terms of how we're organizing things in terms of may choose one of these two, your dosing regimens have not changed at all. And then as you get into pediatrics, again it is

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simply clarifying and simplifying the language between the adult and pediatric protocols.

Amy, if you can scroll down into the paramedic section. Again, your dosing regimens are unchanged. It is just cleaning up the language to prevent confusion. The last part is in the key points and considerations. If you look at these sets of ... compared to the previous, we just simply reorganized all of the key points so that it is far more standard and is related to the class of medications that are being administered. Before it was so many bullet points, you had difficulty in reading it and figuring out what bullet point was applying to the medication that you were administering. We simply clean that up accordingly.

So those are really the changes, so no new additions to this. Something that I would like E.M.S.C. not necessarily at this time, but to consider in the future is what are our options for two things? Number one, ketorolac were E.M.S.C. feels strongly that ketorolac should not be included in any way within the pediatric pain management protocol and secondly, acetaminophen in the I.V. route.

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So acetaminophen is being added -- recommended for addition into the adult formulary. And ultimately something for E.M.S.C., perhaps at a future meeting is to have that discussion when you're prepared to again, specifically speak to ketorolac and whether or not you would want it included in here as a non-narcotic analgesic, as well as acetaminophen. Happy to take any questions.

MR. COOPER: All right. Amy let's if we can plan on putting those two issues on the agenda for next time. But in the meantime, let's you and I get together and we'll form a small working group to focus on these issues, review the literature and so on, have a conference call in the interim to make sure that E.M.S.C. is up to date with this. I see Ryan Greenberg has his hand up. Ryan, of course, you're always invited to speak on anything at any time.

MR. GREENBERG: I just want to say, I have a question. I think you mentioned you were going to bring it up before, but while we had Jeremy here, before he goes out. Any of these changes when we talk about Broselow tape or other things align or

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differ anything with that sizes when you were looking at these or I just haven't done comparison.

MR. CUSHMAN: Yeah. The only -- one of the reasons that this came up is, is what we discussed at med standards, and I believe you've been seen that as well, right, which was that to the best of our knowledge reviewing the Broselow tape specifically the only conflict lied in the dosing of Diazepam at zero point two milligrams, the Broselow tape does not include dosing for Midazolam.

But that has caused confusion in a fair amount of consternation amongst providers because of that. By making at least this change regarding your first dose, because in the Broselow tape, it actually does not specify the route, it just simply specifies the dose. And given that our first dose would be preferably I.M., this will allow the alignment of our protocols with the Broselow tape.

For the Handtevy project, which Amy is probably going to talk about a little bit later on, it's obviously moot because for the Handtevy, we program in it what the protocols are, and then it calculates the volume for us.

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But we did check all of the other things that are within our scope. Obviously there's a bunch of things in on a Broselow that we don't do. But there are no other conflicts with the New York State of Department.

MR. CONWAY: So by way I have one question just concerning the oral dosing that the table lists both pounds and kilos from a patient's safety issue all the other medications are listed per kilo. I just bring it up because we still continue to see med errors as most electronic systems getting rid of the pounds and kilos. So I just bring that up.

MR. CUSHMAN: Yeah, to speak to that, I think that's a phenomenal point. In the area of struggle that I and some of -- kind of -- the protocol working group has, is that because we have not yet quite normalized this information, that it is more likely that a parent is going to say, oh, well, yeah, they're fifteen pounds. And so what we did not want to have is the provider then have to try to figure out what the conversion from fifteen pounds is to kilos, and then look at this table to do that.

And so, I agree, and I think we could go either way, but just -- you know the thought process was that more often than not, parents or caregivers are going to give pounds. And if they're using the protocol as a reference tool, then instead of having them reference two different things, meaning a conversion table and then a medication administration table, we would keep it all in the same spot. But you are absolutely spot on, and I don't know how to reconcile it.

MR. COOPER: Any thoughts about that? You know, Ed is entirely right that we've moved toward all drug dosing per kilogram, but Jeremy and the protocol group have made a very good point that parents are still thinking in terms of pounds. Ed, since you brought the issue up, do you have response to that?

MR. CONWAY: I don't have a simple answer. My concern is more, I don't worry as much making a mistake perhaps with this as with morphine or fentanyl, somebody making a miscalculation, my kid is fifteen pounds, and then somebody doses that. I mean, perhaps this is helpful just as a reminder that people would look at it or do we put some sort of a

memo up there, or like a bullet point or a red point, like please ensure that dosing is in -- or something like that. I don't know.

So many of us have electronic records now that kind of prevent this, but I can see this mistake, kids seizing, the parents think the kid's dying in front of their eyes, mistakes get made. They happen in the hospital unit. I've seen kids that overdosed inadvertently.

MR. CUSHMAN: Yeah. And obviously, we don't have the luxury of being able to weigh our patients in the field. And actually I know what I will do is, I got to go back to our management of pediatric patients section of the protocols. I believe that we speak of utilizing the length-based tape which is, and I think we just need to reinforce, because ultimately that's in the field, our safest option to get an estimated weight based upon their ideal body weight, i.e. their length.

MS. EISENHAUER: I'd also mention to reiterate everybody's comments. One of the main components of the future performance measures, which I'll get into in a few minutes for this grant cycle, for E.R.s, one of the requirements is that all

patients be weighed in kilograms. They did not mention that with E.M.S., but I would imagine that they would hope that that's also the case, but I understand the limitations of working in the field.

MR. HEXEL: So speaking from the field provider perspective here.

MR. COOPER: Any other comments?

MR. HEXEL: Yeah, Dr. Cooper, Doug Hexel. Just speaking as a field provider, if I flip to that or in reality, I'm opening my phone and going to the app and looking and that table pops up, if the weight in pounds is red or highlighted or bold or something, I'm going to look at that again. And why is that different than the red? Oh, okay, because that's the pounds, I'm converting to kilos and this is my dose. So I think we do need to adjust that table somehow.

MS. FEUER: Hello, this is Pamela Feuer. I actually agree. I was going to say something about the visual that if we have to keep pounds in there that it needs to be something that makes the eye not look at the same color table, something that highlights it to be there. But -- and also I think it is a little risky that the next line

says something, milligrams per kilo, and right above you can easily look and look at one column weight and pounds and think that was the kilo weight. I don't know.

MR. CUSHMAN: Yeah, honestly, the more that this conversation is going, the more that I think we just need to remove that column period. You know, we -- we state already within -- within the -- the protocols under the pediatric definition of discussion. Protocols requiring weight-based dosing guidelines, pediatric dosing is calculated on a per kilogram basis and strongly recommended length-based resuscitation tapes. So what I -- I'm, yeah, even now I'm starting to change my opinion on this based on this conversation. I – I -- yeah, let me, I'm not sure that I'm going to be able to make anything look different in a meaningful enough way to be able to even assuage my concerns now that you've made them. So I -- I hear that. Let me see if I can change something. If not it -- it may -- it may be safer to remove it, sorry. Remove pounds entirely and -- and continue to force the issue of -- of weight-based dosing utilizing a length-based tape. So, which will be in kilos by definition.

MR. CONWAY: So just one more. So if push absolutely comes to shove and you decide and has to stay in there, I would just sort of like the highlight the kilograms, the middle column. Because the eye is going to go to where that color is. Somebody will say, oh yeah, we can, because again, when you, the next line is morphine point one mgs per kg. So at least get people thinking in the right way. I understand the limitation because we're going to get into the discussion. I mean, I work at an institution where the E.D. doesn't believe in length-based tapes for a myriad of reasons. And I love them. I mean, I walk around, I'm on service with ... in my pocket, because no one can remember that amount of material when you're in -- crisis.

MR. VANDERJAGT: I'm sorry, and this is Elise VanderJagt. I'm sorry, I -- I had a hard time coming on wrong -- wrong password. And maybe you discussed this already. I agree with what has just been said about making your eyes go to the weight and kilograms. I'm also wondering if you eliminate the pound column if you could put up there at least that, you know one kilogram is two point two

pounds, you know, so you'd have at least some guidance. Hey, it's a matter of time to come.

MR. HARRIS: Please. I wonder if this is meant to be more an educational point and forgive me, I can't see the entire document, but is there a portion at the bottom, sort of like the way we have art in New York City protocols of key points where we put the strike down below, right? So it's not in the middle of the protocol. People aren't going to jump to those weights and use the pounds for kilo flows, but if there is a parent who reports that their kid weighs, you know, thirty pounds, then there's a conversion table on the bottom as an educational point because almost no one is going to break out of just practically speaking. So I wonder if using that just as a reference in a key point section might be more worthwhile.

MR. COOPER: Yeah. From my point of view — this is Art Cooper, from my point of view, I think the point that parents are frankly and not something I had really thought of at -- at great lengths prior to this conversation, I think the fact that parents are thinking in terms of pounds is a -- is really a point that we really need to you know,

really spend some time thinking about. So that we have some way of you know, reconciling pounds, this is kilograms. I totally agree with the approach Matt is suggesting. I think the -- the data is going be in the details in terms of coming up with the right wording and coming up with a -- with a table that, you know, that looks you know that guides the field provider more in -- in the -- in the direction of kilograms rather than pounds, but allowing the pounds piece to be part of it, if that makes sense. Thank you. Any other comments? Matt, are you –Matt Harris, are you still, did you have another comment or is your hand up? Elise, do you have another comment?

MR. VANDERJAGT: I do actually on -- on that table. And I don't -- I don't know what --

MS. EISENHAUER: -- interrupt for just one moment. I have a question from the court reporter, who is the calling user, starting 607-732?

MS. O'TOOLE: Amy, I think that's me, Nickol O'Toole.

MS. EISENHAUER: Okay. Thanks, Nicole.

MS. O'TOOLE: 6694. Yep, you're welcome. Sorry --

MS. EISENHAUER: Oh, that's okay. I don't have the end. Annette, that's Nickol O'Toole. I'm sorry.

MR. CUSHMAN: Elise. Yeah, please go ahead. You had a comment.

MR. VANDERJAGT: Yeah, and I -- and I'm sorry that I had been late and I don't know what you have all discussed with this protocol here. I, first of all, I -- I do agree with Dr. Cooper that parents will say pounds, you know, for sure. And -- and some of the -- the things that have been said are correct, I think, and I do think it might be helpful to have maybe the table lower down as an educational thing. The other question I had about this, and I don't know if you've discussed the medications already, could I just ask that, have you just started discussing that? Or was it all about weight?

MR. COOPER: Mostly about weight, but what's your concern?

MR. VANDERJAGT: My concern is that we don't use Motrin -- ibuprofen not to brand, but ibuprofen for kids that are less than six months of

age. And there's no, there's nothing about that in this protocol. That's number one. And then the second thing relates more to fentanyl. I'm concerned about the one point five microgram per kilogram I.V. is a starting dose. You give that to a small kid, especially, I -- I'm concerned that that's something that's too high of a dose.

MR. CUSHMAN: Just to be clear, all of the dosing is already existing and have been previously approved by both this group and CMAP. So any dosing changes are going to go back on what has already been approved. I -- I'm indifferent. I just want to be clear that I didn't change any of the dosing. I just cleaned up the protocol to reflect things for consistency.

MR. VANDERJAGT: Yeah, I do understand that Jeremy, I just think that however we have an opportunity to look at this again, right? So, I think there is that part of it that I just wanted to -- to say, because fentanyl is like a hundred to hundred and fifty times as powerful, as potent as morphine. And in this case it's one point five is more than that.

MR. HARRIS: May -- may I ask a question, just a data question to Amy?

MS. EISENHAUER: Sure.

MR. HARRIS: And -- and this -- this could be something we can come back to at the end. Amy narcotics, as I'm aware, we have to report to the state, all narcotic administrations. Is there a way, maybe Ryan knows this, if I -- I would think that intravenous to Lisa's point, intravenous fentanyl is probably never given to kids in New York state, I'm going to say they're either -- either not getting treated, you're getting, I.M. morphine, you're getting intranasal, fentanyl. So just, but just in general, the bigger -- the bigger question is, if we do want to reapproach dosing at some point down the line perhaps the data driven approach would be to look at the state registry and see how often these different narcotic options and routes of delivery are actually being used in a given calendar year. So I wasn't sure what access we have as an advisory committee to that data.

MS. EISENHAUER: You give me a data request and I request it from the data informatics unit. So if you give me the specifics of what you

are looking for, so what medications, what routes of administration I can submit that to the data informatics unit and request the information. They may have some questions just so that they pull the correct information. But we can obtain that from.

MR. HARRIS: Okay, I'll reach out to you off -- I'll reach out to you. I have a couple questions about that, but I don't want to take up your committee's time. I'll reach out to you after this.

MS. EISENHAUER: But I -- I do like your points.

MR. HARRIS: Great.

MR. COOPER: Yeah, Matt, I think that's a great, just a great idea. So Amy, let's follow up on that. I think Ryan Greenberg had a -- had his hand up a little while ago, but Ryan, do you still have a -- a word to say here?

MR. GREENBERG: Yeah, so Jeremy, I don't know, it's just taking a look at the collaborative, interestingly enough, there's a lot of resources and stuff in the back of the collaborative, but there's actually nothing for convergence, for weight convergence. So count six kilograms, this

might be the perfect -- if someone else said it, I apologize, but I'm just like.

MR. CUSHMAN: No, I said it, and then I started scrolling through and I'm like, wait a second. It isn't there. It was in a previous version, and I don't think ever made it into these updated versions. You're absolutely right, Ryan. So we'll -- we'll bring that back to the group and figure out where it's best to live --

MR. GREENBERG: But I think something, you know, in that resource area and just, you know, weight, kilograms depend, like, I think that's a quick, you know -- tap on it, bring it down and like you did. Look, most of us are probably going to open up some electronic device and work on that, but if it's not available and this is what's in the truck, it's, you know, a big one to have.

MR. COOPER: Thank you, Ryan, and Jeremy, thank you very much for your willingness to reconsider that that issue and the location in the -- in the document is where it will most likely or most appropriately set. I think Sharon Chiumento has her hand up as well.

MS. CHIUMENTO: Just one other potential option, and if you remove that pound column and instead in the kilogram column, put in parenthesis afterwards what the pound conversion would be. So maybe parenthesis is equal six pounds or whatever -- whatever it might be. So this way the kilograms is going to be the first thing they're going to see. That's what they're going to base their weight on to their diagnosis on, but they got the conversion right there for themselves without giving an extra column, which I think is very confusing.

MR. COOPER: That's -- that's helpful. Jeremy, I guess we'll leave it in your hands and your -- and the protocol group to it again, figure out how best to handle this issue and we'll hear from you next time.

MR. CUSHMAN: Yeah, honestly, I -- I, right now temporarily I'm kind of utilizing Matt's idea, I think it was mess. And I just removed it from those, the pounds from the -- from the table. It looks much clearer, simpler, and then right now it's still within the protocol, but under the -- the key points as a reference. And then we got to make

sure we know how all of these different apps are utilizing and referencing these because if you can't move quickly from -- from one protocol to another then that's going to disincentivize utilizing a table that is elsewhere within the protocols. So we'll take care of it, but great feedback. I appreciate it.

MR. COOPER: Thank you, Jeremy. Any other comments on this particular protocol? Okay, can we have another -- oh, Elise, I'm sorry, go ahead.

MR. VANDERJAGT: No, that's okay. I think Kevin Albert had His hand up as well, but I do have some comments But Kevin, you go first.

MR. ALBERT: No, you can you can go first, Elise, it's fine.

MR. VANDERJAGT: So, again, this, I know these things were already approved, it sounds like Jeremy -- but the question I had was this cardiac monitor, is it understood that that's a cardio respiratory monitor because they really, the issues here with these narcotics is respiratory, and I don't take pulse oximetry in there. So I just wondered the emphasis on cardiac, cardiac is not the

issue with these kinds of drugs. And so what are we doing with that?

MR. CUSHMAN: Again, that's historical language that has been included in consistent throughout the entire protocols. So if it needs to be revisited, it needs to be revisited everywhere. We do not have established as a requirement, the administration -- sorry, the utilization of capnography for individuals that are receiving a narcotic analgesic that would arguably be the -- the best practice. I think we would probably both agree that, that pulse oximetry is insufficient as a -- as a respiratory monitor. And so that I think would need to be a much larger discussion because there are significant implications in terms of any type of requirement for capnography as part of any type of analgesic administration and in some cases, quite frankly reduce the ability to properly manage folks experiencing acute pain. When I think the question earlier was, you know, we really need to see what the data is and do we really have a massive problem here or not?

MR. HARRIS: Yeah, and practicality, I think you pointed out its Matt, Jeremy, that our

practicality no one who's using in title one pediatrics for. I mean, unless --

MR. CUSHMAN: I'd be careful about no one. There -- there are medical directors and systems that make it an expectation. So --

MR. VANDERJAGT: Yeah, I -- I would say, yeah, I would say that I'd say, but I would say, -- that's probably, I would, I would argue for what it's worth that you're probably in a minority. I'm -- I have not screen services.

MR. CUSHMAN: But not -- but not a bad practice. And kudos too, don't know how many people are doing there.

MR. VANDERJAGT: Yeah, I was not. I would just put the chat box. I did not recommend a capnography for the reasons you mentioned. I was concerned about that. It says cardiac and there's nothing about respiratory, anything respiratory, including oximetry and certain is a delay with oximetry. I do understand that.

MR. CUSHMAN: So, so Elise, very specific. What's your recommendation there? What's your –

MR. VANDERJAGT: There needs to be something in there. I think maybe it's the educational piece of it or a bullet point at the top is that it's the respiratory aspects of this that I'm most concerned about. Cardiorespiratory monitor. We have gone away certainly from that with the same cardiac monitor, because if the respiratory issues are very significant. Then you gave morphine to a three-month-old, that is a problem. So that's all, I don't know, -- I would say cardiorespiratory monitor, but that's a bigger discussion as you said. Oximetry, I don't know if that's something that could be at least used, but somewhere in there that, to indicate that the side effects of these are predominantly respiratory. And this doesn't seem to imply that.

MR. COOPER: Amy, in the interest of time let's add this particular issue to the group of considerations that our protocol task force is going to be focusing on during our upcoming conference call. I think Elise raised a good point, but at the same time, we all understand that the -- that the gold standard in terms of respiratory monitoring is entitled. But of course, we also understand that relatively few services are using that particularly in

kids. Is a certain level of you know, of deterioration in oxygen saturation. Something that should be considered as part of, a cardiorespiratory monitoring. I think that's a -- that's a very good point for discussion is Jeremy's indicated. So why don't we add that to the list of things that the protocol task force is going to be looking at. Kevin Albert, you've got a, you've got your hand up.

MR. ALBERT: Yes. Thank you. I am referring back to the Tylenol Dosing Chart. I was just wondering if the term APAP and the top of the right-hand column would be something that confused field providers as an abbreviation for acetaminophen, or if that was commonly known to them. That was it.

MR. CUSHMAN: I think that's a very important point.

MR. VANDERJAGT: It is --

MR. ALBERT: I can add the parenthetical reference or take it out entirely.

MR. HARRIS: I'd take it out.

MR. COOPER: -- just spell out, I see in a minute. But of course, either way.

MR. CUSHMAN: Again, no problem. I'm glad that we're catching these. That is exactly how

it's been written for the last five to seven years. So we'll change it, but that's how it's been and we'll adjust it and move on.

MR. COOPER: Understood, Jeremy, this is no hit on you protocol group. It's just that, that people are catching stuff and that's good for kids. Anything else? Okay. Amy, do we have another protocol to consider?

MS. EISENHAUER: No, that was both of them.

MR. COOPER: Okay. Jeremy, thank you so much. I know you have to leave at 2:00. I deeply appreciate your work and that of the protocol group on these issues. And we'll all stay tuned. Okay. Thank you so much. Okay. Amy, I think it's you're up.

MS. EISENHAUER: All right. So since Dr. Cushman has to leave in nine minutes and he did mention the ... hands heavy project I will let him give a quick update at the top of my report and then I'll take care of the rest.

MR. CUSHMAN: Great. Moving along working there's just a few final tweaks to the report from Data Informatics and allowing us to access it at the regional level, including one medication that was

left out that we're just we're waiting on, from that team, so that we can monitor any hopeful progress, in our dosing. The entire training has been developed and the trainers start this week. Related to that, we're utilizing a -- the trainer model. The app configuration is all complete. Amy was kind enough to spend hours painfully reviewing all of that and how we were configuring things to make sure that they reflect protocol and so forth. So a lot of it was actually more, more backend preparatory work than I think we had bargained for.

But it is set and agencies will actually start participating in that as early as mid-month that are being trained up on that. And we'll track its progress. And more importantly, we've identified processes for addressing any medication concentration changes, which seem like they happen every day. And making sure that we don't have errors related to that. So hopefully the next time this group meets will have how many folks have downloaded and utilized the app as well as what our initial experiences are with it. And with any luck, even a little bit of data.

MR. COOPER: That'd be great. Amy, anything to add?

MS. EISENHAUER: Not to this, but I do have some other things to discuss.

MR. COOPER: Sure. Any comments on Jeremy's recent brief remarks? Okay. Well, again, Jeremy, thank you so, so much for your time today and we'll look forward to ongoing conversations with you in the Protocol group. Thank you again, Amy. Go ahead.

MS. EISENHAUER: Thanks Dr. Cushman, and thank you, Dr. Cooper. So back to the rest of my report. So the E.M.S. grant award, as Ryan had mentioned, was renewed V.A. So the end of March, they gave us the notice of awards sadly across the board, not just New York but across the board they were not able to award the full amount, but it is more than it used to be. So we were awarded one hundred and ninety thousand dollars for this year. And currently for the subsequent three years, each year is one hundred seventy five dollars. So there will be some budgetary review to see you know, obviously what has to go and what can stay, because thirty thousand dollars is not a small amount of money. So that work is ongoing. Hopefully soon they will be sending out the performance measures that we will be measured against.

I know that E.M.S.C. Federal is hard at work at finishing those up. And I will share those with you, as soon as I get them. I know that in the notice of funding opportunity much of the work, some of it is the same. So we're keeping the pediatric emergency care coordinators for both E.D.s and E.M.S. Pediatric recognition programs for both emergency departments and E.M.S. Disaster management is a key component and happily Kate Butler as a party and Matt Wiley from our office were able to help us include some pediatric specifics within some of their work. And I hope that Kate will talk about that during her report. So great stuff happening moving forward. And I'm going to talk more about the E.D. type program and E.D. recognition program during old business. So I won't get into that now in the effort of saving a little time. Let's see.

So the all grantee meeting for E.M.S. for Children is in September. It is sadly the same week as SEMAC and SEMSCO. So it is going to be Jacob and I going and we will bringing back information from that during the December meeting. Some of the things that they're featuring are pediatric recognition programs, how to engage hospitals, how to engage other

stakeholders to participate. So I am looking forward to that because as I mentioned, that's part of our expectations over the next four years. So it'll be great to see what other states are doing outside of the Northeast. I know that Maine, New Jersey, Pennsylvania, and New Hampshire have similar programs to ours. And they were great, helps with references, and things, but it'll be great to see what other states are doing as well, especially the larger states similar to ours like Florida, Texas and California.

So Ryan also mentioned Vital Signs Conference. I know that -- that was in the process of finalizing everything, but some of the topics that we were able to have are pediatric disaster. I know that there was also a class on penetrating injuries that is related to PED's and adults. So we were able to fit that in elsewhere in the conference, which is great. We are going to have Sarah Gruber part of our group do her de-escalation talk for, it's for everyone, but highlighting PEDs. And then also oldies, but goodies pediatric assessment which is always important. And one other medical talk, I believe PEDs respiratory, so important things that need to be reviewed and reminded

of because that's the bread and butter of pediatrics. But then also some new topics that are up and coming.

Also I believe I announced at last meeting that the PAT document had been updated. Thank you, Dr. VanderJagt and Sharon Chiumento for working on that. It was in printing; I believe last time we talked but I now have the documents on my hand where you can access it on our resource page. So that's available. The badge buddies are available and the E.D. or the E.M.S. tech application all of those we have forms for. And you can order those documents that way, or you can apply to be that way. And if you have any questions on that, obviously you can always contact me or Jacob and we'll get you to the right place.

Just want to make sure that I did not forget anything. There is an initiative on pediatric readiness for emergency departments at the federal level. They've been doing webinars on it. We'd love to have many, many hospitals participate. Really EMSC Federal does a lot of the work in guiding the initiatives, putting things together. So yes, there will be some work on the hospital side to do the work at their facility. But it is really supported by E.M.S.C. and E.I.I.C. So if you're interested in that,

I'll be happy to share that information as well. Next meetings. So the next E.M.S.C. and E.I.I.C. meetings will be in person at the Troy Hilton Garden Inn in Troy, New York. And those will be on September 5th and December 4th.

As Ryan mentioned, trying to keep them in line before CMAC and ... so that if we have anything that needs to be suggested or processed through those meetings. We can have our meeting and then it doesn't have to wait another three or four months till the next set of meetings which was very important in deciding some of these dates. So the meeting will still be from 1:00 p.m. to 4:00 p.m. And they will be in-person in the effort to start transitioning back to seeing people in-person. And actually, many of us include myself who are new getting to see each other. I didn't realize that I had never met Dr. VanderJagt in-person until a few months ago when I was out in Rochester. And it felt like I had known him in-person, but then I was like, man, I've never really met you in-person before.

So I think it'll be great to meet everyone in-person, for all of us to meet each other because we did have a lot of new members join. And for all the other providers that attend the meeting to

join us and get to be in the room where it happens, as it were. So, I will be sending out more information on that, how to make reservations, all the details on all of that soon. Also, if you don't have an ID number, I know I've been working with Tara to get them, or if you don't know it please email me and we'll work with Tara to make sure you're squared away for the meetings. Let's see.

MR. COOPER: Okay. Any questions for Amy?

MS. EISENHAUER: I have one more thing. Sure. Okay. But actually maybe this is better. I'll do the safe transport of pediatric patients update after anybody has any questions on these topics.

MR COOPER: Hearing none. Go ahead, Amy.

MS. EISENHAUER: Alright. So at the last ... meetings Dr. Daly had asked me to bring some of the safe transport pediatric patients, the newer devices related to newly born patients. So being able to safely secure patients that are just born, whether it was in the house or in your ambulance, how do we really secure our newest patients with mom and safely get everybody to the hospital. So he asked me

to bring some of those devices and my trustee ... at Birmingham to the meeting to demonstrate some of those items. And Ryan was kind enough to assist me in my demonstration and really got a lot of great questions and interests. And Dr. Cooper had asked me to give an update on our work with safe transfer of pediatric patients that have really been started with my predecessor, Mark Bohlke. And I know that she had done training programs for child passenger safety technicians, who were also first responders, paramedics, E.M.T.s, who worked on the ambulance. I believe it's the University of Indiana and I want to say 2010 or 2011, had put together a program detailing using car seats in ambulances, using the devices that had been developed at that time of which there was only a handful that were designed for ambulances when it's appropriate, how to do that et cetera. And I know that there have been several classes here in New York related to those who would train the trainer. Since then, a multitude of devices have been developed. I know that A.C.R. four, the new emergency pediatric restraint, which is the new A.C.R. four, the P.D.M.A., now has a P.D.M.A. Plus, which is a larger version. Ferno has invented

the KangooFix, which is one of the newly born patient devices, AEGIS' maternity safety belt has come out, which originally was developed for O.P. units and hospitals, but they did some crash testing and adapted some things. And it's also good for use in newly born patient situations in ambulances. And those are just a few of the devices. NASEMSO has an entire list on their website under the Safe Transport of Pediatric Patients header. And if you need that as a reference and you can't find it, again please email me, I'm happy to help and get that information to you. In light of these new advances and learning more about car seats and the cells being updated over the last thirteen or so years, there are new developments in using pediatric restraint devices. I know that we had discussed that as part of the updates for ambulances. So I know that as Ryan mentioned in his report, that there is some public comments coming up. So we'll learn more then. However, as far as training, I know that Linda Efferen just jumped off too. She is on the way to the Child Passenger Safety Technician Conference as well as I will be after this meeting. Many people on this call are either there or going there and are

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going to teach there. So several of the injury prevention coordinators and a variety of the pediatric and trauma centers, who also are C.P.S.T.s and paramedics and have been trained how to use devices in the ambulance under that initial program kind of have gotten together to develop an update for New York State. And I know that's been underway and I need to follow up with that group. But it looked like promising work on including some of the new devices and how to use or not newer safety seats in the ambulance. Related to newly born patients, I've been doing education across the state on how to use the newly born patient devices and sharing that information and bringing devices to different educational opportunities and discussing right best medical practices and how that needs to be considered as more considering transport and how we transport. And in that vein, I will be talking tomorrow at the Child Passenger Safety Technician Conference on that issue. So those are some of the updates. There is some movement as far as the education to keep providers up to date. I did see some great pictures on Instagram from, I believe Ryan Beckfire, who has some very proactive pediatric emergency care

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coordinators. They did some training with real children, not mine, creepy mannequins from Amazon, but real children of different sizes over the weekend. So from the photos, it looked like a really successful event and that everybody had enjoyed it. And any education that I go to where we do the hands-on skills component everybody loves it. They're always, you know, oh, this is so much easier than I thought. So I think just the contraption of the devices, which is a necessity, concerns people or makes them feel uncomfortable. But after they see them used, I think it makes providers feel much more comfortable using that for patients. Any comments on the safe transport of pediatric patients' portion?

MR. COOPER: No, this is really a tremendous amount of work in the evening and really look forward to more on this particularly after the conference that you're attending right after this meeting. It is a very hot topic for us all and has been for some years. And it's gratifying to, seems that it lasts on progress -- in cases in this area. That seems to be a little worthwhile. So because it's really been a difficult, today unsolved problem, and we really appreciate all your work on this and of

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course markets before you. Any other questions for Amy? Okay. Well, I guess, we're up to old business. Let's speak about the pediatric education protocol and check the educational component. Amy, do you have any information on that for us?

MS. EISENHAUER: So I had several training classes forwarded to me. I know Chief Pataky sent me some of their information from We Heard. Sara Gruver sent me her de-escalation work. Also, the E.M.S. E.I.I.C. has some information and documents, reminder documents. So the collection of items has occurred. And I know that we need to schedule another meeting to review them and discuss them and see how to move forward.

MR. COOPER: Yeah. And then ideally, we want to do that sooner rather than later, but to show some of the videos and so on, it might not be so easy to do it online. If it must need -- we could consider, hey, put it off this long, but we could consider doing it as a pre-meeting prior to our September meeting. But I'd like to see if we can't get something done before then if we can.

MS. EISENHAUER: Okay.

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MR. COOPER: Do we have a way through the system of doing videos online that's reliable? I know sometimes over the Internet the videos can be difficult.

MS. EISENHAUER: I will check the content. I think they're PowerPoint. So it might not be -- we might not have the video issue.

MR. COOPER: Yeah, I think -- I think the E.I.I.C. at least has some videos on their website or dot com.

MS. EISENHAUER: Okay. I will do some research and see how we can make that happen without having to wait till September.

MR. COOPER: Thank you. Anything else on the -- station protocol? It's gratifying that we've collected a number of items to review, but now we just have to get the pedal of the metal and get that done. Got it. Okay. So the PET program.

MS. EISENHAUER: Okay. That is me. Okay. I need your guys' presentation. Okay. So, as I mentioned earlier during my report, this is going to be a combination pediatric recognition program for emergency departments and a PET program within that pediatric recognition program. So in many of the

other Northeastern states, it's called Always Ready for Children. We kept -- we kept that vein because we do want to be always ready for children. And that's a huge initiative of E.M.S. at large. Let me see what you guys can see. I have two screens and I'm trying to see which screen is actually doing things. So why have a pediatric recognition program or a PET coordinator at all? Sorry for my technical issues. So it's been demonstrated through a variety of research championed by Dr. Gausche-Hill, so National Assessment of Pediatric Readiness of Emergency Departments and that was in JAMA PEDs in 2015, Emergency Department Pediatric Readiness and Mortality, and critically ill children, which is -- which was in pediatric patients in 2019. And then Dr. Remick in 2019, also Pediatric Emergency Department Readiness among U.S. Trauma hospitals and that was in the Journal of Trauma and Acute Care Surgery. So these research found that the presence of a pediatric care coordinator within an E.M.S. agency, E.D. or hospital, is one of the strongest drivers of improved quality of emergency care for children. And the results from the 2003 and 2013 National Pediatric Readiness Assessments also indicate that the presence

of PET is strongly correlated with enhanced pediatric readiness. So having the right pediatric supplies, having policies already be written, having processes and procedures in place, all of those things associated with readiness is one of the driving factors of excellent care for children. So benefits of having a pediatric emergency care coordinator, and you all may have heard this before, is an improved pediatric readiness score on that National Pediatric Readiness Assessment. Increased staff awareness and competencies in pediatric best practices, right? So making sure that many hospitals the PEDs is your thing, if trauma is your thing, you may have more exposure to pediatrics. But for hospitals and E.M.S. agencies at large, we don't always see a lot of pediatric patients. And I want to say for E.M.S. in 2021, five percent of all of our calls were for pediatric patients. So some people that have lower call volumes may not see a pediatric patient all year. Benefits of having impact is safer, better equipped emergency department for pediatric emergencies, so they will have the right equipment on hand, and easily reached. And sustainable pediatric education and improvement program that ensures kids

always present to a safe E.R. receiving the best care, which I think all of us agree is why we're here doing this work. So what is an emergency department PED, a pediatric champion can be a physician who's a specialist in emergency medicine or pediatric emergency medicine, can be a registered nurse with an interest or training in emergency care of children. And this could be a full-time role if you are blessed like that at your hospital or it could be in addition to other responsibilities as many of us do. And these suggestions come from E.M.S.C. federal and E.I.I.C. related to pediatric readiness in the emergency department, which was a joint policy statement from ACEP, E.N.A. and A.A.P. And then the institute -- the Institute of Medicine's report growing pains from 2006. So some of those responsibilities for the PET would be to promote and verify adequate skill and knowledge of E.D. physicians, E.D. healthcare providers, and other staff. And obviously taught by similar provider level, right? So physicians would be training physicians, nurses would be training the nurses. Other ancillary staff would be trained as appropriate by leader, participating in E.D., pediatric

Q.I./P.I., patient safety, injury and illness prevention and clinical care activities. And some of these -- I know that many hospitals do this because they do this. It's part of their work, especially the education hospitals. But for the smaller facilities, E.M.S.C. Federal does a variety of Q.I. projects. Currently, there is a suicide program in the E.R. or suicide of pediatric patients for emergency department's Q.I. program going on. And I know that they have another one for pediatric readiness upcoming, I believe it's in the fall. So also assist with development and review of E.D. policies and procedures, standards for meds, much like we just did, making sure that all the equipment is up to date, and supplies are accessible for pediatric patients. And ensure pediatric needs are addressed in hospital disaster and emergency preparedness plans. I know that that is a huge work to make sure that the hospital is prepared for a variety of disasters, whether natural or manmade. And we just want to make sure that children have enough supplies, appropriate meds, any specific things that they need. And I know in discussions with a variety of people, pediatric reunification

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with many of the disasters and school incidents going on across the country. Reunification is a huge deal. So, our plan; Always Ready For Children, there are three different levels. So, pediatric engaged means you want to do something, but maybe you haven't before, you don't have a lot of experience, you don't see a lot of kids. So you would complete the National Pediatric Readiness Assessment, which is the interim tool that E.M.S. for Children has put out for the years in between the N.P.R.P., which is the actual survey. And I want to say we did the survey in 2021. The next one I believe is 2024, 2025. So in between, it's the same thing. You just do it on your own. So doing the NPRA, so you have a score and you see where you're at, at this moment in your E.R. And you can do this every three months, every six months, every year, depending on your goals and initiatives. It's up to the individual emergency department. So have that readiness score. So you do get a report after you complete the N.P.R.A. and you definitely get a report, a gap report after the N.P.R.P. So what is your readiness score? So that we know that you did it. And then we can suggest any recommendations, resources. The hope is after the

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program is fully rolled out, that we can do some mentoring between hospitals. You know, hey, we've done this before, you're looking to do this, can we help each other? And then identify an E.D. pediatric emergency care coordinator. So who's going to be the person or persons, because it doesn't have to be just one, it could be multiple, depending again, on -- on your hospital's goals. Identify somebody that we can reach to talk to and who will be responsible for the work, essentially. And then the next level is pediatric ready. Right? So many of the same -- many of the same things except your score on the N.P.R.A., or N.P.R.P. be seventy or above. So maybe you've already done some of this work and your assessment has shown, hey, it's working, it's great, you want to do better. And then for Pediatric Innovator and I'm sure that New York State -- and I know that all of you are a component of many of these systems. Your score would be eighty or above. You would have a pack -- four packs and then also be willing to share your best practices and resources. So what projects did you do? What worked? What didn't work? And I know when talking to people, sometimes what didn't work for you is a better help than what did work.

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Especially because New York has a -- a large range of differences in communities across the state. But saying, hey, we did this and it was an absolute disaster for these reasons. Okay, right? My -- my region, my area, my hospital has similar features. Maybe we don't do that. Maybe we plan something else. So be willing to share those best practices and your resources. And as I mentioned, my hope is in the future years once we get everything kind of settled and off the ground is to do some professional development or do maybe a quick learning day. I know that I would also like to do that for E.M.S., but more education development for E.M.S. And for hospitals as we find out what hospitals need to develop those days for them. So how to participate? Ensure your facility has an emergency department path. I know that many of the hospitals that have reached out that are interested also because this is going to be a requirement for A.C.S. for trauma verification and re-verification in September of this year so many people already have somebody that functions in this role. I know the injury prevention managers; I've talked to work with a team. So I don't think that this will be as much of a reach for

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hospitals as maybe it is for E.M.S., because a lot of the hospitals, particularly the trauma centers, pediatric hospitals, have somebody that does all of this already, which is great. We're just putting a name on it. So also complete N.P.R.P. And again it's at dot org. If you can't find it again, I'm always happy to help. Submit your application with a commitment letter to us. And as we have many forms for many things, we'll have forms for this. Jacob -- Jacob didn't know until now, but that's going to be one of his projects in the next couple weeks as we move this forward. And then of course, start advancing patient care even more than you already are. So some of that guidance and tools, right? You're not doing this by yourself, myself and Jacob, and anybody else in our State Partnership Program are always a resource for anything, E.M.S.C. There is the E.M.S.C. E.I.I.C. site that has a wealth of tool kits research, educational information, a lot of the Q.I. initiatives are listed on this website past -- past Q.I. and upcoming Q.I. So always keep an eye out there if you're interested in projects. And then of course, the N.P.R.P. assessment which will be coming back up, I want to say in 2024, but it might

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be 2025. It's either one. And then of course, The American Academy of Pediatrics, ENA, ACEP, they do a lot of the heavy lifting at the larger level for research. Certainly Dr. Gausche and Dr. Kate Remick are prolific and do a lot of work surrounding pediatrics and pediatric preparedness. So next steps after -- after I speak with all of you, I will be speaking with staff next week. And kind of what we're looking for. I checked with the Division of Legal Affairs, we don't need a vote or a motion, but just kind of a yes, we support this statement is what they said was necessary to move this forward. Jacob and I will work with Public Affairs Group on updating our PAC webpage and resources. So as soon as this is approved and I can move forward, my hope is to have that done. ... is wonderful and super helpful. So I will reach out to him as soon as everything is approved to get that rolling so that it's up there and everybody can sign up. We will start the program rollout to hospitals. And I -- definitely I, but maybe Jacob will join me on some of the local ones. We'll be attending the RTEC meetings over the summer and the fall to talk about this with the regional trauma advisory councils as this is an A.C.S.

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initiative. And I will be working with Patty and Dan to make sure that all of the trauma centers have this information so that they can get on board, and they are enrolled and there is no issues. So that is the next steps for this program. And this is how you can find me. But you all knew that. Does anybody have any questions about the program? I know this is kind of a high-level overview. Our hope was not to make it so, so specific that different levels of hospitals or different regions with different capabilities or initiatives couldn't participate. We wanted to make it all inclusive.

MR. COOPER: Any questions for Amy? Hey, this is a boatload of work. We really thank you for all you're putting into it. Obviously, we recognize that this is a key element of -- of E.M.S.C. and well within your charge, but nevertheless you're doing a phenomenal job with us and they appreciate us. Any other comments or more questions for Amy? Okay, so let's move back to the next agenda item, then. You'll repost that agenda for us Amy?

MS. EISENHAUER: Yes, let's see.

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MR. COOPER: Okay. So Peter, your triage recommendation is the next item on the agenda, Amy?

MS. EISENHAUER: Alright. So give me one second and I will post that. I think I found it. I just want to make sure that you were seeing the correct document. It's a little crazy. Okay. So you should be seeing -- seeing our pediatric trauma triage destinations graph. Since you edited this, Dr. Cooper, do you want to discuss it?

MR. COOPER: I certainly can. So this builds off a document that was created in 2014 by a -- a group composed of members of E.M.S.C. as well as members of the staff. And at that time, it was determined that all pediatric trauma patients must be transported to it from the level one or level two pediatric trauma center if they meet current American College of Surgeons Committee on Trauma field triage guidelines and are able to arrive within fifty minutes. The circumstances have arisen over the past ten years or so. Where -- whereby some exceptions to that absolute requirement seem to be appropriate. Not to say that we don't want patients to go to level one and level two pediatric trauma center, okay? But

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there are circumstances in which that simply isn't feasible, perhaps due to lack of time and transport capabilities among -- among others. So in -- in editing this it seemed to make sense to put a strong should as opposed to an absolute must, as the part of this -- part of this document. So, that's -- that's bullet point number one. Can we slide down, please Amy, a little bit? And of course, same -- same for -- for the second bullet point. Clearly if the -- if the patient still meets field triage criteria upon arrival, you know, at a -- at an adult trauma center or non-trauma center, they should be transferred if, again -- if it's feasible. I can imagine that there are circumstances where, again, if it might not be feasible, might not even be safe. So -- so again, this would be providing some level of flexibility, but with a very strong admonition that that patients should be taken to pediatric trauma center -- designated pediatric trauma center. And the decision to transfer the patient who wants do primary survey, with potential surveys are initiated, ideally within thirty minutes. That's the decision, ideally within thirty minutes. Okay? Initiation of the transfer process should take place as soon as possible

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thereafter, ideally within fifteen minutes. So that'll be a total of forty-five minutes into the -- into the resuscitation. And then ideally, transfer should occur as soon as possible. Thereafter, hopefully within two hours. But again that's depending upon transport resources. So -- so this is the you know -- the -- the whole thrust of the potential suggested revisions are that we want to provide some level of -- some level of flexibility while still maintaining, the -- the -- the fact that pediatric patients belong in pediatric trauma center. And accordance to do that all pediatric trauma transfers needs to be reviewed in a timely manner. So that's basically it. And I invite any -- any questions or comments at this point.

MR. HARRIS: Alright. It's, Matt, may I just ask a point of clarification?

MR. COOPER: Sure.

MR. HARRIS: Thank you. So this is, as you know, has come up a couple of times in the New York City RE/MAX discussions. And there is, I think, a conversation to be had about how a pediatric patient is defined and not by the college. I think that's really well out there. But there seems to be

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discrepancy between how a pediatric patient is defined for treatment and how a pediatric patient is defined for disposition in terms of transport disposition. Just to be clear, are you exclusively referring to pediatrics in this context, is those under the age of fifteen?

MR. COOPER: Matt I can't quite hear you. Can you -- can you please up that last little bit? Please.

MR. HARRIS: Sorry, forgive me. I was just looking for a clarification on are we exclusively referring to pediatric patients as those under fifteen for the purposes of destination determination?

MR. COOPER: Well, that's -- that is -- that is you know open for discussion. If can Amy, can you slide back up to the top? And if you can see --

MR. HARRIS: The reason -- sorry, I was just going to give some -- some context for a moment. I'm driving, so forgive me, I can't see anything. I ...

MR. COOPER: -- if you can see, the last line of the introductory paragraph speaks about

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patients that have not yet reached their fifteenth birthday, it doesn't speak about patients over fifteen or more.

MR. CONWAY: Right. So I guess the reason I bring this back up for the group's discussion are -- and forgive certainly differ for person to you as a subject matter expert in this. When you look at different regions in New York in different protocols, and I -- I haven't reviewed the collaboratives recently, so please forgive my annotate here. But Pete, a seventeen-year-old with asthma may end up in either an adult emergency department or pediatric emergency department, and they are going to be treated under pediatric protocols, even though they're getting in adult medications and probably based on their age and weight. We've been having a big struggle about -- in our -- in our little cohort here at Cohen's about these patients who are fifteen in a day to seventeen and three hundred and sixty four days, where we in the last two years, just some revising context, we received two hundred adolescents, fifteen to seventeen, three sixty four for transfer from adult trauma centers, fifty percent of whom required

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admission. So these would fall under that cohort of kids that granted not discussed in this document because you have your age limitations, but in the bucket you described, if kids who show up in an outside institution because A.C.S. allows them to go there because they're over fifteen, but then it doesn't seem like a lot of these adult trauma centers are admitting this cohort of adolescent patients. So they're showing up to an E.C.S. accredited trauma center for adults, I'm sure being totally appropriately managed, but then not being admitted there for whatever reason. Maybe don't have pediatric expertise, -- et cetera. But do we feel that it's something we need to address in this document? Because I feel like that group gets lost. They are not quite adults, they are not treated as kids, and it's in, I still somewhat ambiguous, I think, what should happen and where they should go if -- at least in our -- in our small cohort here in Queens and Nassau County, you know, we're getting a hundred transfers a year for admission. Well, you're raising a very, very timely issue. You know, I think many institutions are grappling with the same issue as the present time. You know, I mean, it may be as

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simple in some cases as the adult trauma centers may not have a robust pediatric inpatient service, you know, and certainly may not have a pediatric I.C.U. in their facilities. And certainly, for patients requiring that level of care, that would obviously be an issue that would necessitate transfer to a pediatric trauma center, which of course by definition does have to have pediatric handling capabilities. But this document didn't -- didn't initially get into the issue of, you know, separating, you know, if you will levels of response, i.e., level one, level two, trauma consult, that sort of thing. And I think in a sense what you're saying, Matt, correct me if I'm wrong, is that you concerned that there are significant members of adolescent patients between their fifteenth birthday and their eighteenth birthday who perhaps don't meet level one or level two criteria who are -- who are just getting transferred to the adult center or sorry to the pediatric center just because, you know, it's trauma and adult service at the center hospital for whatever reason, may not feel comfortable dealing with those kids. Am I hearing your point correctly?

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MR. HARRIS: Well, I think there's sort of two groups. There's the groups sort of essence sort of minimal trauma that are -- are not cancer evaluating at adult institution because they're not comfortable or fill in the blank. But I think perhaps even more impressively, there's fifty percent of these kids is adolescents who get transferred to us get admitted, right? So one of us who get admitted.

MR. CONWAY: Right.

MR. HARRIS: So you can make -- you can make the argument that in a geographically appropriate area, had they just gone to the children's hospital, there would be no need for secondary transfer. I guess that's kind of the point I wanted to bring up is that I wonder we seem to be giving pretty clear guidance that if you're under the age of fifteen and you can't quite get to a pediatric trauma center, go to the adult place and we'll transfer and that's fine. I guess do we want to offer similar guidance for that fifteen to eighteen group because it seems like that's what's happening either way, or do we want to make the same sort of soft recommendation that actually should be fifteen

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to eighteen year olds or fifteen to seventeen, three sixty four. Should we actually go to the pediatric trauma center? I guess, I'm not, I defer to you as the trauma surgeon here to help answer that question where they should be taken primarily.

MR. COOPER: Well, Kim Wallenstein is also on this call, and she's our also trauma expert. And I think you framed the question very well, but I'm first going to turn to Conway because I've seen his hand up. Ed?

MR. CONWAY: Yeah, a quick question. I know, we're using various ages as cutoffs, but a lot of the institutions go up to age twenty one. So I know we're talking less than fifteen now. We're cutting it off at eighteen. But I think probably the majority of pediatric institutions, now I don't know what you guys put -- but we do go up to twenty one here. I'm just putting that in the mix.

MR. HARRIS: Trauma.

MR. COOPER: Excuse me. Your adult trauma surgeons just sort of the pediatric group and since eighteen to twenty one.

MR. CONWAY: So we just got our level two designation, so we'll -- we'll take everything up

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to twenty one. There are certain rules that they will go to the adult surgical I.C.U. if it's a bullet to the chest, a headshot, they think they need to go back to the O.R. But we -- we co-manage both ages. Under fifteen, we have PED surgeons that are involved and then up to twenty one are trauma surgeons take care of them.

MR. COOPER: The PED surgeons are involved for the fifteen to seventeen, right, or no?

MR. CONWAY: No, the adults will do everything over eight -- seven or eight. They have an agreement. I think it's age eight.

MR. HARRIS: Okay, I think right, Ed, yeah.

MR. CONWAY: Sorry, go ahead Matt. Yeah.

MS. HARRIS: I was just going to say, to answer Ed's question, I think that in the -- in the five boroughs, I would say that it's most common that adult emergency, I'm sorry, pediatric emergency departments are up to eighteen, a few to twenty one, N.Y.U., I think it's a twenty five. But I think -- but I think that currently the fire department and the ordnance department, we enact each drugs, take

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people under the age of eighteen, not for trauma, but for medical to a pediatric emergency department if they meet PED's GED criteria. So Ed's point is well taken.

MR. COOPER: Yeah. Kim Wallenstein, do you have any thoughts about this?

MS. WALLENSTEIN: Yeah, hi. It's Kim Wallenstein. It's -- it's a great point. I actually hadn't thought of this issue before with the -- the transfer being done to adult trauma centers and then transferring to pediatric places. I think -- I would, I don't know how I feel about putting language in about transferring a fifteen to seventeen year old perhaps to pediatric trauma centers, because you're going to get a whole range of different places. Like, for example, as people were saying, like where I am at upstate, we're a separate level one pediatric and a level one adult trauma center. And as pediatrics we -- for trauma, it's under fifteen. So you can say, oh, transfer those sixteen year old trauma patient to the pediatric trauma center, which would be us, but it would be the adult trauma team taking care of them. So it's -- you don't get the same thing that you think you're getting,

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transferring them to a pediatric center. So it makes covering -- which is a little more tricky.

MR. COOPER: I think Kim is right. I think that there's a tremendous disparity statewide between how different facilities handle the adolescent group. I think it's probably more common for the --the above fifteen age group to be handled by the adult trauma surgeons at least initially. And bringing the pediatric surgeons in as you know as needed. But again, that's totally institution specific. I'm going to recognize Ed Conway and Ed, please add your thoughts to the discussion at this point. Ed?

MR. CONWAY: Sorry, I just, I left my line in for too long. I just took it down.

MR. COOPER: Okay.

MR. CONWAY: One is enough.

MR. COOPER: I see that there's a couple of comments in the chat. And they by and large tend to confirm what's been said already that there's quite a bit of disparity. I think that Lisa has pointed out that in Rochester, the adult trauma surgeons take care of those patients, but they're admitted in the pediatric I.C.U. But that would

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still necessitate a transfer to a pediatric facility that has a pediatric I.C.U. And then I guess it would be to that facility to decide which group of surgeons was -- was involved in -- in the care of those patients. I think this is a pretty complicated issue. Perhaps what we should do is to set up a -- a conference call, Amy and discussion with physician a little bit more detail and then bring us back to the next meeting. Does that make sense to everyone?

MR. HARRIS: I'd like to participate in that conversation --

MR. COOPER: I am sorry.

MR. HARRIS: I was just saying, yeah, I was just saying I would love to participate in that conversation. Thank you.

MR. COOPER: Oh, sure. Of course. I think that Mr. Douglas mentioned this to me privately that in areas outside they're pretty good. Therefore, there are very few places that can actually be looking at trauma centers within fifty minutes, which is part of the reason for being a little bit less, if you will hard and fast about -- about the "muscular" was in place prior to this. I guess I still think that it's probably worth a longer

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the discussion that we have time for during this meeting that a small group that has a specific interest in this area probably should get together and discuss it and we'll bring it up at the -- at the next meeting. I don't think there's any rush in getting this off but there we are. So does anybody disagree with that approach? Okay, Amy, so let's -- let's set up a working group. Anybody that wants to be part of that, please let Amy know. I certainly will that -- that Aaron has said he wants to be part of that. Anybody else that's able to participate, please let Amy know and we'll get this thing set up. And I think your perspective would be very useful from Jacobi if you take kids way up to the age of twenty one. So that would probably be -- be very helpful.

MR. CONWAY: I'd be glad to participate.

MR. COOPER: I see that Brooke Lerner wants to be part of it and certainly Kim Wallenstein, so that's great. Okay. So -- so let's do that and I'll give her some -- some homework. We did discuss, I think, the length based discuss resuscitation tape a little bit earlier. Is there anything more we need

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to discuss about that Amy or do we cover everything pretty much? I think we did that really.

MS. EISENHAUER: I just have a short update. So Megan Williams, her paramedic class was reviewing the protocols and how the pediatric protocols and how -- how the dosages are written versus the -- on the light base meditate. So she emailed me this morning and said she was not able to make today but also mentioned that her class has done a bulk of the work and that they are putting together a document with their findings. So I anticipate that being ready for the next meeting. And we'll probably have an interim subgroup meeting. Just a little break. Yes. And then we'll present the findings at the next meeting in September.

MR. COOPER: Yes, please. But make sure we have -- current meeting. I know that Elise VanderJagt and Nickol O'Toole have both said they want to participate in the -- in the work group. So we will do that for trauma.

MS. EISENHAUER: Next.

MR. COOPER: Tell me. New business we've already covered that. So I think we are up to.

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MS. EISENHAUER: I think -- I think we have one -- one item brought up at the meeting. I know Dr. Winslow, are you able to unmute?

MR. WINSLOW: Yeah. Yeah, thanks, Amy. How are you?

MS. EISENHAUER: Good, how are you?

MR. WINSLOW: It kind of ties in with this whole trauma discussion, but one thing that's come up in our region, and we've discussed ... heart attack is the current new red criteria as approach is pediatric trauma patients, as -- as its red criteria for ages zero to nine, systolic blood pressure less than seventy plus two times even in years. And many of the E.M.S. providers do not take pediatric blood pressures, especially on very small children, ages zero, one and two, and three for a couple of reasons. Not to mention the fact that it's difficult on a -- on a very small child who's injury may be not cooperative to get an accurate reading anyway. So our concern was that if that's the criteria, shouldn't there be an alternate such as or the pediatric assessment triangle. That's what we teach in ... it allows for the pediatric patient to be assessed without documenting a blood pressure reading

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and gives you valuable information and also a systolic level blood pressure that low is obviously a very late sign of shock.

MR. COOPER: These are good points. The -- the only issue that I've seen with -- with -- with what you suggested is the fact that there -- there was strong pediatric representation on the national work group that put together the changes in the ... triage guidelines. And secondarily I'd be very surprised if SACC isn't going to -- isn't going to endorse the national guidelines, you know, for youth in New York State at its upcoming meeting. I could be -- I could be wrong, but I'm guessing that is what will happen. But I certainly, you know, think the points that you're making are -- are -- are strong ones. I think we all are familiar with the difficulty of trying to get blood pressures on -- on small children. You know, and I think -- I think that this is something that perhaps the workers is looking at trauma triage could actually, you know, secondarily take a look at the -- the groups tend be getting together with the triage anyway. Is that -- is that -- is that an approach that would work for you, Jason?

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MR. WINSLOW: Well, we already started on an educational piece from ... it's really an educational piece. I don't mean to change a protocol but just realize that if that is your one criteria for red, you're missing a lot of sick children. So what we're doing as an educational piece is that there are other indicators of pediatric serious injuries.

MR. COOPER: Sure.

MR. WINSLOW: Such as skin colored temperature and condition, and increased work of breathing, generalized look of the patient. So we're look working at it with our two pediatric trauma centers working in concert to put out an educational piece for our providers. But it's something that I -- we kind of plan to continue to work on. I'm curious to see if there's other regions that would be similar educational material. I don't need a protocol to be changed. I'm just advising that -- that although is a parameter that can be followed is probably not the best one.

MR. COOPER: Well, you know, once again, I'm not sure that we're going to have a whole lot of success in changing that national protocol,

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but your educational piece I think would be very helpful, you know, to this discussion. And I would like to invite you, if you don't mind, to -- to join you know, the pediatric trauma triage group and as an additional item of business for that group, perhaps you could present your -- the work that you've been doing and your region. Does that work?

MR. WINSLOW: Sure. Yes, I happen to work at --

MR. COOPER: Great.

MR. WINSLOW: -- pediatric trauma center for the last fifteen years of my practice at Good Samaritan. We see adults and children. But one thing I can tell you is -- is that blood pressure is often not even done in the trauma room as the first order of business.

MR. COOPER: Yeah, you're absolutely right. I think most of us who work in trauma centers would -- would you know, share their experience.

MR. WINSLOW: Amy, if you want to include me, I'd appreciate it.

MR. COOPER: Yes, that would be great.

MS. EISENHAUER: On the list.

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MR. COOPER: You are hereby included, sir.

MR. WINSLOW: Thanks.

MR. COOPER: Right. Okay. And Amy anything else before we move on to update to our partners?

MS. EISENHAUER: I guess not. Did you want to discuss pediatric strokes Dr. Winslow?

MR. WINSLOW: Yeah. Yeah, sorry to get both of my agenda items off in one scoop, but I will tell you, it has come up in our region as we look at regionalization of stroke care because we have three pediatric, sorry, we have three regional stroke centers and ten primary stroke centers. That there's no such thing as a New York State designation for pediatric stroke, and yet when you read them, the collaborative protocol that we all use, it groups adult in pediatric stroke together and states take patients to a pediatric stroke center. I'm sorry it says take suspected stroke patients to a stroke center. So I just bring it up for discussion. I don't want to create a new protocol, but just realize that some stroke centers may not be able to or should be taking care of pediatric stroke patients, which

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are very rare entities and are a little different animal than the adult. And I just wanted to show have the group look at the fact that currently pediatrics are included in the adult stroke protocol, which is written for adults.

MR. HARRIS: Hey, Arth, can I add with a quick response.

MR. COOPER: Sure. I think you've identified an important gap. Was that Matt who wanted to -- who wanted to respond?

MR. HARRIS: Yeah. I think Earth, correct me if I'm wrong, I think in the city, I don't believe Nassau, but I think in the city when this discussion came up to Jason's point I think we changed the recommendation and the language to say that pediatric sepsis stroke should go to a PEDs critical or City Center, recognizing that most pediatric strokes are not ischemic and usually require more pediatric expertise than necessarily out of the all the O.O.H.s Adult Comprehensive Stroke Center, that increasingly brings up an important point that you know, I think the, the destination of being a pediatric critical facility or pediatric capable facility with an I.C.U. is probably a more

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appropriate destination than the closest to Adult Stroke Center.

MR. COOPER: Other comments?

MR. VANDERJAGT: Hi. This is Elise VanderJagt, I just totally agree.

MR. COOPER: Please ... go ahead.

MR. WINSLOW: Yeah. I totally agree with what's been said. I think I like the last comment that these patients with pediatric strokes need to go to a pediatric critical care center because the etiologies are very variable. And that's probably the better place to go than a standard adult stroke center because they're quite different in etiology and potentially management. So -- but there is nothing, I believe again in our protocols that would suggest that, and maybe that should be an area to be recognized. All of our own institutions, we have developed a pediatric stroke protocol. We do have that. So I suspect other pediatric critical care or pediatric children's hospitals with those kinds of facilities will probably also have similar protocols and then that's where they're located rather than the standard adult stroke center.

MR. COOPER: Yeah. I will--

MR. COOPER: I'm sorry.

MR. WINSLOW: I'll share with the group that I brought this up with the collaborative protocol discussion meeting about a week-and-a-half ago. And the consensus among the collaborative working group was that because there's no separate guidance for pediatrics that they're better off in an adult stroke center than no stroke center at all. However, I kind of disagree with that. I do think that they were better served in a pediatric capable center, and so it's just a point of discussion. I also think it may be wise, and this was my recommendation, was to simply delete the word pediatric from the stroke protocol and having the vagueness of a pediatric patient that presents with stroke be that it's a rare entity that requires either medical control to be involved for a transport decision or just to flag it into something different. But leaving in pediatrics with adults now makes you take pediatric stroke patients to adult stroke hospital by protocol, and that was my whole point.

MR. VANDERJAGT: This is Elise --

MR. COOPER: Okay.

MR. VANDERJAGT: Sorry.

MR. COOPER: Go ahead Elise.

MR. VANDERJAGT: Yeah. I'm not sure that I'd eliminate -- I'm not sure that I would eliminate it because there is such a thing as where the trauma can occur and hemorrhagic stroke that can occur. So I'm not sure what I would -- how I would think about it entirely, but I am a little bit concerned about eliminating it unless you are interested in looking at a separate protocol completely.

MR. WINSLOW: You know, that would be the way the other protocols have been written. It's interesting that this one grouped them. When you look at the remainder of the protocols, they all have adult and pediatric separated, and this is one vestige of a previous generation of protocols that is currently being reviewed. We are new to the collaborative working group here in Suffolk. We just went live with the protocols this January, and we're still finding these issues. It's my opinion is to write a separate pediatric stroke protocol and instead of taking them to an adult stroke center, you could say taking preferentially to a pediatric

capable center, because there is no such state thing as a New York State designation for pediatric stroke.

MR. VANDERJAGT: But I do think it might be helpful, like you said, Jason, is to, maybe there should be that separation of pediatric stroke versus adults stroke, like they separated out seizures, like they separated out pain rather than inclusive, including it, but there needs to be done a separate protocol, and I think that's not an unreasonable thing.

MR. COOPER: Okay.

MR. WINSLOW: I'll be--

MR. COOPER: Yeah. Let's -- there's enough, you know, smoke and fire around this issue that I think we need to get together a conference call and -- and take it through. In general, I think that you know that, that the comments that have been made around the target that for the great majority of pediatric strokes, you know, the pediatric I.C.U. is the best environment. But there are, there may be occasional exceptions to the rule that Dr. ... has pointed out in terms of a hemorrhagic stroke, for example. Such a child might do better in a stroke center or a designated stroke center. But I do think

we need to come up with some specific recommendations if we think that the, a pediatric stroke protocol ought to be separated out from the current protocol. So let's plan on Amy getting together about the work group, I can see --rolling your eyes with the thought of -- of a not yet another group, but -- but I think this is, and we thank you, Jason, for bringing this up because it is an important enough issue that we should probably have a specific position on it. Jason, did you have anything else? Did you have anything else? Jason?

MR. WINSLOW: Sorry. No, I was just saying thank you. Please include me in the group.

MR. COOPER: Sure.

MR. WINSLOW: Or maybe also we could -- maybe also we could discuss it when we're in state council next week.

MR. COOPER: Of course.

MR. WINSLOW: Thank you.

MR. COOPER: You will clearly be included, and again Elise you would be part of that, kind of where you pay your employer, you're both pediatric intensive units. I don't know if you want to be part of it or not, I'll leave it to you. But

certainly your comments would be, you know, very helpful, and if the other folks want to be part of this discussion?

MR. HARRIS: It's Matt, I would.

MS. EISENHAUER: And I got you, Nickol.

MR. COOPER: Okay. Okay, wonderful. Thank you. Okay. There we are. So is there any other new business that didn't quite make it to the agenda? Well, hearing none at the moment let's move on to update from our -- from our sister advisory committees the D.O.H. Partners. Brooke and Peter, I don't know if Peter's on. I know Brooke is on.

MS. LERNER: Yeah, I didn't see Peter. I can tell you -- just recomplete, so hopefully Peter and I will still be with you in September, but we won't know until the results of the recompete come in. The seizure study that you all approved has been running in Buffalo. We've enrolled twenty six children. It's going well. That's using the emergency exception from informed consent and looking at age-based dosing compared to weight-based dosing. Well, last time I was here, I talked to you about our TRAC study, which is looking at bundles care and a

checklist for respiratory distress. We're going to be -- we're finishing our notification and community consultation plan, and so we'll be starting to share with the Buffalo community that, that study could be done here and getting acceptance for that. And I think that is all that PECARN is doing, but it's all very exciting.

MR. COOPER: Brooke, thank you so much for your report. And for those of you who may not know Brooke as well as I've had the pleasure and honor of knowing Brooke over the -- these many years. Brooke is amazing. She's made so many incredibly important major contributions to E.M.S. care. It's -- the list is almost endless. And we're just very, very lucky that that she's with us here in New York State, and you know -- and you know, of course you see this every time she speaks because she comes with data, you know, and -- and proposals for data on which the base decisions that are made. She's a really -- really a model of an academic scientist. So, Brooke, thank you for all your contributions there, so important to the world in which we function.

MS. LERNER: Thank you for your kind words, and I am ecstatic to be back in New York, so I'm happy to be where I grew up.

MR. COOPER: Great, great. You know, I grew up in Western New York, Brooke, so, you know, we both love the cell. So I'm informed that Amy Jagareski from the -- from the Bureau of Occupational Health and Injury Prevention, you know, affectionately named BOHIP is not with us today. And unfortunately, a successor has not been named. So we'll have to wait until September to hear from BOHIP. I don't know if anyone's up from Family Health, Marilyn Kacica are you with us today?

MS. KACICA: I am here and I've been listening.

MR. COOPER: Oh, great.

MS. KACICA: No updates.

MR. COOPER: Great. I'm sorry, I can't see with, with the agenda up. I can't see everybody on the screen. So --

MS. KACICA: No problem.

MR. COOPER: -- you kind of were here. So tell us -- tell us what you've been doing?

MS. KACICA: We -- you know -- we haven't been so much involved in the pediatric framework lately. It's been a lot of women's health and abortion work. So that's kind of been keeping us busy.

MR. COOPER: I'm sure. Okay. Well, we're -- we're grateful for your participation because you certainly have been busy with us in the past. So we hope that, that the future issues arrive that need your outstanding input. We'll be -- we'll be able to, you know hear from you at that time. Thank you.

MS. KACICA: Yeah.

DR. COOPER: Okay. Kate Butler, as a party from Health Emergency Preparedness Central Office. Katie, are you with us? I think I saw your name.

MS. BUTLER-AZZOPARDI: I am here. Thank you, Dr. Cooper.

MR. COOPER: Great. Can you say a little --

MS. BUTLER-AZZOPARDI: I just have great things that are germane for this group today. As many of you know, we have some federal

requirements to work on specific surge annexes for the State of New York. And we will be starting the process from the chem surge plan and, and response annex shortly. So I did want to actually disclose to this group if there's anyone who would like to sit on the expert into the group for as we're, when we're cracking that for the state, and then additional guidance for the regional level. Please reach out to me or reach out to me through Amy. There's anyone who has any interest or if you have any suggestions that would be greatly appreciated.

MR. COOPER: Dr. Kate, can you say a little bit more about, about what, what has entailed in this project? So we'll have a better sense of who might be able to help you?

MS. BUTLER-AZZOPARDI: Yeah. So what we -- so over the course of our five year cooperative agreement, we have had a requirement to do five separate specialty surge annexes. So this year we're just wrapping up the radiological surge. We get to have PEDs very early on in our cooperative agreement infectious disease. And so what we have been doing is the approach we take as far as we do for cracking some of the larger documentation that we bring

together, you know, the best of the best across the state to help inform that document. So what we're doing is, so usually is two to three meetings that are hybrid and or with a virtual option to really kind of go through some of the things that would go into that. It's not truly an operational document because it's really a rollup of everything that's happening within the state. But the roll-up of the actions for New York State Department of Health, so in that same vein we are working to do that, that chem -- chemical surge response annex. And usually we do kind of a -- an overarching one meeting that's kind of broader strokes, and then kind of tease it down to really inform that document as we prepare to submit it to our federal partners and have it available for our regions to use for their use. Does that helps?

MR. COOPER: Yeah. That the focus for the -- so that's great, so the focus for this particular time is on the chemical surge, correct?

MS. BUTLER-AZZOPARDI: Correct. Yes.

MR. COOPER: Okay. Alright. And if there's anyone with a particular expertise in that area please get in touch with Amy and, you know, and

Amy and I will work to identify someone who can fulfill that role for you, okay.

MS. BUTLER-AZZOPARDI: Yeah, it's really interest only if, if there's someone who has any interest, we -- but we, I did want to because this was a really great venue to, to float that for some of the minds on this call, so I do appreciate that.

MR. COOPER: Sure. Anything else?

MS. BUTLER-AZZOPARDI: I just had the last thing, Amy did mention when she was going over some of the Always Ready for Children Initiatives is that, so we have the, the luxury that we get to directly fund one hundred thirty six of the hospitals outside of the New York City region through our hospital preparedness program. We've been working over the last couple months to try to crack a deliverable for our next grand year that involves the hospitals doing the National Pediatric Readiness Assessment. We essentially can offer them a carrot to go in and do the survey. So hopefully as we, and we have had to have designated this as a required activity for them, so we should have a one, it'll give a nice little boost for the folks that are

looking towards that always ready program. And we'll have that as some of that additional data and the facilities will have that, that progress report that you get back from the system. So we were able to build that into their contracts for next year. I'm actually really excited. I think it's going to be really helpful across our two grand programs, not even as far as what we're trying to do, but also very important for some of our work that we're doing across the state.

MR. COOPER: Yeah.

MS. BUTLER-AZZOPARDI: So I'm glad that that got through, and it was -- I'm really looking forward to kind of this, this cross activity between our two grand programs, because I don't know that that's happening in other parts of the nation.

MR. COOPER: Got it. Okay. Thank you so much. Anything else from -- from -- from you, Kate?

MS. BUTLER-AZZOPARDI: Yeah. Okay. That's all I have for now unless anyone has questions.

MR. COOPER: Anyone have questions for Kate? Okay, then Drew Fried from Long Island, Health Emergency Preparedness. Are you with us today?

MS. EISENHAUER: I do not see Drew our list of participants.

MR. COOPER: Okay. We'll move on to the Quality & Patient Safety/Sepsis Initiative. Alda or Linda or Kate or George, are you one or more of you on the line?

MR. STATHIDIS: Yeah. Hi, good afternoon, Dr. Cooper. Yeah. This is George Stathidis with the Office of Quality and Patient Safety.

MR. COOPER: Hey, George.

MR. STATHIDIS: How are you? I'm going to share my screen. I have a slide deck to share with you here. I will actually give a quick update, and then I have my colleague with me Stephen Goins going to give an update on the slides here. I'll walk through that. So before we jump into the slides, just a brief update for the substance program. Since we last met for here at the E.M.S.C. meeting, we actually released our 2019 report. That report was sometime in the making, of course, it got

interrupted by the COVID pandemic. However, we were able to get all of secure all our approvals and release that report. And that is what we're actually going to go over here today. That was an interesting report that we actually did some risk adjustment for the pediatric population, which was the first time that we were able to do that. And Stephen will go through that in a couple moments. But that's what we're going to talk about today. In addition, we are still working on our 2021 Annual Report that we have all that data in-house right now. We're going through our research team, I should say, going through extensive validation and discussions on how we'll present that data and will be a new format. So it's not quite ready yet for live for prime time. But of course, our process is usually that we'll bring any initial results to our pediatric sepsis advisory group, which I know Dr. Cooper and Dr. ... I know you're both on that. So you -- we will probably see some preview of some data in the coming months. I'm not sure exactly when we'll have that available, but we are working on it quite seriously here. And then in addition, we just wrapped up data collection last week for 2022 data for adults and for pediatric

population. So we have quite a bit of data in-house that we're working on right now. I would almost venture to say that we're buried in data, but we are working on that and we're working on again putting the reports together. So I want to turn it over to Stephen Goins from our office. He's a Research Scientist and introduce yourself and then we can go through a slides here.

MR. GOINS: Yes. Thank you, George. You can hear me, okay?

MR. COOPER: Yes.

MR. GOINS: Alright. Great. Thanks. Yeah. So I would agree with George. We are buried in data. I'll back him up on that. But yeah, so good afternoon, everyone. I'm -- yeah, as George mentioned my name is Stephen Goins. I'm the Director of the Bureau of Vital and Health Statistics in Q.P.S. And one of the roles of bureau is to provide analytic support for the New York State Sepsis Initiative using the data collected through the initiative. And that includes more recently, as George mentioned, the development of risk adjusted mortality model for the pediatric severe sepsis population that I'll be presenting today and that was

included in our 2019 report. George, if you don't mind, go ahead, please. And one more thank you. Okay. So I'll just start with a brief overview of some high level characteristics of the pediatric severe sepsis population in 2019. So the table on this slide shows the volume, distribution and population incidence rates of pediatric severe sepsis for age, group, sex, and race ethnicity. There were a total of six hundred and twenty-four severe sepsis cases in patients' age less than eighteen years old in New York State in 2019. And while incidence is thankfully much, much lower than what we observed in the adult population within the pediatric population, incidence is highest among the youngest patients. As you can see here, that's patients' age less than one year old and then second highest among patients age one to two years old. There is a slightly higher incidence among males versus females in 2019, though, not that much of a difference in race. And then in terms of race and ethnicity again, not huge differences in race but we did see incidence was highest among the black non-Hispanic population and lowest among the Native American Pacific Islander and multiracial population. So I will note that the

sample size is quite small for that group with only thirteen cases before me. Next slide, please.

Thank you. So next here, I just want to give an idea of our approach to developing the model. So we decided to build a multi-variable mixed effects logistic progression model. The primary feature of this model is to account for outcomes clustering by hospital, which we did detect in this population. So that's why we went in that direction. The outcome we chose to represent mortality was thirty-day all cause mortality, post presentation of severe sepsis. So we did consider a ninety-day outcome, but ultimately decided that that approach could capture additional deaths that were unrelated to sepsis. And so we stuck with the third-day. Also note that the intent of this model was to assess trends in risk adjusted mortality over time in this population. It's a little bit different from what we do on the adult side where we intend our model to facilitate comparisons of hospital performance. But really, we like the sample size to take this approach for pediatrics. And I won't go through all the exclusions here, but I just do want to note that we did exclude newborns. That is patients who were born

in the hospital and developed with severe sepsis or septic shock before they were discharged. And for patients who had more than one hospitalization for severe sepsis, we only included a single hospital for ... patients.

And calling all those exclusions ultimately, we ended up with one thousand four hundred and seventy-four eligible cases from 2017 through 2019 model.

MR. COOPER: Steve, can you just comment on the unmatched SPARCS Group? That seems like a pretty big group.

MR. GOINS: Yeah. Yeah, certainly. So we added that exclusion because we actually use our SPARCS data in order to facilitate our match to BS. So to determine our thirty-day all cause mortality outcome. We use vital statistics but we don't directly match vital statistics to our sepsis data. We actually go through our match to SPARCS in order to determine that outcome. So that's why that's added here as an exclusion is because yeah, obviously without the SPARCS match, we can't detect a vital statistics outcome. So yeah, and I will.

MR. COOPER: Sorry. What is SPARCS? I'm sorry for those ...

MR. GOINS: I'm sorry. Yeah. So SPARCS, I'm going to make sure I get the acronym right, Statewide Planning and Research Cooperative System. It's a database that the D.O.H. has been collecting I think since 1987. But it contains all institutional hospital discharge and E.D. visit data reported by the hospitals to the D.O.H. And it's a pre-adjudicated administrative data. So it contains things like patient demographics, which we use the link here as well as like a diagnosis and procedural information as well.

MR. COOPER: The reason I ask the question is simply we often find -- and the -- in reviewing the trauma data, from the trauma registry, we often find that when we measure the SPARCS that, that, that either one or the other has resulted in a miscode of some kind, and it may not be a real trauma case. I just wondered if there was some sense that the mismatch is here indicated that these patients might not have been septic or in fact, they are septic, but for some reason SPARCS didn't include them. Any sense of that at all? I think this -- to

get my understanding as to whether we could be missing something here if, but there's a skew here somehow that is contaminated your data set. That's all.

MR. GOINS: Yeah. No, certainly. Yeah. Well, the first thing I do want to know is typically our -- there are a fair number of cases excluded here, but the match rate to SPARCS that we normally get is pretty good. Ninety plus percent, obviously we wish it was better. And actually, I think we're improving our process for future years to kind of boost that match up. But yeah, we have -- we do typically make comparisons between severe sepsis diagnostic criteria that we see in SPARCS versus what we have collected in our sepsis database. And I don't remember the exact numbers off the top of my head, but it tends to be pretty good. I would say in general, we tend to see more cases classified or reported to us rather, I should say, as severe sepsis. In the sepsis initiative data than we do compared to SPARCS, but we usually defer to our data collected through the initiative at least in this case, in this historical data here because the definition of severe sepsis was based off of clinical

medical record abstraction, right, whether or not it resulted in a diagnosis. And we've usually --

MR. COOPER: Let me ask the question. Yeah. Let me ask that question in another way. If you were to have included those cases as opposed to excluded them, would it have changed the outcome in any way?

MR. GOINS: So the reason we did not include them is because they're at least the way our outcome was defined, it would've depressed our mortality outcome, right? Because necessarily because we didn't have them match the SPARCS, we could not detect a mortality outcome for them in vital statistics. So that was really the intent behind excluding them as far as if we had used in-hospital mortality, for instance, which we would've for all those cases and we would've included them, it may have changed the results here. But we usually do an evaluation of in-hospital mortality in addition to our thirty-day and at least in those true comparisons, there wasn't a significant impact on the -- at least the crude trends that we saw when we did that.

MR. COOPER: Okay. Thank you.

MR. GOINS: Yeah. No, great questions. Hopefully, I answered that directly enough, but --

MR. COOPER: Close enough.

MR. GOINS: Alright. Great. Thanks. Thanks, George. Okay. So I know in the previous slide, we called this the -- or we -- I called this the 2019 risk adjusted mortality model, but we did actually use three years of data seventeen through nineteen to build the model. This is done primarily to increase the sample size for this analysis, but also, obviously having three years of data allows us to examine trends and mortality over time. And the way we chose to evaluate that was by trending the standardized mortality ratio or S.M.R. by quarter across the three years in our analysis. So the S.M.R., if you're not familiar, represents the ratio of observed mortality outcomes to the number expected based on the risk factors in the model. So an S.M.R. greater than one indicates worse mortality than unexpected, while an S.M.R. less than one indicates better mortality than I expected. This is sort of the simplified standard in interpretation when evaluating results from a standard logistic

progression model. But the interpretation does hold even for when using a mixed model as we did here.

Next slide. George, thank you. Okay. So moving into the results here. So the chart on this slide is showing trends in the statewide S.M.R. including ninety five percent confidence intervals by core. So on the X-axis here, you can see the quarter of discharge from 2017 quarter one through 2019 quarter four. Well, S.M.R. is plotted here on the Y-axis. The dot, of course, represents the S.M.R. estimated for that quarter. And then those lines extending vertically there are the confidence interval. And then the lines here, we have colored to represent whether or not the S.M.R. is -- the quarterly S.M.R. is statistically higher or lower than expected in the quarter. And then just lastly here at the bottom of the chart, we have the number of hospitals contributing cases to the S.M.R. in each quarter.

So as you can see, there's a fair amount of variability in the S.M.R. for -- from quarter-to-quarter, it hops around and we have pretty wide competence intervals. In fact, we only have two instances where the observed outcomes are

statistically different from expected. So yes, seeing 2018 Q4 there, we have mortality significantly lower than expected and then in 2019 Q4 where mortality is significantly higher than expected. So I would say, in general, we don't really observe any peer trend in the pediatric risk adjusted mortality in this field.

MR. COOPER: Have you looked at anything beyond fourth quarter in 2019 yet?

MR. GOINS: No, not to this point. So yes, we have a pretty consistent data source from 2017 to 2019. But you know, we've sort of changed our data collection since then. So we haven't looked at anything.

MR. COOPER: I only asked because you know, the fourth quarter 2019, you know, performance was good compared to the rest of the experience. And I wondered if we were -- we're just beginning to catch the first little bit of COVID there. I don't know, we're not recognizing just a thought. That's all.

MR. GOINS: Yes. No, no, no. I'm still. Sorry. I was just stewing on that. Yeah, yeah, yeah. I mean, possibly. But yeah, I mean --

you're right, right, right. Yeah. And so certainly that's the outlier, right? And it is statistically significant. I was just looking here, right? We do see the bump in Q4 in 2017, and then of course, in 2018, it's statistically lower.

MR. COOPER: Yeah.

MR. GOINS: So yeah, it's kind of -- okay, so next slide. Next, chart. Okay, so this next chart is a similar view, but add the element of case volume in here. So again, quarter along the X-axis, but now we have case volume in addition to the SMR on the Y-axis. So that colored line on the chart represents the same SMR data points as in the previous chart. And then the bars here represent case volume. So the dark green representing patients who died within thirty days of a severe sepsis presentation. And then the light green representing patients who survived at least thirty days following presentation.

And I think the point I just kind of want to emphasize on this chart here is just kind of the remaining influence of small sample size on these trends. So even though, we have a -- we would seem at least have enough cases in each quarter overall in

order to produce stable estimates here. The number of outcomes in each quarter is relatively small, right. So ultimately, that means that our SMR is very sensitive to swing in just a handful of mortality events. And this likely contributes to some of the -- that wide variability that we see.

MR. COOPER: Right?

MR. GOINS: Yeah. Like, again, yeah, that big swing 2019 Q3 to Q4. I mean, it's almost a doubling of mortality events, but it's still only seven deaths.

MR. COOPER: Right, right.

MR. GOINS: Alright, George, last slide. Okay, so just a way of summary, so as I mentioned, we didn't really observe any clear trends in risk adjusted mortality in the pediatric population for the years that we studied here. However, we do really recognize their limitations to our data collection and modeling that that might obscure any trend that we could observe. I mentioned it before, small sample size really limits the statistical power in this analysis.

And I'll also note that the data collected through the sepsis initiative used here was

designed and constructive more specifically for the adult severe sepsis population and to facilitate risk adjustment in the adult population. So maybe data that is more tuned to the pediatric population with regards to risk factors would likely improve the performance of the model here.

And then just lastly and kind of related to that point, there's often additional complexity in the diagnosis and treatment of severe sepsis in the pediatric population, somewhere you're aware, that's something that we are often from the -- our pediatric sepsis advisory group. But that also makes risk adjustment for this population more challenging.

So I suppose in a way of closing, I would say, well, our ability to model pediatric sepsis mortality may currently be limited. We are intending to continue to work with the data, the pediatric data that we have available to develop appropriate outcome measures for this population.

MR. COOPER: Okay. Well, as always, the presentations for your group is -- the presentations are very thought-provoking. We appreciate your time in presenting this data, George,

and certainly even more important your time in putting it together. That obviously for us, our main concern continues to be early recognition, and early treatment measures that are likely to potentially limit the unsure effects of severe sepsis. And as you pointed out, the data probably is not quite robust enough yet in terms of volume being more than anything else. Get us an opportunity to look at those minor points.

But we go not, and hopefully, as we look at the next group of data, which I'm hoping you might be able to have for us by September, maybe, maybe not, I don't know. But I certainly hope so. Maybe, we'll see you know, a bit more of a trend toward improvement. But that will await your analysis. So thank you very much. Does anybody else have any questions for George or Steve? Okay, well, thank you so much. Mike McEvoy, are you with us?

MS. EISENHAUER: Mike had emailed me that he might have a conflict and I do not see him on our list.

MR. COOPER: Okay. Well, ... And finally STAC & Pediatric Trauma Subcommittee, we have not met in quite some time, Kim Wallenstein, do you

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have anything for us? I don't know that we have that since the last meeting of EMSC, so I don't know we have anything new to bring some stuff of these trauma. There may have been --

MS. WALLENSTEIN: Yeah, very brief --

MR. COOPER: Go ahead. Wallenstein.

MS. WALLENSTEIN: Nothing really -- nothing really new. The last staff meeting, because we know was not held, so we did have a brief interim meeting in March and we talked about it, a few issues with our TEQIP collaborative data as well as our -- the new standards of mental health screening that are going to be with our verification. But we will hopefully be able to meet again before our next E.M.S.C. meeting, if we're not going to have a pediatric subcommittee meeting at the next staff that's coming up within the next couple weeks, because it conflicts with the American Pediatric Surgical Association Annual Meeting where most of us are going to be. So I don't think we would have a good forum there. So we are not going to hold that, but we will try to get an interim meeting in place to talk about some more initiatives.

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MR. COOPER: Great. Thank you. Okay. Well that we had a lot of ground covered today. I anticipated that this meeting would probably extend until four-thirty, but I'm fortunately wrong and I see Amy as smiling as well. So I know she's pleased that we're done a little bit early, but I see that Sharon Chiumento has her hand up and has something to share with us. You're muted, Sharon.

MS. CHIUMENTO: I just wondered if we've had any progress on the pediatric education materials that we were working on trying to develop educational materials and things like that. Has there been any progress on that at all?

MR. COOPER: On the education stuff?

MS. CHIUMENTO: Right.

MR. COOPER: We did speak about that. We did speak about that earlier in the meeting. Amy has collected a whole slew of --

MS. CHIUMENTO: I remember -- senior moment.

MR. COOPER: That's okay. That's okay. We all have those -- even those who are younger than seniors, so there we are. Thank you, Sharon. Anything else?

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MS. CHIUMENTO: No.

MR. COOPER: Well, in that case, wow, we are finishing twenty-five minutes ahead of schedule. I'm sure that that will allow everyone to run to the nearest coffee yard to recharge. And our next meeting, Amy, will be when September --

MS. EISENHAUER: September 5th in Troy, New York at the Hilton Garden Inn from 1:00 p.m. to 4:00 p.m.

MR. COOPER: That is before or after Labor Day, that sounds like it's after Labor Day; is that right?

MS. EISENHAUER: It's after.

MR. COOPER: Pardon?

MS. EISENHAUER: It's after Labor Day.

MR. COOPER: After Labor Day. So that's Thursday after Labor Day then, correct?

MS. EISENHAUER: Yes.

MR. HARRIS: Can you share the location one more time, Amy?

MS. EISENHAUER: Hilton Garden Inn in Troy. And I will be sending out more information to everybody as we get. Just a little bit closer probably June to make sure everybody has the

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information they need. But I want to make sure that you guys have the date so you can mark it off. It is an in-person meeting. It is in the Capital region. So I will help with the travel stuff, but I wanted to let you guys know, because I know that everybody has crazy schedules and we need to make plan up here. The train is not far from the city. So if you like Amtrak, the train is near the hotel, not too far, if you didn't want to drive, so some options.

MR. COOPER: Thank you, Amy. So this --

MR. HARRIS: I've only train like twenty minutes, is that cool? Okay. ... few seconds. I'm sorry. Alright.

MS. COOPER: Matt, I'm sorry, I didn't quite hear you. Matt? Okay. So I just wanted to remind everyone that our custom in the past have been to meet at 875 Central Avenue, where the Bureau of E.M.S. offices are located. We are not meeting there. We are meeting in Troy. So for those of you who will be coming up the morning of the meeting, please don't go to the wrong place.

And Amy I know you'll count -- I can count on you to remind me because, I've spent so many

years going to 875 Central Avenue, right? Good, well end up in the wrong place. So again, Hilton -- hired in for everybody and we will see you in September, okay? Take care everybody. Have a great summer and we'll look forward to a whole bunch of conference calls, mostly in July, because I know people are largely going to be away in August, okay? Thank you. Take care everybody.

MS. EISENHAUER: Thanks. Hi everyone.

MR. COOPER: Thank you for a great meeting.

(Off the record)

(The meeting concluded at 3:38 p.m.)

I, ANNETTE LAINSON, 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 117, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 2nd day of May, 2023.

ANNETTE LAINSON, Reporter

I