12/4/2023 – E.M.S. for Children – WebEx
NEW YORK STATE
DEPARTMENT OF HEALTH
E.M.S. FOR CHILDREN
ADVISORY COMMITTEE

DATE: December 4, 2023
TIME: 2:12 p.m. to 4:14 p.m.
CHAIR: ARTHUR COOPER
VENUE: WebEx

Reported by: Becky Foster

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2 **APPEARANCES:**
3 Alexander Bleau
Amy Eisenhauer
4 Benjamin Kasper
Brian Clemency
5 Chief Pataky
Dr. Albert
6 Dr. Elise Van Der Jagt
Dr. Matthew Harris
7 Kate Butler
Kim Wallenstein
8
Kris Alfonso
Megan Williams
9
Nicole O'Toole
10 Patricia Riley
Peter Brodie
11 Peter Dayan
Ryan Greenberg
12 Sharon Chiumento
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2 (The meeting commenced at 2:12 p.m.)
3 **MS. EISENHAUER:** Good afternoon,
4 everyone. Thank you so much for all your patience.
5 We are ready to go. Annette, you can go on the
6 record.
7 **CHAIRMAN COOPER:** Oh, good afternoon,
8 everyone. My name's Art Cooper. I have the honor of
9 chairing the -- this committee at your request. This
10 is the December 4th, 2023 meeting of the E.M.S. for
11 Children Advisory Committee to the New York State
12 Department of Health. We're delighted that you're
13 all here and as the first order of business, I will
14 ask Amy if she will confirm attendance and ensure
15 that we have a quorum to proceed.
16 **MS. EISENHAUER:** Thank you, Dr.
17 Cooper. Dr. Cooper?
18 **CHAIRMAN COOPER:** Here.
19 **MS. EISENHAUER:** Dr. van der Jagt?
20 **MR. VAN DER JAGT:** Here.
21 **MS. EISENHAUER:** Dr. Albert?
22 **MR. ALBERT:** Present.
23 **MS. EISENHAUER:** Bruce Barry? Sharon
24 Chiumento?
25 **MS. CHIUMENTO:** Here.

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2 **MS. EISENHAUER:** Dr. Conway let me
3 know that he will be absent. Dr. Feuer? Pamela
4 Feuer let me know that she would be absent. Dr.
5 Calleo also let me know that he would be absent.
6 Doug Hexel let me know that he would be absent.
7 Nicole O'Toole?
8 **MS. O'TOOLE:** Here.
9 **MS. EISENHAUER:** Dr. Bombard let me
10 know that she would be absent. Dr. Harris?
11 **MR. HARRIS:** Here. Thank you.
12 **MS. EISENHAUER:** Chief Pataky?
13 **MR. PATAKY:** Here.
14 **MS. EISENHAUER:** Jason Haag let me
15 know he would be absent. Ben Kasper?
16 **MR. KASPER:** Here.
17 **MS. EISENHAUER:** We have a quorum.
18 **CHAIRMAN COOPER:** Thank you very much.
19 First order of business will be approval of the
20 minutes from the September meeting, I'm presuming
21 everyone has had an opportunity to review them. They
22 were sent out prior to the meeting today. Are there
23 any additions, deletions, or corrections to the
24 minutes? Hearing none can I have a motion for
25 approval? Bruce Barry. Thank you. Dr. Harris?

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2 **MR. HARRIS:** Second.
3 **CHAIRMAN COOPER:** Dr. Harris second.
4 Thank you.
5 **MS. EISENHAUER:** Just for reference
6 because the court reporter is virtual, can everybody
7 state their names? Because she's not in the room to
8 see us, so if we could just repeat that motion.
9 **CHAIRMAN COOPER:** This is Dr. Cooper,
10 Chair. I ask that -- that a motion be made to
11 approve the minutes.
12 **MR. BARRY:** Motion by Bruce Barry.
13 **CHAIRMAN COOPER:** Thank you. And?
14 **MR. HARRIS:** Second. Matt Harris.
15 **CHAIRMAN COOPER:** Thank you, Bruce
16 Barry and Dr. Harris. That would be great. That's
17 great. Any discussion on the motion? Hearing --
18 hearing none, All in favor, please signify by saying
19 Aye.
20 **ALL:** Aye.
21 **CHAIRMAN COOPER:** Opposed? It carries
22 without dissent. Thank you. Our next item of
23 business is going to be a little bit out of order
24 because our -- I know. Our -- oh, that's right. I'm
25 sorry. Usually our director goes first, but today

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2 it's our E.M.S. grant report going first. So Amy,
3 please take it away. Do you have your own
4 microphone?
5 **MS. EISENHAUER:** I do.
6 **CHAIRMAN COOPER:** Okay. She has her
7 own microphone.
8 **MS. EISENHAUER:** Hello, everyone. So
9 very quickly, the Always Ready for Children Pediatric
10 Recognition Program has received two applications.
11 And I am in the process of reviewing them and sending
12 out acceptance letters. So we're very excited. The
13 two hospitals that applied, SUNY Upstate in the
14 Syracuse area, and Oishei out in the Buffalo region.
15 So we are excited to have hospitals applying. Of
16 course, we want every hospital to have a Pediatric
17 Recognition Program. So if you have questions, need
18 more information I'm happy to help. You can also
19 find more information on the Always Ready for
20 Children Program on the E.M.S.C. State website. So
21 National Association of State E.M.S. Officials has a
22 Pediatric Restraint Device Testing Advisory Group.
23 Yes, all of that.
24 So I'm a member of that group. And we
25 are in the process of writing what pediatric

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2 restraint device testing should be. And these are
3 suggestions that will go to S.A.E. and future -- in
4 the future, after this document is completed, the
5 hope is to actually do testing and have pediatric
6 restraint manufacturers and car seat manufacturers
7 test those devices in ambulances. Because currently
8 in the United States, there is no testing for any of
9 those devices. So we want to make sure that the
10 equipment that we're using for kids is evidence-
11 based, just like any kind of clinical care we
12 provide. So we are in the process of writing those
13 recommendations.
14 Previously we had to write definitions
15 and engineering as a profession is very different
16 than medicine as a profession, and yet we use the
17 same words, which mean entirely different things,
18 which -- so it took a little bit of time to -- to get
19 the definitions down, but we have them down and we're
20 into the recommendations. So hopefully within the
21 next six months, ideally the document will be
22 complete and they can edit it and start the next part
23 of the process. So I do have a presentation for the
24 new grant performance measures for E.M.S. for
25 Children from HRSA. I'm going to leave that to the

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2 end. I did want to share about a new feature that
3 HRSA, the grant sponsor has. So we have Family
4 Action Network members as a part of our committee.
5 Nicole O'Toole is one of them. And we're vetting for
6 the other spot currently.
7 So we have two members on our
8 committee as roles according to regulation. But now
9 HRSA -- and so FANS also do projects, you know,
10 around the country, et cetera, do other work for
11 education but they want the FANS to be more involved.
12 So starting with the next meeting Nicole and in the
13 future her fellow FANS, as they get vetted and join
14 us, will provide an update at each meeting. So if
15 you have any questions for Nicole about FANS or -- or
16 for me about the -- the FAN program please let us
17 know.
18 So in April, our grant was renewed, as
19 I have shared. Give me one moment. Our grant was
20 renewed. In August they sent out the official
21 performance measures document. So any grant has
22 measures by with the -- by which the grant sponsors
23 judge your performance, hence performance measures.
24 And we have to report on them.
25 So I have to provide a report annually

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2 back to HRSA on what we did, how the meetings went,
3 what projects we've done, what we've published, any
4 kind of outreach for education that we've done. I
5 have to provide that every year. And ideally, they
6 want it to be according to these standards, to reach
7 their goals on a state and a national level. So they
8 have broken it up a little bit differently, this
9 iteration. So there are performance measures
10 associated with emergency department readiness,
11 performance measures associated with pre-hospital
12 readiness, and then also performance measures
13 associated with disaster readiness.
14 So Performance Measure 1.1 is a
15 Pediatric Readiness Recognition Program. So we have
16 the Always Ready for Children Program. And we've
17 combined some of these performance measures to work
18 together because they do kind of naturally flow that
19 way. So the program goal is to increase the
20 percentage of hospitals with an emergency department
21 recognized through a Statewide, territorial, or
22 regional program that are able to stabilize and or
23 manage pediatric emergencies. So we are starting
24 with the Always Ready for Children Program to provide
25 support to emergency departments to be able to

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2 achieve that. And so the national targets, so this
3 would be all fifty-nine programs, so it's fifty
4 states, District of Columbia, and then I believe we
5 have eight territories.
6 So Puerto Rico, U.S. Virgin Islands,
7 Guam, United Mar -- Mariana Islands and some others.
8 So they all have programs. So there's I think fifty-
9 nine programs currently. And so across those
10 programs, fifty-nine percent need to have a program
11 by 2027, which is yeah, four years from now when this
12 grant runs out. So this grant cycle. As State
13 targets, so what they would like our State target to
14 be is that forty-five percent of all of our
15 hospitals, depending on what State you're in, will
16 have an E.D. recognized through that kind of program.
17 Okay. So we -- they also want a
18 hospital E.D. Pediatric Emergency Care Coordinator.
19 And so the goal is to increase the percent of
20 hospitals that have a designated nurse, physician, or
21 both. Our program asks for both because there are
22 slight differences in education across either that
23 really is best spoken to with a PECC with that
24 experience. So we included both who coordinate
25 pediatric emergency care. And this could be a full-

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2 time role, a part-time role, or this could be some --
3 somebody else that's already kind of doing these
4 activities. And that could be the person, right? So
5 we -- we don't need a whole new person to do this,
6 just somebody that is familiar.
7 And so the national target, their hope
8 is that seventy-five percent of all hospitals with an
9 emergency department would have a designated PECC by
10 2027. And they asked the State target to have
11 seventy-five percent of all hospitals with an E.D.
12 have a designated nurse, physician, or both. They
13 also ask that hospital emergency departments weigh
14 and record patients weights in kilograms. And so the
15 program goal is to increase the percent of hospitals
16 with an E.D. that weigh and record children in --
17 record weight of children in kilograms. And I'm
18 happy to say that our last N.P.R.P., I believe we had
19 like ninety-eight of the hospitals that responded
20 record and weigh pediatric patient weight in
21 kilograms. So we're already kind of ahead on this
22 one.
23 And so the national and the State
24 targets HRSA requests eighty-four percent. So we've
25 already kind of met that based on their standards.

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2 So yeah, very exciting. And then also they ask for a
3 hospital emergency department disaster plan. And
4 that's to increase the percent of hospitals with an
5 E.D. that has a disaster plan that addresses the
6 needs of children. And this is another thing that
7 could be an addition to a disaster plan they already
8 have. But just making sure that children in
9 pediatrics, having appropriate supplies for them,
10 having appropriate needs. So something like
11 pediatric reunification, right? Like having a plan
12 for that so that families can be reunited after
13 disaster, right?
14 Considering those needs that might be
15 more -- that might be needed by children, that might
16 not be needed by an adult. And so the national
17 target and the State target for that is seventy-five
18 percent by 2027. So the performance measures for
19 E.M.S. So they are requesting a pre-hospital
20 pediatric readiness recognition program. So similar
21 to our Always Ready for Children Emergency Department
22 Program. The plan is that in the next few years, we
23 will revamp the pre-hospital PECC program to look
24 more like the E.D. ARC program. So it would have a -
25 - a readiness component with a survey. And so some

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2 of that is being handled by HRSA and our E.M.S.C.
3 data center. So the hope is that we'll be in the
4 next few years, we'll be rolling that out. So the
5 national target is twenty-one percent of states or
6 jurisdictions having this program by 2027. And State
7 target is twenty-five percent.
8 We will roll the pre-hospital
9 emergency care coordinator for pre-hospital agencies
10 into that. So we already have the pre-hospital PECC
11 program that has been ongoing since 2019. And we're
12 very excited to have over two hundred and fifty
13 E.M.S. agencies in our State that participate in that
14 program. And I think we're at about three hundred
15 actual pediatric emergency care coordinators. So
16 some agencies have more than one, so larger agencies
17 have multiple people to achieve those means. So I
18 think that we are on the way to meeting the score by
19 2027, which is fifty percent. And hopefully once we
20 add the recognition components and even more support
21 than we already give, I think that will increase
22 these numbers.
23 So pre-hospital use of pediatric
24 specific equipment, that goal is to increase the
25 percent of E.M.S. agencies that have a process

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2 requiring E.M.S. providers to physically demonstrate
3 the correct use of pediatrics equipment. This is a
4 repeat from last grant as well. And so up until
5 recently we've been using recertification as -- as a
6 piece of this. I know that N.R.E.M.T. is changing
7 the algorithm of -- the algorithm a little bit, and
8 our education department has been working on that.
9 So as soon as I know more about how we're doing
10 skills checks and how that piece is going to work for
11 education my hope is to work with education to kind
12 of revisit this or come up with a solution. But the
13 national target and the State target are both forty-
14 six percent of E.M.S. agencies.
15 And I would also say that this will
16 probably be rolled into that pre-hospital pediatric
17 recognition program, and then also pre-hospital
18 disaster plan. So just like -- just like hospitals,
19 the goal is to increase the percent of E.M.S.
20 agencies that have a disaster plan that includes or
21 addresses the needs of children. And so the national
22 and State target are seventy-five percent for both of
23 those. There is a FAN performance measure and that
24 is family representation on the State E.M.S.C.
25 advisory committee. So I'm happy to say that we meet

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2 this with flying colors because we have a FAN. And
3 then we have some other FANS in the vetting process.
4 So we have met and we'll meet this and also happy to
5 say that it's required in regulation. So it's
6 standardized, not going anywhere anytime soon.
7 Does anybody have any questions about
8 any of the performance measures?
9 **CHAIRMAN COOPER:** I do, Amy. Two
10 things. First of all, some of the folks with a
11 little bit of gray hair, that may only be Elise and I
12 at this point, I don't know around the table,
13 remember that when recognition for pediatric
14 emergency services really got started in Southern
15 California with the, so-called EDAP program,
16 Emergency Departments Approved for Pediatrics.
17 Hospitals that earned that designation had the
18 opportunity to display a big teddy bear that said
19 EDAP on it outside their emergency departments. And
20 I'm just wondering, since we have the Always Ready
21 for Children buttons available now for -- for team
22 members, is there any thought that hospitals might be
23 able to get a larger version of this that says Always
24 Ready for Children that they could post outside?
25 It would be a -- I think it would

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2 really serve to raise the general public's sense of
3 the importance of being ready for children, as well
4 as to give the hospitals themselves a little bit of a
5 marketing boost. What say you?
6 **MS. EISENHAUER:** So I have been --
7 since -- since the program was approved in June, I
8 have been talking with a public affairs group on what
9 we can do for recognition and promotion. I have
10 talked with our representative about having some sort
11 of certificate that emergency departments can
12 display. I don't know about the bear, because the
13 bear and marketing are kind of a point of contention
14 but we are working on it. And I do agree that
15 recognizing hospitals that are either engaged, so
16 they want to be -- want -- they want to improve their
17 care for children. And I think all of the hospitals
18 do, right? We always want to be prepared.
19 But whether they're engaged, they are
20 prepared, or they're innovators because we do have a
21 staggered scale that any of them should be recognized
22 for doing this important work. So it is in progress.
23 **MR. VAN DER JAGT:** Amy, this is Elise
24 van der Jagt just for identification. This is great
25 actually. I -- I -- and I agree this completely, Dr.

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2 Cooper. There are two things that came up just in
3 these last few weeks about this recognition program.
4 So one is in my own area, and I was dealing with
5 seven hospitals in our particular region. There was
6 not very much knowledge among the hospitals about the
7 program. So I am concerned that, you know, do
8 hospitals really, have they gotten the message that
9 this is available for them? I don't know how many
10 here have had that experience, but I was kind of
11 amazed that, you know, at least in the Finger Lakes
12 region where I am, that seven of the hospitals in one
13 of our systems, you know, that they were -- this is
14 like totally news to them, and yet it's been out
15 there since the beginning of the summer.
16 So that's number one. The second
17 thing that came up relates to this as well, is that
18 the -- some of the questions came up, well, what does
19 it really mean? You know, what do you mean by
20 recognition? And I think that, that underlying that
21 is, well, if we're going to get recognition, it would
22 be nice for the public to know that we are a
23 recognized hospital, whether it's at tier one, tier
24 two, or tier three. And so I think those are the two
25 things that I discovered literally in these last two

2 weeks when I did a presentation on the -- on this
3 whole new system.
4 **MR. HARRIS:** Hi, Matt Harris. I -- I
5 think there's a couple things to consider here
6 because we want this to be an -- a more than a merit
7 badge, right? So I think when and it's a potentially
8 contentious topic. I think also looking both in New
9 York City and also at the State, that, you know, when
10 you look at other recognitions of programs, trauma,
11 and stroke, there are accreditations you can get from
12 American College of Surgeons. I forget the name of
13 the stroke organization. And while I think it would
14 be a tremendous step forward for organizations just
15 to participate and take the survey once, to get a
16 great idea of where they stand.
17 And for those on the call who may not
18 be familiar, you know, when you go through the
19 survey, the nice -- probably the most valuable part
20 of it is the gap analysis you get at the completion.
21 And then there's a -- a set of online tools, which
22 are totally free, correct me if I'm wrong, Amy, but
23 totally free. Because the intent is to do the gap
24 analysis, and then for departments to understand how
25 they can improve. And really it should be a dynamic

2 assessment, right? We find we're deficient in
3 equipment this year. We remedy this, we -- we do our
4 assessment the following year and some cadence. So I
5 do think it's valuable in recognizing the work that
6 these emergency departments are doing, but it's a
7 timestamp, right?
8 And I think that this should lead to a
9 broader discussion about how we define pediatric
10 capable and pediatric critical care capable
11 institutions in the State. Because we have strict
12 definitions for intensive care. We have strict
13 definitions for neonatal intensive care, and we lack
14 both in the city and in upstate or the -- the rest of
15 the State. There's a city-centric thing to say, I'm
16 sorry, for the rest of the state, we lack well-
17 defined definitions of what it means to be a
18 pediatric critical care accepting institution. So
19 while I think it's great, and I would support people
20 publicizing that they're actively participating as a
21 Peds Ready or Peds Innovator, I forget the middle
22 ground.
23 We just have to be careful that it
24 isn't done once and they get labeled a Peds Ready
25 program, and then there's a shift in management or

2 shift in priorities, and they fall off the radar. So
3 just something to think about how we create a
4 dynamic, ongoing recognition process that -- that
5 puts some teeth on it. Thank you.
6 **CHAIRMAN COOPER:** If I might respond
7 to -- to Dr. Harris's comment not in a negative way,
8 but just by way of reminding everyone on -- on the
9 meeting who is attending either in person or
10 virtually, that a number of years ago an effort that
11 grew out of this committee, and particularly led by
12 our late great colleague, Dr. Bob Cantor from
13 Syracuse ensured that we actually have regulations
14 for pediatric intensive care units in State code.
15 And in order to be recognized by the State as having
16 a pediatric intensive care unit on your operating
17 certificate, you know, it's required that you meet
18 the -- that you meet those -- those standards. But
19 Dr. Harris is entirely correct that there's -- you
20 know, there is no mechanism for, you know, for timely
21 re-recognition if you want to -- if you want to call
22 it that.
23 There's simply the expectation that
24 once you are duly recognized by the department as
25 having a pediatric intensive care unit that meets

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2 those regulatory standards that it's your
3 responsibility to, you know, to - to maintain those
4 standards. Understanding that, you know, if
5 something, you know, dreadful were to happen to a
6 patient in your facility, and it was found that you
7 had a PICU on your operating certificate, but in fact
8 you did not, you know really meet those standards, it
9 -- it might be a, you know, a -- a difficult
10 circumstance for the hospital to be able to defend.
11 In any event that there is -- there is a mechanism in
12 State code that -- that defines you know what you
13 must do to -- to be a pediatric intensive care unit.
14 So in that sense, there are standards already. I see
15 Dr. Harris wants to respond.
16 **MR. HARRIS:** Sorry, for me, just a
17 point of clarification. I think this is a vernacular
18 issue. When I talk about pediatric critical care
19 receiving, I'm really referring to the emergency
20 departments. What defines a freestanding emergency
21 department or a hospital emergency department to
22 receive critical children now, recognizing that there
23 are many, many parts in the broad geography of New
24 York State where there is a hospital and that's,
25 that's actually where the merit of the Peds Ready

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2 Program and the ARC program is most profound, right?
3 Because I think we have the pleasure in some parts of
4 the State to have many institutions to choose from.
5 So there's a -- an incredible opportunity for our
6 colleagues in more suburban and rural and super rural
7 places to use the Peds Ready and the ARC program to
8 guide their continued success.
9 But I think that there's still an
10 opportunity for us to evaluate how -- what -- what
11 the regulatory requirements might look like, what
12 that picture could be envisioned for, to describe
13 from a regulatory perspective what emergency
14 departments need to have to receive critical children
15 without making it too arduous. Sorry for the
16 clarification.
17 **CHAIRMAN COOPER:** If I could, again,
18 respond to that. This is not the first time we've
19 been down this road. And some of you will recall
20 that oh, in the mid to -- mid 2010s, we had a major
21 quality improvement program under -- under or
22 supported, or underwritten, I should say, by the --
23 by the National E.I.I.C., the MSC Innovation and
24 Implementation Center to look at, you know, various
25 things. The project that we in New York State chose

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2 was looking at data comparing hospitals, in effect,
3 comparing hospitals that were, you know, that had
4 stronger pediatric resources versus those that did
5 not. And it was our hope at that time that that
6 would be the basis to strengthen the regulations.
7 There were regulations put into place
8 together with the PICU regs back in the mid 2010 --
9 2014 I believe, that did -- that did upgrade the
10 requirements for pediatric emergency departments to
11 some extent, but not to the extent that that this
12 committee felt was entirely appropriate. The -- the -
13 - there were major changes taking place in the health
14 department leadership at that time. And even though
15 the data that we presented to them were really
16 exceptionally strong in terms of showing that, you
17 know, that emergency departments that were, you know,
18 prepared to deal with children's issues, frankly, did
19 a -- did a, you know, a better job in terms of
20 mortality outcome.
21 You know, the -- the -- the department
22 leadership at the time felt that it needed more
23 evidence because these -- that data was based upon
24 hospitals, you know, filling out surveys and the --
25 the department felt that a -- some level of, shall we

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2 say, verification of those -- those self-reported
3 data, you know, would be -- would be in place before
4 the department felt it could ask the, you know, the
5 community at large, particularly the hospitals, to
6 endorse a program that, you know, actually
7 strengthened the pediatric emergency department regs.
8 It may be time for us to revisit that -- that issue.
9 And I can assure you that now that this issue's been
10 brought up, thank you, Dr. Harris for doing so. I'll
11 -- on behalf of the committee, I'll have that
12 discussion with Director Ryan, who at one time had
13 indicated his desire to provide some support for a
14 verification process that looked at the data.
15 I think it -- at this point, we would
16 have to go back and re-look at the most current
17 version of the pediatric readiness data. And so that
18 would require some additional support from the
19 department to assign someone in the in the -- in DMAR
20 the -- this -- the Department Statistical Bureau to,
21 you know, re-look at that data see if the results are
22 the same, and then verify. But I -- I think it's --
23 it's been almost ten years since that process began,
24 and there's no reason that we can't at least explore
25 the possibility of moving forward on -- on that. You

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2 know, but that will be up to Director Ryan and the
3 department, of course. But thank you for bringing
4 that up, Matt. Amy, I had one -- I had one other
5 question about the performance measures, but I think
6 you want to go first here on this issue.
7 **MS. EISENHAUER:** Yes. So Amy
8 Eisenhauer. So there is some work with verification.
9 So this is kind of in response to Dr. van der Jagt
10 and then also to the verification piece. I have been
11 attending the regional trauma advisory committee
12 meetings as I'm able across the State to share about
13 this program. And I've been working with the
14 Pediatric Subcommittee of the State Trauma Advisory
15 Committee on how to get this integrated into some of
16 the smaller hospitals. And I'm sure Dr. Wallenstein
17 is going to talk later about this in her report,
18 because it was a big topic at the pediatric
19 subcommittee and at STAC. So there is some
20 verification piece to an extent contained within the
21 A.C.S. guidelines, the new, I believe, gray book.
22 **CHAIRMAN COOPER:** Right. Correct.
23 **MS. EISENHAUER:** Yes. Okay. I'm --
24 I'm looking at Patty from trauma designation about
25 which color book it is. So the gray book, and I

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2 believe it's 5.10, 5.10, yeah. So requires any
3 trauma hospital, whether they want to be designated
4 or re-designated to take the survey. And at that --
5 at that point, that is the big thrust of our
6 pediatric recognition program. And then to have a --
7 a plan to address the gaps. So E.M.S.C. Federal, HRSA
8 Federal has been working with A.C.S. on how do we
9 integrate this. So there is some plans for
10 verification and re-verification in the works. I do
11 understand that that doesn't necessarily entirely
12 encompass the smaller, you know, more rural hospitals
13 where I think the larger program in general is
14 targeted for pediatric preparedness and having those
15 capabilities and education.
16 And so that was a discussion at the
17 Pediatric Subcommittee of STAC. And we'll hear more
18 about that later in this meeting. So there -- there
19 has been some discussion around these things. And
20 then, oh, Dr. Cooper, I forgot your point that I
21 wanted to address. Maybe it was that, see if I was
22 lucky. Yes. So these are all excellent points and
23 we have been in different arenas trying to work on
24 addressing them.
25 **MR. VAN DER JAGT:** Amy, if I could say

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2 something about that as well here. Yes, I'm very
3 familiar with the trauma regulations. Because in our
4 institution that's came up, the importance of the --
5 the P.E.C.C.s and the importance of this gap analysis
6 and the -- and the assessment. You know, eighty
7 percent of kids are seen in non-trauma centers, you
8 know, that go to the E.D. So they're actually seen
9 in the smaller hospitals that we, certainly in rural,
10 Upstate New York, we have a lot of. And so I am
11 going back to my very first question is, how do we
12 make sure that these hospitals are even aware of this
13 program? Because again, I -- my anecdotal experience
14 was that they were not aware of this at all, even
15 though it's been out three or four months.
16 And this is an opportunity, I think,
17 for those smaller hospitals to at least get an -- do
18 their assessment and seeing how they can improve what
19 they have so that they can take care of children in
20 those rural areas where there are small hospitals.
21 So I'm asking how we can move that forward. The
22 trauma piece is, I know it's going -- being in --
23 discussed with the trauma committee, but it's these
24 smaller hospitals especially that I'm concerned
25 about.

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2 **MS. EISENHAUER:** And so that -- that
3 was what we discussed at the pediatric trauma
4 subcommittee meeting. How do we get those smaller
5 hospitals? And there were some ideas. I mean, we
6 can certainly talk about that here, but I think
7 that's going to be part of Dr. Wallenstein's report
8 later.
9 **MR. BARRY:** It's Bruce Barry. Being
10 on the rural side of things and working in small
11 hospitals, just wondering if there's also a way to
12 broaden the definition of the coordinators. We have
13 some of the smaller hospitals that employee E.M.T.s
14 who may also be involved with the PECC programs, who
15 might be willing to, you know, kind of chair, you
16 know, champion this in place of, you know, a nurse.
17 Or also some of the hospitals are largely staffed by
18 P.A.s, nurse practitioners versus physicians. Would
19 that be an acceptable alternative to the M.D. role?
20 **CHAIRMAN COOPER:** To -- to my -- to --
21 to my understanding, you know, the whether you're in
22 a hospital or whether you're in the pre-hospital
23 environment, the pediatric emergency care coordinator
24 role does not -- does not necessarily physician or
25 nurse specific. Unless things have changed. Amy is

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2 nodding her head vigorously that I'm -- that I'm not
3 quite on point about that. So Amy, perhaps you could
4 tell me what has changed.
5 **MS. EISENHAUER:** Sure. So the Pre-
6 Hospital Pediatric Emergency Care Coordinator
7 program, so for E.M.S. agencies could be an E.M.T. or
8 paramedic. That is separate from the Always Ready --
9 currently separate from the Always Ready for Children
10 Emergency Department Program. And so I will look
11 into the -- the nurse practitioner, right? Because
12 they have a doctorate to -- not necessarily, okay.
13 So -- so I will ask up the chain because I -- I know
14 that that's probably not just happening in New York.
15 But for the Always Ready for Children Emergency
16 Department Program, we request that there is a nurse
17 and a physician PECC. So there would be two PECCS
18 for each hospital.
19 If they wanted to add other team
20 members, so like Ben does -- does other work within
21 the hospital. Okay. Thank you. So right then, does
22 other work with injury prevention. He could be a
23 member of their team but they ask for a nurse and a
24 physician. A lot of it in any of the evidence based
25 from E.M.S.C. and HRSA is really surrounding

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2 education and competency. And how educated -- I'm
3 trying to say this nice. How education is received
4 by practitioners, whether they're a nurse, or a
5 physician, or other member of the emergency
6 department team from that educator or the person
7 putting that information out. So I think they tried
8 to recognize some of the interpersonal relations that
9 could happen in emergency departments.
10 **MR. VAN DER JAGT:** If I could make a
11 comment on that as well, since I just researched some
12 of this out. They write in this project, which is a
13 national project, indeed, as -- as Amy said, requires
14 a physician PECC and then a nurse PECC. And both of
15 those individuals really should be actively involved
16 in emergency care. That's another part of this.
17 What we have done where I am at our children's
18 hospitals, we have those two people, but then we have
19 actually added a nurse practitioner who is part of
20 the disaster planning for the children's hospital.
21 So it's -- they're not the substitute, they're not
22 the nurse PECC, but they are supplemental. And we
23 figure that those three people would be -- it would
24 be a -- a good fit would be as an additional
25 supporting thing.

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2 It also says in the discussion about
3 readiness in the readiness project, that you can also
4 solicit, you know, P.A.s, other folks who are giving
5 care rather than a physician. And that, that really
6 is important. Because many of the smaller hospitals,
7 they actually function with physicians' assistants or
8 nurse practitioners. So it makes sense that they are
9 part of it. But it -- and remember, a nurse
10 practitioner is also a nurse, you know. Right.
11 Initially. So.
12 **MR. HARRIS:** Just a quick question.
13 Going back to the original comment, Amy. Do you
14 present at all at HANYS or Greater New York Hospital
15 Association?
16 **MS. EISENHAUER:** I would love to
17 present at HANYS or the Greater New York Hospital
18 Association.
19 **MR. HARRIS:** How do -- how do we get
20 that invite to happen?
21 **MS. EISENHAUER:** That's what I would
22 like to know. I can work on it. I'll talk to Ryan.
23 Because I know he knows some of the folks, and I know
24 also that we've had some involvement with FIPIC and -
25 - and other groups.

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2 **MR. HARRIS:** Right. So Andrew Dahl, I
3 think, is the last name.
4 **MS. EISENHAUER:** Yes.
5 **MR. HARRIS:** At Greater New York, has
6 been very active in a number of pediatric projects.
7 And I think would be -- I'm not sure if he's
8 listening, but he be really engaged. I'm -- I'm
9 going to vol -- volunteer him.
10 **MS. EISENHAUER:** Okay. So I'll reach
11 out to him. I actually worked with Mr. Dahl on an
12 ambulance at one time.
13 **MR. HARRIS:** Yes.
14 **MS. EISENHAUER:** Two years ago.
15 **MR. HARRIS:** He still -- he still
16 makes some occasional appearances in New Jersey, I'm
17 told. Yeah.
18 **MS. EISENHAUER:** Yes. So I'll reach
19 out to Andrew and see how we can get included on
20 their agendas. So Patty, always prepared. I love
21 her. Did bring up some of the documents from the
22 E.I.I.C. and E.M.S.C. Federal. So if you're curious
23 and you happen to be here, I have the assessment, if
24 you want to look at the questions. But also, there's
25 a checklist on pediatric readiness in the E.D. And

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2 at the top it lists what the physician coordinator
3 what kind of -- what criteria they should meet the
4 nurse coordinator, what criteria they should meet.
5 And then in an asterisk, it says an advanced practice
6 provider may serve in either of these roles, so
7 either physician or nurse PECC. And then there is a
8 guideline toolkit for further definition of those
9 roles. And all of this information comes from a
10 joint policy statement called Pediatric Readiness in
11 the Emergency Department from 2018.
12 And this was supported by American
13 Academy of Pediatrics, ACEP, and Emergency Nurses
14 Association. And if anybody has any questions out
15 there on the -- in the internet world please email me
16 and I can share these resources with you as well.
17 **CHAIRMAN COOPER:** Thank you, Amy. So
18 I have just one follow-up question on the recognition
19 issue. And a -- a second question about one of the
20 performance measures, the follow-up on the -- the
21 recognition issue is, you know, to be sure that we're
22 looking at the signage part of it. I really do feel
23 that those signs outside the E.D. do make a
24 difference. We're all familiar with the fact that
25 every hospital displays its joint -- Joint Commission

2 accreditation certificate, you know, at the front
3 door. It's usually in a little frame about this big,
4 copy of it. Everyone just walks by it and doesn't
5 realize that the hospital is Joint Commission
6 accredited. And you know, or at least most do.
7 And I -- I think that, you know, that
8 simply posting a certificate in the emergency
9 department helpful, no question, you know, might not
10 be enough to catch the eye of the -- of the general
11 public and, you know allow our hospitals to really,
12 you know, say, hey, we are ready for children and --
13 and so on. So I'm going to ask that in Amy's, you
14 know, follow-up on this, that the signage piece be
15 added to the -- the list. The second question I had
16 is on the -- the -- the disaster plan. The -- the
17 performance measure that Amy showed us lists
18 emergency department disaster plan. I can tell you
19 that in New York City that, you know, an extensive
20 effort was made through the New York City Pediatric
21 Disaster Coalition under the New York City Department
22 of Health and Mental Hygiene to ensure that every
23 hospital had a -- had a pediatric annex to its
24 overall disaster plan, which included you know issues
25 with respect to the emergency department, but also

2 other facets of pediatric care in the hospital.
3 And -- and I'm just concerned that
4 this is -- this performance measure seems to focus
5 exclusively on the E.D. as opposed to on, you know,
6 the overall hospital itself. And of course, the
7 hospital itself needs to be ready because there may
8 not be the ability to transport patients, you know, -
9 - you know, in -- in the event of a major disaster to
10 a facility that does have special resources for kids.
11 So I think some clarification on that piece would be
12 helpful. Amy, do you have any information on that or
13 is it something we'll need to follow up on?
14 **MS. EISENHAUER:** So I can say that
15 these performance measures and all the information in
16 that presentation came from E.M.S. for Children
17 Federal and HRSA, who is the grant sponsor. The
18 grants while we are interested in that continuum of
19 care of pediatrics, right. From -- from pre-
20 hospital, right. That 911 call to the pre-hospital
21 agency to the emergency department, right. And then
22 working with our partners inside the hospital, right.
23 Which is why we have a variety of -- of pediatric
24 specialties here in our group. The grant itself
25 really focuses on the emergency component of it. I

2 surely can reach out to the folks at HRSA and see,
3 you know, what they're doing around that.
4 I know that they do work with ASPR on
5 making sure that all of that is kind of integrated.
6 And I will say Kate Butler as a party is here from
7 Hospital Healthcare Preparedness, and I don't know if
8 you have any other comments about right in-hospital
9 past the E.D. what the State does with that, or what
10 ASPR is doing with that as part of our grant program.
11 **MS. BUTLER:** We did it. We did have,
12 and I actually had something that part of this was
13 going to be part of my report out, is that separate.
14 So we did, as part of our -- for the hospital
15 preparedness program, we did have to do a pediatric
16 surge annex for both the regional offices,
17 essentially our coalitions and the State. So that
18 did speak to some of that as far as how that trickles
19 down directly into what they'd be doing at the
20 facility level. They don't do a lot of detail.
21 Unfortunately, our -- our funding partners at -- at
22 ASPR don't want us to be funding the facilities
23 directly. We are still doing that to the best of our
24 extent for as long as we can. So we have a very
25 tough time doing further saturation into actual

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2 facility level planning, because so much already gets
3 covered with the accreditation bodies.
4 So it is something that we've have
5 been had to pull back from because we pre -- in the
6 previous iterations of the grant, we were able to do
7 a lot more of that, that direct planning with the
8 facilities as it relates to stuff like that. So
9 we're just -- there's activities, but it's probably
10 not to the -- to the degree in which we would
11 probably find most comfortable.
12 **CHAIRMAN COOPER:** Okay. Well, to be
13 continued, we'll get further information. We're
14 meeting again in just a couple of months, so in
15 February. So hopefully by then we'll have -- we'll
16 have additional information for you on many of these
17 subjects. And I really want to thank Amy as always
18 for her, you know, extraordinary efforts on behalf of
19 the children of New York State. And just by way of
20 reminder, you know, while Amy's pointed out that the
21 grant itself at the federal level, or -- or the work
22 of the E.I.I.C. in terms of readiness is really
23 focused on, you know, pre-hospital and emerge -- and
24 emergency department care that -- that E.M.S.C. as
25 envisioned by the federal government from the get-go,

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2 actually begins with prevention, then through access,
3 you know, and then to pre-hospital, then in-hospital,
4 through acute care, including critical care, and
5 finally to rehabilitation.
6 All those areas are considered to be
7 under the rubric of E.M.S.C. You know they're
8 focused on children who present with an emergency
9 condition but are focused on all aspects of the -- of
10 that child's, you know, transit through the --
11 through the -- through the system of healthcare as it
12 relates to that child's initial presentation, as, you
13 know, as an emergency case. So that's -- that's --
14 that's E.M.S.C. in a nutshell. And clearly, we focus
15 most heavily on –- on, you know, pre-hospital and in
16 hos -- in-hospital emergency care, because as we all
17 know, the fifteen to thirty minutes that the child
18 spends in the care of, you know, acute care providers
19 dealing with the -- the actual in front of you
20 medical emergency, are among the -- the most critical
21 minutes of the -- the child's entire, you know,
22 course of care.
23 But nevertheless, E.M.S.C. does
24 incorporate that broad swath. So just so everyone
25 remembers that it's sometimes forgotten and it's

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2 always worth repeating, which is why I did. So that
3 is that and I see there's a question, please.
4 **MR. KASPER:** Yeah. Ben Kasper. Just
5 a question because I was just kind of thinking just
6 before we get too far beyond the -- the PECC is there
7 any funding that's available to help out with any,
8 like, gaps that some of these, mainly the rural areas
9 might have like either equipment gaps or something
10 along that line through the grant funding to help
11 support that?
12 **MS. EISENHAUER:** So the grant funding
13 that we get annually is primarily used for funding
14 staffing, making sure that we have the equipment that
15 we need, the programs that we need, et cetera. And
16 I'll be honest they had told us that we would get an
17 increase to two hundred and five thousand per year
18 this year that ended up being a hundred and ninety
19 thousand. And in the following years, it'll be a
20 hundred and seventy-four and some change. So the
21 grant is not -- the -- the initial grant itself is
22 not necessarily really prolific. It is enough to
23 fund basic operations.
24 That said, sometimes E.M.S.C. puts out
25 funding for special projects. I know that there was

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2 funding for special products for disaster
3 preparedness and putting up some disaster centers of
4 excellence through E.M.S.C. There was some pre-
5 hospital rural money from a few years ago that we are
6 working on providing some tools and education for
7 rural E.M.S. providers that -- that work is ongoing,
8 and I'm hoping will be announced next year as soon as
9 all of the pieces come together. So that currently,
10 no, not that I know of directly through E.M.S.C.
11 That's not to say that there couldn't be other rural
12 healthcare grants.
13 And I'd also think that this is a
14 great time for a plug of our Rural Health Task Force
15 which is New York State Rural Health Task Force
16 appointed -- governor's appointment council will be
17 having some open forums over the next several days to
18 hear from the public and to share what work they've
19 been doing at the State level. So this may be a
20 question to bring to them. And there will be a
21 meeting tonight from seven to nine for council
22 members of our council STAC and SEMAC and SEMSCO. So
23 you are all welcome to attend.
24 **MR. CLEMENCY:** I was just thinking
25 about the, like, incentivizing people to participate

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2 in the program. And a plaque is great, right? It
3 gives a certain level of, like, notoriety and
4 recognition, and I think that's awesome. Although it
5 probably shouldn't be something that's, I don't know,
6 too -- sometimes you can have too much. And because
7 especially at least in the area where I'm at in -- in
8 Western New York, it's every place is a specialty
9 center. And so we don't want people to bypass a
10 pediatric site and maybe perhaps go to a site that
11 doesn't focus and doesn't -- doesn't have the
12 capabilities of taking care of high acuity pediatric
13 patients as well.
14 But I think that to promote a little
15 bit more buy-in, because I go personally out to these
16 rural centers all throughout our catchment area, and
17 sometimes the answer is, this is rural healthcare.
18 Because it doesn't necessarily, you know, they don't
19 have the funding. They don't have the equipment.
20 There's obviously knowledge gaps that -- that exist.
21 But they also do serve very highly injured and sick
22 individuals, especially within like the Amish
23 community. When they come in, they're usually like a
24 self-pay, so they're very hurt or very ill. So I
25 think that to help kind of promote that if we were

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2 able to make it so we could be supportive almost
3 financially that would probably entice them to
4 participate in the program a little bit more
5 willingly.
6 **CHAIRMAN COOPER:** Thank you, Brian.
7 Always a tough issue. And you know, I can assure you
8 that your thoughts will be passed on, whether, you
9 know, funds will be forthcoming from the State is
10 another matter. But that's something that, you know,
11 hopefully, you know, as we pursue, you know, the
12 issue of, you know, increase in readiness that all --
13 for all hospitals across the State, that that's
14 something we'll -- that will be discussed. Okay. It
15 is just by way of a time check, it is now almost two
16 forty-five. We have a lot more business to get
17 accomplished. I'm mindful of the fact that we
18 started late. But I still want to try to get all of
19 you out before the -- before the sun decides to leave
20 us for the day.
21 And so we're going to move right on.
22 Director Ryan's report will follow as soon as he
23 returns from his other meeting. So now we're going
24 to move into old business. And the floor is now --
25 now -- now belongs to Dr. Elise van der Jagt and

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2 Sharon Chiumento, who will talk about the changes to
3 the pediatric ambulance triage card that you see on
4 the screen before you. I know this print is kind of
5 small, but you know, we did discuss this at some
6 length last time, and I know that Elise and Sharon
7 did address those concerns. And I'm hopeful that
8 we'll be able to approve this and moving on to the --
9 to the department for their approval and so on.
10 Elise?
11 **MR. VAN DER JAGT:** Yes. And by all
12 means Sharon, feel free to interrupt. Okay. So
13 Sharon and I looked at this -- this tool after last
14 September's meeting. In the meeting the -- all the
15 things that are in there currently were addressed,
16 and we were essentially charged mostly with
17 reformatting it so that it was more easily legible.
18 But a couple of points that I think are to be -- to
19 made on this. And there -- there are some things in
20 yellow here and just wanted to address some of that
21 too. So starting on the left box there just notice
22 that the -- the -- the milliliters, the L has been
23 capitalized. That was a recommendation from the
24 committee last time, just to make sure that there was
25 no confusion about that.

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2 That asterisk and then also the plus
3 sign relate to the different concentrations of
4 Epinephrine, which are to be different. They're
5 different, whether you give them -- you give them
6 endotracheally or whether you give them IV or IO.
7 You see that it says also, if no, IV/IO is in yellow.
8 And I think that the initial recommendation was that
9 that should be removed. But I think our thinking
10 was, and correct me if I'm wrong, Sharon, about this,
11 but our thinking really was that that should stay
12 there because the preference is always IV or IO if
13 you have that available to you. So they're not
14 equal. And that's why we left it in there.
15 And then I think the other thing I
16 wanted to just note here, the -- there had been some
17 recommendations made to remove Amiodarone, Lidocaine
18 Magnesium. The group last time felt that they should
19 be continued on here. Remember that this tool is not
20 exclusive to protocols, the collaborative protocols
21 in the State. In fact, as you can see at the very
22 bottom of this, and I don't think -- I don't think I
23 see it up on the slide, I don't know why that's,
24 maybe you scroll it up a little bit, Amy, or
25 whoever's scrolling it. On the bottom there it -- it

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2 says this reference card should not replace or
3 supersede regional pre-hospital medical treatment
4 protocols, because they are a little bit different in
5 different places.
6 This is meant to be a much more
7 universal tool, could even be used in E.D.s. So we
8 decided last time as a group to leave those
9 medications on there that -- that are currently on
10 there. Is there anything else, Sharon, that we
11 needed to add on this? I think those are the main
12 considerations that are reformatting, just to make
13 sure that people could read it. And it's up really
14 for endorsement, I guess.
15 **CHAIRMAN COOPER:** Yes. Are there any
16 responses, comments to Dr. Van Der Jagt's description
17 of the changes that were made at the recommendation
18 of the committee? I have one very, very minor
19 formatting issue that I'll ask Elise and -- and
20 Sharon to -- to address. You have a plus sign there.
21 **MR. VAN DER JAGT:** Yes. It needs to
22 be bigger size.
23 **CHAIRMAN COOPER:** Well, it's not just
24 that. I believe that the actual accepted format for,
25 you know, a continuing list of as -- asterisk, if you

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2 will, the next one would be a single dagger. And
3 then the next one after that is a double dagger. And
4 the next one after that is a -- is one of those
5 swirly section signs. So other than that minor,
6 extremely minor it looks like a sort of a -- a plus
7 sign with a slightly longer bottom bar, you know?
8 But -- but that's technically the -- that's
9 technically the -- the next thing on the list.
10 **MR. VAN DER JAGT:** So are you
11 suggesting a double asterisk?
12 **CHAIRMAN COOPER:** No, no, just a
13 single one here. Oh, no, no, no. I'm suggesting
14 here that the -- that the plus sign become a single
15 dagger as opposed to a plus sign.
16 **MR. VAN DER JAGT:** Oh, that's fine.
17 **CHAIRMAN COOPER:** I can send that to
18 you if you want, but just so we're -- we're --
19 **MR. VAN DER JAGT:** I could say you're
20 killing me.
21 **CHAIRMAN COOPER:** -- bibliographical.
22 But listen, you know, you always kill me, so every
23 once in a while, I have to.
24 **MR. VAN DER JAGT:** No, that's fine.
25 We could do --.

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2 **CHAIRMAN COOPER:** That's easy to see.
3 **MR. VAN DER JAGT:** What we need,
4 right? We need basically a motion to approve this.
5 **CHAIRMAN COOPER:** We do.
6 **MR. VAN DER JAGT:** No second is needed
7 because it came out of a committee, so.
8 **CHAIRMAN COOPER:** We do, I -- is there
9 someone -- actually -- actually, it's because it came
10 out of a committee, it's -- it comes as both a motion
11 and as -- as a second --
12 **MR. VAN DER JAGT:** Even better.
13 **CHAIRMAN COOPER:** -- from the
14 committee. So at this point, does anybody have any
15 discussion on the motion brought forth by the
16 revision committee chaired by Dr. van der Jagt and
17 Ms. Chiumento? Is there any discussion? And all in
18 favor please signify by saying aye.
19 **MEMBERS:** Aye.
20 **CHAIRMAN COOPER:** Opposed? Okay. It
21 carries without dissent. So this will be moved along
22 with that one minor, extremely minor.
23 **MS. CHIUMENTO:** I just found the
24 dagger, so I will be glad to replace it for you.
25 **CHAIRMAN COOPER:** Thank you. As you

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2 can see in my own writing, I use a lot of asterisks
3 and daggers. So I'm familiar with the -- the -- that
4 thing. Anyway, that's great. So Sharon, it's now --
5 it's now your -- your turn to talk about the
6 pediatric agitation education group.
7 **MS. CHIUMENTO:** All right. So the
8 group met last week on a -- a -- a call of us online.
9 And so we decided that we needed to move forward with
10 developing the video. We were -- we were hoping that
11 we could come up with a script that we could borrow
12 from somebody else, but that did not seem to pan out.
13 We looked for, you know, other pre-done programs
14 videos. Most of the ones we found were either adult
15 oriented or hospital oriented. So we didn't really
16 find any E.M.S. pediatric related videos really in
17 the diffusing of a child -- an agitated child. So
18 we're going to move forward with that. We had four
19 or five people who were particularly interested in
20 working on the scripts. So hopefully within the next
21 several months or so, we will start working on
22 developing those scripts.
23 And but we -- we now have a Boardable
24 area so we can specifically develop things together
25 and move things back and forth, and hopefully get

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2 them approved, and then, we'll -- we'll have
3 physicians take a look at it, make sure that
4 everything is the way it should be. And before we
5 actually do the videoing. We have some video
6 opportunities both in New York City and from Findley,
7 as well as up in Monroe, Livingston. And then Amy
8 let us know that the department has opportunity to a
9 rise that is needed so that it will fit onto the --
10 the vital signs C.M.E. website. And then we can talk
11 about after that, what steps we need to take as far
12 as making it some kind of potentially a mandatory
13 training or, you know, for C.M.E. research, that type
14 of thing. But that -- but that's for the future.
15 So for the moment, it's -- it's kind
16 of a work in progress. And if anybody who's not
17 already decided that they would like to work on the
18 scripts would like to do it, so please let me know.
19 And -- and we will add you to the list. I think
20 that's it. I don't think there's anything else.
21 **CHAIRMAN COOPER:** Thank you, Sharon.
22 This is for all of you who are participate --
23 participating in this project. I know Chief Pataky
24 is part of this as well and others this is really a -
25 - as we know, a super important project. And, you

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2 know, we need to continue to move on this as
3 expeditiously as possible. We need to get, you know,
4 materials out to our -- our colleagues both in the
5 field and in the emergency department about, you
6 know, how to do this and -- and so on. And I deeply
7 appreciate on behalf of all of us, you know,
8 especially the children that we are here to, you
9 know, champion that this group is moving forward.
10 So thank you for all your work on
11 this, Sharon. And please convey our thanks to Dr. --
12 Dr. Feuer among others. Okay. Thank you. That would
13 be Dr. Vera Feuer in this particular case, rather
14 than Dr. Pamela Feuer. Dr. Vera Feuer being the
15 child -- Child and Adolescent Psychiatrist who's been
16 working both with us and with the –- the -- the
17 federal E.I.I.C. program, or I should say national
18 E.I.I.C. program under federal grant to develop tools
19 for management of pediatric agitation. Okay. Now
20 Megan Williams, I just want to just say a word about
21 Megan. Many of you may not know Megan, but Megan for
22 years was the -- was the Director of the Paramedic
23 Program at LaGuardia Community College where I got to
24 know her. She's now directing the program at -- at
25 the Manhattan Community College. And she's amazing.

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2 And she is going to tell us all about
3 the length-based resuscitation tape that group –-
4 that -- that's been looking to resolve potential
5 discrepancies in between the -- what's printed on the
6 tape and what's in the collaborative protocols and
7 how -- how we hope to see those very minor
8 differences resolved. Megan, please.
9 **MS. WILLIAMS:** Thank you very much.
10 Yes. I am now over at the borough of Manhattan
11 Community College. And as such, when this came up
12 about six or eight months ago at the last State
13 meeting about discrepancies in the resuscitation
14 tapes it was a phenomenal project for the paramedic
15 students to take and do a gap analysis on and learn a
16 lot of information in the process. So thank you for
17 that as well. We will probably do it every year,
18 even though it won't need to be done. So overall --.
19 **CHAIRMAN COOPER:** Actually, Megan it
20 does need to be done on a frequent basis because once
21 a year, as you probably are aware the -- the State
22 has an opportunity to revisit the protocols, you
23 know, and so -- so this is, of course, an ongoing
24 project and I appreciate your desire to continue
25 after this first go round.

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2 **MS. WILLIAMS:** Absolutely. We just
3 won't give them the results of the last year. All
4 right. So we kind of ended up down a little bit of a
5 rabbit hole. We started with the Broselow
6 resuscitation tape and comparing them with the
7 collaboratives and went down the rabbit hole of,
8 there are many different types of tapes and many
9 different types of resources. So I have a little bit
10 of a show and tell for anybody that wants to look at
11 some of the resources. The first question that we
12 served to answer was the differences in medication
13 dosages, specifically looking towards the Broselow
14 resuscitation tape, and then adding on a couple of
15 other ones. Because why not? And it did not seem to
16 have a lot of appreciable differences in dosages,
17 minus -- minus literally like eighteen or nineteen
18 medications, not to being on the resuscitation tapes
19 across the board, no matter which kind of
20 resuscitation tape we looked at.
21 And it's due to their resuscitation
22 tapes, they're not for outside of cardiac arrest that
23 they were initially made for. So we're looking at
24 about eighteen or nineteen different drugs, depending
25 upon the resuscitation tape when looked and compared

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2 to the collaborative protocol. So on that note, we
3 kind of also ended up down more of the rabbit hole
4 into, well, what else is out there? And it led us
5 naturally to electronic resources. In addition to
6 the paper length-based resuscitation tapes brought us
7 to Handtevy, brought us to Muru, brought us to a
8 number of electronic resources where you put in the
9 weight.
10 And it is a more comprehensive list
11 because the online resources or apps not only do the
12 drug dosage for you, you just put in weight, whether
13 it's pounds or kilograms, but they also are more
14 inclusive of every medication. So those nineteen
15 that were pretty much missing as well as with that
16 that they do all of the drug dosages for you. The
17 downside is obviously, unless they come like Handtevy
18 with the color coding you wouldn't be able to
19 estimate the weight. So that's one of the downsides
20 to a strictly electronic. So overall, the initial
21 question of how much is missing from length-based
22 resuscitation tapes, well, about eighteen or nineteen
23 drugs overall that are not resuscitation based,
24 including benzos and some other ones that we would
25 want for -- for emergencies in a -- in a pinch obv --

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2 obviously.
3 But overall, the differences in
4 dosaging is not appreciable. It's just the massive
5 difference in, we don't have all of the drugs that we
6 would want readily available without having to do
7 drug dosage calculations. That's where we ended up.
8 I know we had a little bit of a conversation over
9 where does that leave us on resources to recommend,
10 but that I'll turn over to you guys as well, having
11 completed the gap analysis. Any -- anyone that wants
12 to take a look at any of the resources that I brought
13 or have any kind of discussions on that stuff, by all
14 means.
15 **CHAIRMAN COOPER:** Thank you, Megan.
16 Any questions or comments for Megan so far? I just
17 want to, hearing none, and I hope that I'll, you
18 know, my -- my own comments will maybe spur some
19 additional discussion. Don't feel you have to
20 discuss it if you don't have anything to say, but you
21 know, pretty much, you know, whatever device you may
22 be using to calculate pre-hospital drug doses, okay?
23 They're all going to be -- you know, if there -- if
24 there are slight differences, they're all going to be
25 in a pretty narrow range, okay.

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2 Certainly, if there is a -- a national
3 or international standard for a drug dose, and we
4 know that for most resuscitation drugs there are
5 such, you know, standards the ILCOR standards, you
6 know, which of course translate into the American
7 Heart Association/PAL Standards with which Dr. van
8 der Jagt is very familiar having served on that group
9 for many, many years. Certainly, if there is an
10 international standard, you know, that -- that should
11 probably be the, you know, the -- the reference gold
12 standard for us to be using. But you know, again,
13 because most of these drugs have a -- have a
14 therapeutic range, as you're all aware, you know, if
15 there's a very slight difference, it probably is, you
16 know, of, you know, very, very little import and so
17 it certainly would not be, you know, unacceptable,
18 you know, in a circumstance like that to go with
19 whatever device you know you may have available to
20 you.
21 I -- I think the -- the more important
22 issue really focuses on, you know, what we want out
23 of the -- these adjunctive devices. The whole idea
24 of having a device to help you, you know, figure out
25 what the appropriate dose is in, you know, in a short

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2 New York minute, okay or less, okay, is to allow you
3 to avoid sitting there on your device, calculating
4 the dose with your, you know, handheld computer, cell
5 phone, whatever it is you're using, iPad, what have
6 you. And while that doesn't take time -- doesn't
7 take a lot of time. We all know that no task takes
8 zero time. And we also know that there are
9 circumstances, particularly during resuscitation,
10 where, you know, you know, where even those extra,
11 you know, thirty seconds or so, or whatever it might
12 be, you know, that it may be diverting the provider
13 away from support of the airway, breathing and
14 circulation, which of course is the -- the primary
15 issue.
16 Remember, all these drugs are advanced
17 life support maneuvers and everything we're focusing
18 on here, you know, fundamentally is at the basic life
19 support level, preservation of, you know,
20 ventilation, oxygenation, you know, and -- and
21 profusion. You know, do we really want providers to
22 be spending a lot of time doing -- you know, doing
23 various calculations. We want -- we want something
24 quick, not and dirty, but quick and pretty darn
25 clean, you know, to help them make a quick decision

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2 about what dosage ought to -- you know, ought to be -
3 - ought to be used. And, you know, that's where the
4 -- that's where the length-based devices, you know --
5 you know, are -- are so useful and why they've become
6 so popular.
7 The fact that they don't, you know,
8 include the, you know, the eighteen or nineteen other
9 drugs that we -- you know, that we include in our
10 pre-hospital formulary, you know, with the possible
11 exception of benzos, which of course, you know, in --
12 in seizure management is -- is, you know, obviously
13 have to be given early -- as early as possible with
14 that possible exception, you know, it may not be
15 necessary to include, you know, the eighteen or
16 nineteen drugs on a -- you know, on some kind of
17 device. In most other cases, you're going to have
18 the time to do a weight-based calculation, which is,
19 you know, which is obvious in kilograms, of course,
20 which is obviously, you know, kind of the gold
21 standard, so to speak.
22 But you know, at the -- you know,
23 there's the other concern that people have raised
24 about the fact that with our epidemic of obesity, you
25 know, that the -- for -- for really very overweight

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2 kids for, you know, lipid-soluble drugs, okay? The
3 Broselow tape or other similar versions of length-
4 based -- resuscitation tape, you may slightly
5 underestimate, you know, the -- the -- the amount of
6 drug that's actually needed, because a lot of that
7 drug is going to end up, you know, in adipose tissue.
8 You know, but, you know, for most of the
9 resuscitation drugs, you know, they are -- you know,
10 they're not lipid based and -- and, you know, and so
11 it turns out to be, you know, something that maybe is
12 a little bit less of an issue for the acute kind of,
13 you know, cardiac arrest or near cardia arrest --
14 cardiac arrest scenario that the resuscitation tapes
15 were made to -- you know, were made to -- to address.
16 So, you know -- you know, my concern
17 is that, you know, and -- and I expressed this pretty
18 strongly during the call, as Megan will remember, you
19 know, that, you know, we really don't want to be
20 doing anything that diverts our pre-hospital
21 colleagues' attention away from supportive airway,
22 breathing, and circulation. You know, unless there's
23 an absolute compelling need to do so. And when we
24 first introduced the -- the -- the pediatric
25 protocols into New York State back in the mid-1980s,

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2 the approach that was taken was something that we, at
3 the time called conservative, yet permissive meaning
4 -- meaning based very strongly on -- on very good
5 B.L.S., okay?
6 But not wishing to deny any child the
7 benefit of an advanced life support intervention
8 where there was a compelling -- you know, a
9 compelling, you know, a reason to do so. So for me,
10 speaking now, not as chair, but as simply a member of
11 this working group, you know, my -- my -- my sense
12 was that we really need to be -- to -- to maintain
13 our focus, you know, on ensuring that, that -- that
14 we really are committed to the resuscitation core in
15 terms of those –- in -- in terms of those devices,
16 and, you know, and continue doing an appropriate
17 weight-based calculation, you know, for other drugs,
18 you know, for which we have a little bit more time.
19 I'm not going to say leisurely, but,
20 you know, a little bit more time again with a -- with
21 -- with, I would argue the -- the single exception of
22 benzodiazepines, which is something that we do need
23 to address, because if we find a child who's actively
24 seizing at the scene, you know, certainly we want to
25 be able to address that. But those were my personal

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2 concerns in -- in -- in this issue. So where do we
3 go from here? That was Megan's, you know, sort of
4 challenge to the group at the end of her remarks. I
5 think what we do, I -- I personally, I think we want
6 to tell our -- our SEMAC colleagues, number one, it's
7 not clear there'll be meeting, by the way, on
8 Wednesday.
9 We want to tell our SEMAC colleagues
10 number one, that -- that if there are minor
11 differences between, you know, the length-based tapes
12 and other devices, you know, that fall within, you
13 know, an acceptable very narrow range, that there's
14 no reason to say regional protocols should abandon
15 those -- those approaches. You know, as long as the
16 differences are, as I say, within the narrow range
17 and where there happens to be an international
18 standard with the ILCOR standard, for example, that
19 they -- you know, that they're consistent with that.
20 And that's 0.1 to 0.2, that we want to
21 make sure that we retain the focus on resuscitation
22 drugs per se, because we really want to, you know,
23 ensure that our provider's focus does not get
24 diverted from support of the A.B.C.s. You know, and
25 last that we -- you know, that we make a

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2 recommendation that, you know, that -- that whatever
3 we do, we find a way to ensure that critical
4 medications that may not be resuscitation drugs per
5 se, but, you know, have a -- have a -- a major impact
6 upon a child's, you know -- you know, outcome in the
7 field such as benzodiazepines for seizures, you know,
8 that drugs like that, you know, should be somehow
9 added to whatever needs to be done.
10 I think that summarizes kind of where
11 we ended up as well as my personal views. You know,
12 and again, I'm speaking at the moment, not as chair,
13 but as a member of the -- of Megan's working group.
14 And I -- I know that -- I know that Dr. van der Jagt
15 always has extremely wise things to say, particularly
16 about issues like this. So I'm going to see if he
17 has any -- any comments before he has a chance to
18 press that red button himself.
19 **MR. VAN DER JAGT:** Wise is not
20 necessarily the case, but I often have things to say.
21 My wife keeps telling me that. So I just had a quick
22 question about it. So it sounded like the
23 resuscitation meds was not the issue because those
24 doses are all within pretty much the same no matter
25 what length-based tape you use or whatever you use.

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2 So how many medications are we talking about where
3 there might be slight differences from our protocols?
4 If we're talking about thirty medications, that's one
5 thing. You know, if we're talking about two, that's
6 a whole different issue.
7 **MS. WILLIAMS:** We are really talking
8 about five or six with the most appreciable
9 difference, and we're -- so we're looking at things
10 like dexamethasone for two weight-based dosages are
11 slightly off. That instead of 0.6 milligrams per
12 kilogram for a 9-kilogram patient it's 5.4 milligrams
13 on the Broselow tape. Specifically, the Broselow
14 tape. So we're talking about a very small difference
15 of 5.1 milligrams, 5.4 milligrams. For about 5 of
16 these medications are an even narrower. And then
17 we've got some that we have a range on the
18 collaborative, it's just barely outside of that range
19 for synchronized cardioversion. The biggest one is
20 Naloxone. So for two of the weights, it's 0.9
21 milligrams overall, as opposed to 2 milligrams, which
22 is the collaborative. So that's the biggest
23 difference, is that it's double the dose in the
24 collaborative as opposed to the length-based device
25 is half of the dose.

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2 **MR. VAN DER JAGT:** Right. And -- and
3 I think, just to sort of understand the issue, the
4 issue is that if they -- if they're in an acute
5 situation, they use the length-based device you're
6 essentially deviating from our standard of care. Is
7 that correct?
8 **MS. WILLIAMS:** Correct.
9 **MR. VAN DER JAGT:** So I understand the
10 issue.
11 **MS. WILLIAMS:** Yes.
12 **MR. VAN DER JAGT:** Right. And I have
13 one further question just to try to clarify this a
14 little bit. Of those differences, like the length-
15 based tape that you're talking about that has a
16 difference from the protocols, are those widely used,
17 or is it only that it happens to be out there and
18 it's different? Because if nobody uses it anyway, it
19 becomes a bit of a moot point.
20 **MS. WILLIAMS:** I don't have that data.
21 **MR. VAN DER JAGT:** Is this something
22 that like Bruce or some -- some of the paramedics can
23 --?
24 **MR. HARRIS:** Do we know at all if --
25 and -- and Ryan or Director, correct me if I'm wrong,

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2 but how this might be impacted on the Muru app that
3 the State has adopted?
4 **MS. WILLIAMS:** Right. So that's why I
5 don't really know the answer to that question as to
6 how much does this affect, because when you look at
7 the amount of people using Muru, I don't know how
8 many people are using Muru as opposed to this.
9 **MR. HARRIS:** So -- so just because
10 this question came up in a research meeting earlier
11 this week it does sound like, and I have no
12 proprietary interests in Muru whatsoever. But it
13 does sound like you can query through Muru by user
14 and by the region to which they sign in. Not
15 necessarily -- I mean, they could be signing in at
16 home just looking at the app to become familiarized
17 with it, but you can query and get some baseline
18 data. I'm not sure with other apps or the web-based
19 tools how you can get that level of granularity.
20 **MS. WILLIAMS:** Yeah. I --.
21 **MR. GREENBERG:** Sorry, Ryan Greenberg,
22 for the stenographer. What was the question?
23 **MS. WILLIAMS:** The question that we
24 were looking at was -- well, we're specifically
25 looking at drug dosaging for pediatrics, and then we

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2 were looking at how much of the difference in the
3 length-based tapes does it make a difference when
4 we're comparing it to like the online apps? How much
5 are we actually running into this problem and that
6 discrepancy? And then we started talking about Muru,
7 Handtevy just electronic apps.
8 **MR. GREENBERG:** Sure. I can't speak
9 on the other apps, but I think you were just talking
10 about too, there is absolutely the ability for us to
11 dive deeper into who -- what the app is being used
12 for. So actually, we have data on that. It actually
13 was just posted or is available for, actually, I
14 think it's even online for how many users there are
15 in Muru, what the top protocols are per region. So
16 we can see if pediatrics are the -- are top usages in
17 the regions, diving deeper into it beyond that, I'm
18 not sure. I think that's something though that, you
19 know, it's great questions. And then I think that'd
20 be a great question for Jeremy too, who's using
21 Handtevy or is on a pilot program through E.M.S.C. to
22 use Handtevy in the MLREMS area to see if that's
23 something that they can track there.
24 So if this is something that we want
25 to look into, I think it's something that we can try

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2 and find further out.
3 **CHAIRMAN COOPER:** You know, I think
4 that Matt has raised a really great question and I
5 think that Director Greenberg has given us, you know,
6 if you will, an invitation or extended to us an
7 invitation to look into this data a little bit more
8 deeply, you know, and see where we go. As I
9 mentioned earlier in the meeting, it's only two
10 months until we have our next meeting. So, you know,
11 and with a good chunk of holidays in between, so
12 we're really looking at, I think, about a month's
13 worth of time to, you know, get a -- get a good look
14 at -- get a better look at this data. And maybe we
15 can answer Dr. van der Jagt's question as to, you
16 know, how many of these, you know, drugs may be
17 involved and, you know, and so on.
18 And whether the -- whether we're
19 talking about, you know, minor differences in dosage
20 that really have very little impact on the system
21 overall because they're being so infrequently used.
22 So I think that's a great question. And -- and I --
23 I -- I think that perhaps rather than, you know, move
24 forward at this time with a specific recommendation,
25 getting a little bit more information from the Muru

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2 app would be very helpful. And also, maybe from the
3 Handtevy folks as well if that's possible.
4 **MR. GREENBERG:** And I think, Mr. -- I
5 think --
6 **CHAIRMAN COOPER:** Go ahead, Ryan.
7 **MR. GREENBERG:** -- Steve Blocker from
8 Muru is even here, I know Dr. Cooper, you might be
9 leaving after, but it might be something to at least
10 have a small huddle after the meeting or something
11 else. I just want to be on record too and there's
12 this stenographer. I did not volunteer for a
13 committee. I was not -- didn't want to chair
14 anything. I didn't -- but no happy to help in any
15 way and in that front.
16 **CHAIRMAN COOPER:** I think you
17 volunteered us Director Greenberg rather than the
18 other way around. But we'll leave that for another
19 day.
20 **MS. WILLIAMS:** So I'll reach out to
21 Steven Blocker and I'll add Ryan Greenberg to the
22 emails. And I'll also -- I'll reach out to Handtevy,
23 although I already know I'll reach out to the regions
24 that are using Handtevy. It tends to -- it's more
25 expensive, so it's a limited number. But I know that

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2 Muru definitely has that data and I feverishly
3 searched my email to get that data that they just
4 sent out about the most commonly used protocols, et
5 cetera, et cetera, and was unsuccessful. But I will
6 connect up with him this week and get back to you
7 guys on that information.
8 **MR. VAN DER JAGT:** Yeah. I think the
9 -- the first thing is to find out that those numbers
10 -- to make sure that also there is no significant
11 difference between the two. In other words, that
12 could result in an adverse event for a patient. You
13 know, if they use, say the length-based tape versus
14 the protocol or vice versa, I suppose that that --
15 that's -- the safety is really the important issue.
16 But there's another issue that I think maybe we could
17 maybe talk about that in February even, is that the
18 question of if someone from E.M.S. deviates from the
19 given protocol that we have in place based on the
20 length-based tape, because that's what they have
21 handy, what are the repercussions for that?
22 You know, I mean, do we say that's not
23 a problem, or do we say it's acceptable? And if we
24 say it's acceptable, where are we -- where do we go
25 with that? You know? Because then you start

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2 deviating from protocols. And I think that that does
3 become a question that we have to -- to struggle with
4 a little bit and try to figure that out. Because I
5 think that would be in the forefront of somebody's
6 looking at a run sheet and said, hey, you didn't use
7 the right dose. It's not according to the protocol.
8 Well, we have a tape, you know, and it says that's
9 the dose. So now we have a little bit of a dilemma,
10 both maybe legally as well as -- as otherwise, you
11 know. So I think that we do need to struggle with
12 that a little bit. And Dr. Harris has a --.
13 **MR. HARRIS:** Maybe I'll just say throw
14 in a resource for your look at. In 2020 or 2021, a
15 group of us from the N.A.M.S.P. Pediatrics Committee
16 published a pediatric safe dosing -- pediatric
17 medication safety position statement. If you look
18 under Mark Cicero, C-I-C-E-R-O, he was the -- the
19 principal investigator, lead author rather. And --
20 and you know, I think one of the -- one of the
21 tenets, and it's -- it's really just a summary of
22 best practices. But one of the things that I think
23 we should consider that provides some degree of
24 leeway to avoid unnecessarily instilling a penalty on
25 someone who's, you know, following best guidance is,

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2 you know, typically with medication and others can
3 correct me if there's institutional variability here,
4 but, you know, a medication dosage within ten percent
5 is typically a reasonable and even deviations of up
6 to twenty percent are acceptable.
7 I think the question would be for me,
8 if you had to draw a line in the sand is where do you
9 see deviations in dosing greater than twenty percent
10 of the weight estimated dosing? And then one thing
11 we haven't sort of brought up here, because we're --
12 you know, we're relying so heavily on the weight is,
13 you know, there's the dosing recommended and the
14 dosing administered. Those are not always
15 concordant. And I think certainly as our practice in
16 my home institution, my home E.M.S. institution, that
17 we review all high-risk meds that we define as
18 basically opiates and benzos. And based on the
19 reported weight and, you know, and reported weight
20 being, you know, and at best okay, estimation of
21 weight, right? A whole separate conversation for
22 another day.
23 **MR. VAN DER JAGT:** I think that those
24 are really pertinent comments because we run into
25 this in the hospital all the time. You order a dose

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2 of ibuprofen for a kid and they say, well, you know,
3 it's three hundred and thirty-one milligrams, you
4 know, well, the kid gets three hundred and twenty-
5 five, you know, and so there's a percent that we
6 can't. And I think because the length-based tapes
7 also, it's an estimate as best as we can, get as
8 close as you possibly can. So but maybe something
9 like that could be addressed in general in a
10 statement in the protocols just overall that these
11 are our best recommendations recognized and that
12 there might be small variations in that within maybe
13 the ten to twenty percent range that Dr. Harris says,
14 you know.
15 So it's -- we -- but I think it's
16 something we need to recognize. This is innately a
17 problem with any medication. And if you get kids,
18 you know, if you take them orally, you know, you
19 can't guarantee that they get it all anyway, you
20 know, so there it is, always that becomes an issue.
21 But I just think we have to make sure that the E.M.S.
22 provider is in a safe plane that they don't get
23 penalized for something that is just really not that
24 relevant. And then -- and I'm concerned about that
25 part too, you know, so.

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2 **MS. WILLIAMS:** Absolutely. And if
3 you're using Cicero's and looking at the ten percent,
4 we're really only talking about maybe one or two
5 drugs, and then we're talking about a small
6 difference on anaphylaxis versus the use of an auto
7 injector or the length-based, they don't talk about
8 that at all. Right? So you've got some things there
9 that would need to be addressed. Overall, the drugs
10 other than naloxone, less than ten percent of a
11 difference. And a lot of it is a range that was
12 given as well. But some of the things like the auto
13 injector would be a bigger issue of, they're saying,
14 the tapes are saying, no, that's not even an option,
15 right? So that's going to be a humongous disparity
16 when you're talking about what did the provider
17 actually do based on the tapes as opposed to our
18 protocols. And yeah.
19 **MR. HARRIS:** Just out of curiosity on
20 that same vein, would that then change in theory for
21 like a check and inject where they're drawing up
22 medications?
23 **MS. WILLIAMS:** Yes. So it's fine for
24 check and inject. It just doesn't say that an auto
25 injector is used at all, whereas there is the option

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2 in our collaboratives.
3 **MR. HARRIS:** Just like one thing to
4 keep in mind too, for like the pre-hospital
5 environment, they face a lot of different obstacles
6 than you do in hospital. Instead of having too many
7 credential providers to perform certain duties and
8 roles and responsibilities, you know, you don't have
9 enough. And so I think that basically whatever the
10 E.M.S. provider feels most comfortable with, as long
11 as it's going to fit within that range, and we're not
12 talking about a great deal of variance, I think that
13 that, like me personally and being from that realm is
14 -- should be encouraged because if you encourage
15 people to maybe have to react and do basically simple
16 mathematics before, you know, common core math was a
17 thing, you know, you have them do that. But if they
18 mess up a decimal point one way or another, instead
19 of talking about a variance of being only, you know,
20 five percent or less, you're talking about giving ten
21 times or one tenth the medication.
22 And then, so it's like, what would we
23 rather support? And we already know too that like we
24 -- we just hosted a study about just determining
25 weights and, you know, their actual weight is

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2 obviously the absolute but a parent's suggested
3 guess, you know, our confident estimation that would
4 be next up. And then we actually, to Dr. Cooper's
5 point when you have to take into the body habitus, we
6 actually used a popper scale, and then that was more
7 accurate than a length-based resuscitation tape
8 because it takes into account the arm circumference.
9 You can toggle a little bit up or down depending on,
10 you know, the habitus of the child. And -- and then
11 actually the least accurate was a provider
12 estimation.
13 But so I think that just if we're --
14 we're talking about relatively small numbers of
15 variants in comparison to, you know, somebody making
16 -- making a mathematical error and having an adverse
17 outcome that could be much worse, I think.
18 **CHAIRMAN COOPER:** Well, you're hired
19 doc, you're now a member of this work group so -- so
20 let's make sure that we bring this issue up along
21 with, you know, any others that need to be brought
22 up. And I do think we want to try to get this
23 wrapped up with a -- with a solid recommendation no
24 later than our next meeting. So Megan, I'll ask you
25 to really, you know, take the lead on that and make

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2 sure we get one, maybe even two meetings squeezed in,
3 but in time for Amy to get whatever needs to be
4 gotten to the E.D.C.C. process. Okay. Director Ryan
5 it's my understanding that you have been invited to
6 go next because you have to run somewhere. So
7 please.
8 **MR. GREENBERG:** Series of meetings
9 today. I -- I'm going to keep it brief because I
10 think Amy can do a lot of the -- the updates. But
11 just wanted to talk a little bit about the bureau and
12 some bureau activities. We are super excited that
13 we've done a lot through COVID and I feel like the
14 value of what we've done and a lot of work that we've
15 done has really been recognized. We've been awarded,
16 not awarded, we've been granted a number of new
17 positions. So we have an educator position that's
18 open right now, but the bigger picture is we'll
19 probably hire somewhere in fifteen to twenty new
20 staff members over the next couple of months. So
21 really excited about that.
22 Part of that will also be hiring
23 additional council staff members, so support for Amy
24 and her team in -- in running councils like this.
25 Processing paperwork, assisting in, you know, things,

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2 programs like what Megan's working on and -- and
3 other stuff like that. And so I think that's just --
4 that's some of the biggest news that's going on in
5 the bureau right now. And, you know, what's, you
6 know, important to us is for our ability to -- to
7 further support you and do things. There's some
8 additional long-term goals, including some reworking
9 of our, you know, websites and -- and additional
10 methods to be able to get information out.
11 And I bring that up to this group
12 because one of the things that -- that we notice
13 around the State, and I think it goes both while our
14 district chiefs are out doing inspections and things
15 like that, as well as, you know, in conversations
16 when -- when we're being held is that people say, oh,
17 I didn't know about that, or and nowhere to find
18 that, or, it's hard. And we recognize that our
19 website is challenging at times to navigate; that was
20 Bruce nicely laughing at it. We recognize that and I
21 think, you know, in the next period of time we're
22 going to see some updates to that. And that will be
23 able to then further help programs like the PECC
24 program both in, you know, for E.M.S. agencies as
25 well as hospitals and some other initiatives that are

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2 there.
3 So a lot of good stuff, you know, on
4 that front. And we're excited to be doing it and
5 supporting it. We are also, you know, kind of
6 looking at the model of E.M.S.C. in the bureau and,
7 you know, is it always going to be a standalone kind
8 of Amy and well, one other person who left us, but
9 then came back to us? Or are there methods to be
10 able to have additional support around, including
11 student assistance and some other things that you
12 think are small things, but as this group decides
13 that they want to do more, those roles and things
14 become much more, you know, of a major impact to us.
15 So we're excited to, you know, to work to build on
16 that one too.
17 Last but not least the -- you know,
18 we're -- we're seeing some things move forward both
19 on education regulations as well as equipment and
20 equipment standards. The education regulations will
21 be out for public comments starting Wednesday.
22 They'll be open for two months. I encourage
23 everybody here to take a look at them. And then the
24 equipment standards, which is a bigger one, kind of -
25 - of an influence on this group. Because it will

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2 bring in a series of pediatric requirements and
3 safety equipment requirements. It's not out for
4 public comment yet, but my bet is probably between
5 now and the next meeting that will -- will come out.
6 And so hopefully we'll see that when it goes through.
7 So that's about it. Like I said, I'll keep it short,
8 but I'm happy to take any comments or questions or
9 concerns.
10 Sorry, one last thing. We are looking
11 in 2024 or even 2025, because it takes us some times
12 and I -- I think some of our docs around the table
13 know that things don't happen quickly in the bureau,
14 but we're looking to start doing possibly some poster
15 research publications. So what we can look at as a
16 State, we have a lot of, you know, look, our call
17 volume is, you know, north, you know, it's -- we have
18 millions of calls a year, which is millions of
19 opportunities to look at research opposed to some of
20 our sistering States that will have literally three
21 hundred thousand calls Statewide. So looking at some
22 of the, you know, opportunities that we might have to
23 do some poster research projects, and I say it like
24 that because they're small and reasonable and we
25 probably can find a little bit of funding to -- to

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2 help back it. And then to be able to take that on
3 the -- on the road.
4 I know Amy is big about getting the
5 New York name out there, but taking those research
6 projects to -- to, you know, other neighboring states
7 and letting them see it. Our NASEMSO conference, our
8 E.M.S. Foresee and our HRSA grants and things like
9 that. So if you're thinking of something or have
10 something on the back burner from a research idea
11 that you think you need a small amount of funding,
12 then we would like to start considering that one. I
13 would say reach out to Amy on that time. That's all
14 I have. Thanks.
15 **MR. VAN DER JAGT:** Ryan, could I just
16 ask a quick question about that?
17 **MR. GREENBERG:** Absolutely.
18 **MR. VAN DER JAGT:** Is there -- is
19 there statistical support for something like that?
20 If there's access to say the pre-hospital care
21 records and you have that information, is there
22 statistical support? Would that be possible to be
23 funded?
24 **MR. GREENBERG:** Yeah. I think -- I --
25 I think internal to -- to the bureau we'd be able to

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2 support with some statistical stuff. I think that's
3 part of what we'd need to look at, what the proposals
4 would be for a research project. How much, you know,
5 kind of depth it would take and why we're looking at
6 doing more, you know -- you know, poster research
7 projects, that smaller kind of let's get the ball
8 rolling on some research in -- in the State and
9 within us and then taking it to the next level. So I
10 think there's absolutely some support, you know, we
11 absolutely would be able to -- to look at, you know,
12 our data set that we do collect in -- in some of the
13 dynamics that are there.
14 Peter right now is going, what is he
15 saying? But no. But no, you know, we will -- we'll
16 look at that and like I said, you know, kind of, it
17 just depends on how in depth that goes, you know,
18 large, you know, kind of research projects, we just
19 don't have the money right now, but smaller stuff,
20 absolutely. And -- and also keeping in mind E.M.S.
21 for Children is not just about E.M.S., it is more
22 global and I think we look at, you know, the hospital
23 side of things and too, so if there's anything that
24 we can do, I can't speak outside of our data set, so
25 just keep that one in mind. But if we were to look

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2 at other things or something.
3 **CHAIRMAN COOPER:** Just to tag onto
4 Director Ryan's comment, while I already made the
5 point that E.M.S.C. is not only E.M.S., the truth of
6 the matter is that children are never going to fare
7 any better in the system than adults are. And
8 anything that we do to support, you know, improved
9 E.M.S. care for children directly impacts on improved
10 E.M.S. care for adults as well. You know, little,
11 tiny things, drug doses notwithstanding, but, you
12 know, any system fixes we put in place for kids are
13 going to make things a whole lot better for adults as
14 well. So just to keep that part of it in mind.
15 Okay. Director Ryan, thank you so much. Were there
16 any other questions for Director Ryan at this point?
17 All right, hearing none.
18 We're going to go again a little bit
19 out of order because we know that Professor Peter
20 Dayan has -- has another meeting a little bit later
21 today. I want to before we recognize him, however, I
22 just want to take a -- take a moment to ask you all
23 for a moment of silence in honor of Dr. Brooke
24 Lerner. Brooke an amazing person, paramedic, one of
25 the first paramedics to earn a PhD has been -- has

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2 been an -- an amazing asset to all things E.M.S.
3 including E.M.S.C. has -- has published scores of
4 research papers in -- in all areas of E.M.S., but
5 again, including E.M.S.C. and Dr. Lerner very, very
6 tragically died this past fall of a -- of a very
7 serious illness. And we will all miss her
8 tremendously. And so I'll ask for a moment of
9 silence in honor of Dr. Lerner. Thank you all. A
10 dear friend of mine as well as a dear friend of many
11 around this table. Peter, please.
12 **MS. EISENHAUER:** I have the documents
13 you guys sent, so just tell me which one you want
14 displayed and I'll pop it up.
15 **MR. GREENBERG:** While he walks up and
16 just a reminder, when you do walk up ,first name,
17 last name, and spell your name for the stenographer.
18 One other thing, we are working on updating our -- we
19 kind of have a map of the State for all our councils.
20 So we'll be asking for headshots of everybody. If
21 you don't have, we're happy to help facilitate that
22 as well. But so just keep that one in mind. If you
23 get an email from Amy in the near future, that's what
24 that's for to be able to show and also have on our
25 website who the representatives are and who your

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2 primary agency is, or who you are affiliated with
3 here. So not just necessarily the seat that you
4 fill, we'll show that as well. But if you do have a
5 primary agency that you would like to make sure that
6 we get that correct and have that on there as well.
7 Thanks.
8 **MR. DAYAN:** Hi Art, thank you so much.
9 This is Peter Dayan, D-A-Y-A-N is my last name. I'm
10 a representative from the PECARN network. I actually
11 am the P.I. for one of the nodes at PECARN and I'm at
12 Columbia University in Manhattan. Our thank you
13 first for recognizing Brooke. I can't tell you how
14 much we miss her, and think of her every time
15 anything pre-hospital comes up. So I'm just going to
16 give a brief update of a couple of ongoing studies in
17 PECARN, which you probably know at this point, has
18 really taken on the pre-hospital research mantle in -
19 - in a major way, particularly over the past decade.
20 That includes two ongoing pediatric pre-hospital
21 trials, very large pediatric pre-hospital trials.
22 One that is called The Pediatric Dose
23 Optimization for Seizures in E.M.S. Trial, which is a
24 national study comparing standardized midazolam
25 dosing compared to standard delivery to see if it

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2 decreases seizure duration. This is kind of apropos
3 to what you all were talking about previously. And
4 Buffalo is participating in that, Buffalo E.M.S. is
5 participating in that.
6 **MR. CLEMENCY:** So for PediDOSE,
7 Buffalo has now enrolled forty-five cases and we have
8 already block randomized over to phase two.
9 **MR. DAYAN:** Thank you. The other
10 study that just got started is being led by Dr. Henry
11 Wang. And it's titled The Pediatric Pre-Hospital
12 Airway Resuscitation Trial or Pedi-PART, which is a
13 trial that's comparing the pre -- predom -- the three
14 predominant pre-hospital, pediatric airway
15 techniques, bag valve mask, supraglottic airway, and
16 endotracheal intubation to determine the -- their
17 efficacy in children. And the study has been
18 initiated with procedures related to exception from
19 informed consent are ongoing. And the last study
20 that I'm going to turn over to Brian is concerning a
21 study term T-RECS.
22 **MR. CLEMENCY:** Yeah. Brian Clemency,
23 University of Buffalo. And I am I guess the interim
24 nodal P.I. during the transition for the -- the CHAMP
25 Network. For T-RECS this is a bundle of care

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2 optimization study of pediatric asthma. It's a pilot
3 study in anticipation of a larger federal grant in
4 the future. And we're -- we're one of three sites.
5 What's I think nice for New York in terms of external
6 validation is that our protocol looks a lot like the
7 best practice model proposed by T-RECS. And so while
8 we're asking for this committee's support to
9 participate it's our position in our discussion with
10 other members of this committee that we don't think
11 we need a protocol change in order to participate in
12 this study.
13 One thing that's a little different is
14 that part of the best practice model is to give three
15 doses of nebulizer at once. You -- we know that when
16 you put three doses in a single ampule, it doesn't go
17 any faster. It just lasts longer. And so that is
18 functionally the same as giving three in a row. And
19 we think that is a standard that's being done in lots
20 of hospitals and E.M.S. providers already. So that
21 was the only thing that was sort of different in our
22 discussion. So I guess the ask of this committee is,
23 number one, to support this study but also to
24 acknowledge that a study like this, if it doesn't
25 change the protocol, probably doesn't need formal

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2 approval.
3 **CHAIRMAN COOPER:** Discussion? Hearing
4 none, would anyone like to make a motion about this
5 proposal? We're not in a position to approve it per
6 se, but we certainly can endorse -- endorse it. And
7 -- and I think that's primarily what you're looking
8 for from us.
9 **MR. DAYAN:** Yes.
10 **CHAIRMAN COOPER:** Is there someone who
11 would like to make such a motion?
12 **MR. KASPER:** Ben Kasper to endorse.
13 **CHAIRMAN COOPER:** Thank you. Is
14 there a second?
15 **MR. HARRIS:** Matt Harris. I'll
16 second.
17 **CHAIRMAN COOPER:** Matt Harris is a
18 second. Thank you very much. Any discussion? All
19 right. Well, hearing none, all in favor, please
20 signify by saying Aye.
21 **MEMBERS:** Aye.
22 **CHAIRMAN COOPER:** Opposed? Okay.
23 Done. And that was easy.
24 **MR. GREENBERG:** Question. So what is
25 the expectation of that nexus? So -- so there's

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2 support from the council, but just to understand next
3 steps or what expectations are.
4 **MR. CLEMENCY:** So -- so the -- the --
5 you know, the question that I had with Amy was
6 whether or not we needed approval to perform this
7 study. And she felt it was best for us to bring it
8 to these council meetings and ask that question. I
9 think longer term, it's probably helpful if we have
10 some general guidance as to what kinds of prospective
11 research need formal approval, because they'll be
12 changing the protocols versus which ones are
13 encompassing or close enough to the existing standard
14 of care that they probably need to be provided to the
15 department for information, but probably don't need a
16 formal review process.
17 **MR. GREENBERG:** And the proposal is to
18 do the research based out just the region that you're
19 operating in, the agencies that you're in, or
20 Statewide?
21 **MR. CLEMENCY:** This is a single agency
22 study.
23 **MR. GREENBERG:** Single. Okay. Just
24 confirming that one.
25 **MR. CLEMENCY:** Yep.

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2 **MR. GREENBERG:** So in essence, this is
3 really a study that's being done by an agency with
4 their data and brought here, and thank you by the
5 way, for situational awareness and to see if you
6 know, kind of anything from that point.
7 **MR. CLEMENCY:** I think the only
8 difference is that it's prospective. So I mean, we
9 are consenting patients. We are doing it
10 prospectively as opposed to a retrospective study,
11 which there would be no discussion of, I would
12 assume.
13 **MR. GREENBERG:** Terrific. Thanks.
14 **MR. CLEMENCY:** I think the only other
15 thing I would add is just to give an update on CHAMP
16 following Dr. Lerner's passing. She had named Manish
17 Shah, her successor, who had been very involved in
18 the CHAMP node and who was the P.I. nationally for
19 the PediDOSE study. We've been discussing this with
20 HRSA and with Manish over the last few months. The
21 tentative plan right now is to continue to keep the
22 CHAMP node based out of Buffalo through the end of
23 year one of the grant, which ends in August or
24 September of '24. And Manish Shah who would be at
25 Stanford will be a sub-award to University of

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2 Buffalo. After that, the award -- award probably
3 will be moved to Stanford but University of Buffalo
4 will become a sub-award. So the goal is to continue
5 to have PECARN and -- and PE -- and CHAMP worked on -
6 - on the west side of the State for the next three
7 years of the grant, and then afterwards to kind of
8 figure out where to go from there.
9 So I think the node is in excellent
10 hands, and I'm really happy that it's continued to
11 support research in Buffalo through T-RECS and
12 PediDOSE, and hopefully other studies in the future.
13 **CHAIRMAN COOPER:** Any comment or
14 questions for our PECARN colleagues? Okay.
15 **MR. GREENBERG:** Sorry, last one.
16 **CHAIRMAN COOPER:** Oh, go ahead.
17 **MR. GREENBERG:** What was the time
18 period for it?
19 **MR. CLEMENCY:** I'm sorry. For the
20 study or the -- or the transition?
21 **MR. GREENBERG:** Study.
22 **MR. CLEMENCY:** The study is scheduled
23 to start in January. It is a two-year trial. It's a
24 two-year study.
25 **MR. GREENBERG:** Great. Thanks.

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2 **MR. HARRIS:** Dr. Dayan, do you mind
3 speaking, just because this organization has a -- a
4 large breadth of representatives both here and
5 virtually, how other E.M.S. agencies in the future
6 can participate in the important research that PECARN
7 does?
8 **MR. DAYAN:** Sure. And I -- I think
9 it's -- again, I won't take much time. But as
10 PECARN's E.M.S. portfolio increases, it's -- it's
11 clear to many that we'll need other agencies to
12 participate in studies. It's just not possible for
13 one agency to take on many prospective trials at
14 once. So there are some of the studies, like I
15 talked about Pedi-PART, they're going outside of the
16 PECARN network, so they're beyond it. So the -- for
17 people who are interested, just come to me and I can
18 get you engaged in PECARN and make you aware of the
19 studies that are coming up or, and the protocols and
20 potentially to be a site.
21 **CHAIRMAN COOPER:** Thank you, Matt and
22 Peter. Okay. Thank you. Good luck, guys. So I
23 think now we're back to the -- our routine. We have
24 seventeen minutes left to go before four o'clock, but
25 something tells me we'll be able to go quickly. Amy,

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2 you want to tell us about the stroke work group?
3 **MS. EISENHAUER:** Amy Eisenhauer. Yes.
4 So we had two meetings of the pediatric stroke work
5 group. There were some questions brought up, I want
6 to say several SEMAC/SEMSCO meetings ago about
7 pediatric stroke. And through discussion with stroke
8 designation and the stroke advisory committee, so
9 much like our committee there's a stroke advisory
10 committee. There has been much discussion on
11 pediatric stroke and pre-hospital care and ED care
12 and where to take pediatric patients that are
13 experiencing signs of a stroke. So we had our own
14 work group, which included several physicians outside
15 of our group including Dr. Winslow, Dr. Dailey, who
16 is also on Med standards, SEMAC, SEMSCO and on this
17 stroke advisory group, Dr. Cushman, Dr. van der Jagt,
18 and I believe Dr. Cooper were both at some of these
19 meetings.
20 So there was -- and also there was
21 some data requests, so hospital data, which was pre -
22 - which was provided by stroke designation group.
23 And then our own data informatics team provided some
24 data on how many pediatric stroke responses E.M.S. in
25 New York State responds to in about a year. And it's

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2 about seventy per year, right? Some years were
3 sixty-eight, some years were seventy-two, but it's
4 about seventy per year out of approximately two
5 hundred thousand pediatric calls and four million
6 calls across the State. So in reviewing some of this
7 information there will be an update, and I believe
8 this was talked about at the last Med standard,
9 SEMAC, SEMSCO. There will be an update to the stroke
10 protocol to advise E.M.S. providers having pediatric
11 patients experiencing stroke-like symptoms to call
12 medical control.
13 Because as we know stroke care across
14 the State you know, depending on where you're at and
15 what kind of facilities you have varies for -- for
16 treatment and where you might take those patients.
17 But also, the amount of pediatric specific centers
18 varies. So the -- the advisement eloquently put
19 together by the unified protocols in New York City is
20 to call medical control when having a pediatric
21 patient experiencing stroke. And I believe that
22 passed through. So that'll be updated when the
23 protocols are updated. Also, we had further
24 discussion about education for pediatric stroke
25 events mainly that pediatric patients have strokes

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2 and providing some -- some continuing education and
3 information for that. And it was decided that that
4 will be taken on by the medical directors regionally.
5 So again, due to differences
6 regionally, whether that's stroke scale or resources
7 in the area, that regions would take care of that on
8 their own. And so that was kind of the outcome from
9 -- from the work group meetings.
10 **CHAIRMAN COOPER:** Okay. Questions for
11 Amy? So more to come on -- on this in the future,
12 but an ongoing issue and, you know, I think our
13 general sense in the past has been that children with
14 strokes probably belong in pediatric intensive care
15 units. And we need to find a way to ensure that
16 they're getting there. And you know again, there'll
17 be more -- more on this this topic at a future
18 meeting. Elise, do you have a -- a question?
19 **MR. VAN DER JAGT:** Yeah. Just -- just
20 a question about that, Amy. So these are seventy
21 patients that were identified by the E.M.S. community
22 as possibly having stroke. Do we know what the
23 outcome of those patients were? Because I think
24 that's the other side of that coin. There could be
25 potential identification, but if only, let's say one

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2 of those ended up having truly a stroke we might --
3 that might be important information.
4 **MS. EISENHAUER:** So there was no
5 correlation between the pre-hospital and the hospital
6 data. This was -- the questions were --.
7 **CHAIRMAN COOPER:** Sorry, Amy. You
8 mean no correlation was made or there was no
9 correlation?
10 **MS. EISENHAUER:** There -- there was no
11 attempt. And I'm going to explain in a moment. So
12 the -- the data requests were for information on how
13 many. Some of the hospital data was a little more in
14 depth, like whether the patient passed away or
15 returned home or went to, you know, a -- a more acute
16 rehab facility. But the E.M.S. data was not aligned
17 with that. So the patient matching did not happen.
18 **MR. VAN DER JAGT:** Amy, I'm sorry, was
19 the data pulled from hospital diagnosis or from
20 E.M.S. run sheet working diagnosis?
21 **MS. EISENHAUER:** There were two sets
22 of data pulled. One was from E.M.S. data, from hos -
23 - from our E.M.S. charts, so from our run sheet as we
24 used to call them. So it was pulled from E.P.C.R.
25 data, and then the stroke designation group pulled

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2 the hospital data from -- from their hospital
3 diagnosis.
4 **MR. VAN DER JAGT:** So you
5 retrospectively evaluated those patients to see if
6 they arrived by E.M.S.?
7 **MS. EISENHAUER:** There was some, yes.
8 **MR. VAN DER JAGT:** Okay.
9 **CHAIRMAN COOPER:** It would seem that
10 if we're talking only about seventy patients, it --
11 it -- and the simple question is whether they really
12 did in fact have a stroke? It sounds like maybe, you
13 know, maybe one day's work for one of those student,
14 you know, helpers that -- that -- that Director
15 Greenberg was talking about, maybe -- maybe that's
16 something that could be done quickly in advance to
17 the ne -- in advance for the next meeting, and then
18 we'll really -- we have a little bit more information
19 on how to potentially craft a response.
20 **MR. VAN DER JAGT:** Yeah. And I -- and
21 I agree with that. I just think that if we're
22 looking at this information, we need to have all the
23 information, because that may actually inform how we
24 might put a protocol together for, you know, for --
25 for -- for management of potential pediatric strokes.

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2 So but you have to have both sides of it. You have
3 to figure out, you know, how many, but also
4 particularly some of the details of that, if that's
5 possible.
6 **MS. EISENHAUER:** After the
7 conversation that I had during the last pediatric
8 stroke work group meeting, I think that probably we
9 should approach the work group and the other members
10 involved to have further discussion.
11 **MR. VAN DER JAGT:** Yeah. Okay.
12 **CHAIRMAN COOPER:** Right. But that
13 doesn't preclude our trying to do a matchup, right?
14 I -- I wouldn't think; that sounds pretty easy. No?
15 **MS. EISENHAUER:** I wouldn't qualify it
16 as easy. I can look into how -- what would be
17 necessary to make that happen as it's two separate
18 sets of data and for other work groups that I am a
19 part of, that's not just a one-day process, but I can
20 ask if we can have that process occur. There may be
21 data use agreements that need to be put into place
22 for that to happen. However, I do advise that if
23 this is the request to work further on this project
24 outside of updating the current collaborative
25 protocol as to what it's been updated, that we should

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2 have a meeting of maybe you, Dr. van der Jagt and Dr.
3 Cooper with those members were in -- that were in the
4 stroke work group to discuss the furthering of the
5 work.
6 **CHAIRMAN COOPER:** That sounds fine.
7 Okay. Two other quick items before we get to our
8 updates from our sister committees. And I'm, again,
9 mindful of the time. We have two items of new
10 business not yet discussed. The Lifepak issue and
11 the pediatric protocol sedation issue. Do we have
12 reports from --?
13 **MS. EISENHAUER:** So I am the Lifepak
14 and Lifepak 15 pediatric A.E.D. capabilities report
15 person. So while I was -- and this has been brought
16 up before in reference to if you have an A.E.D. or a
17 monitor and you want to use defibrillator pads, you
18 need to use the appropriate pads to go with that
19 unit. So NASEMSO a few years ago released a document
20 that said that. However, while I was attending
21 E.M.S. World as a part of the safe transport of
22 pediatric patient meetings Dr. Dailey was also there.
23 And through a conversation with Stryker there was an
24 awareness brought that the Lifepak 12 and Lifepak 15
25 monitors do not function as pediatric defibrillators

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2 when in the automated mode.
3 And there was some discussion with Dr.
4 Dailey about raising awareness around this because he
5 did not know and he was obviously upset because he
6 wants his agencies to be prepared for all
7 emergencies. And then there was discussion, you
8 know, in the leadership level around making our
9 council and other councils aware that this is out
10 there. There is a letter that NASEMSO put out. So
11 in that same letter with the A.E.D. pads, right?
12 Using the appropriate pads for the appropriate age
13 with the appropriate monitor, there is a section in
14 there advising that if you have a patient under eight
15 and you are using one of these two monitors, you need
16 to have another option for pediatric defibrillation
17 if it is in the automated mode versus the manual
18 mode.
19 **MR. VAN DER JAGT:** If I could address
20 that a little bit, because we went through this
21 extensively at our hospitals to the point that our
22 children's hospital has ZOLL defibrillators and our
23 adult hospital has Lifepak 12 Stryker. And this is
24 indeed the case that the A.E.D. function on that
25 multifunction monitor, it's the A.E.D. is not

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2 designed for patients that are under twenty-five
3 kilograms. And it's probably better doing it by
4 weight rather than by age, actually, with our obesity
5 clinic or obesity epidemic. So that is correct, and
6 I think everyone should know that. I think the other
7 side of that coin is if there's a pulseless arrest
8 and the patient is, it's, you put the A.E.D. on, even
9 the A.H.A. says an adult A.E.D. is better than no
10 A.E.D. So I think it's an important distinction
11 there.
12 If on the other hand, if the patient
13 is talking to you but happens to be in -- needs to
14 be, you know, a cardiovert or something, that's a
15 whole different issue. But pulseless arrest, if you
16 do not have a pediatric A.E.D. that's functional for
17 less than twenty-five kilograms, the A.H.A. does
18 recommend to move ahead with adult defibrillation
19 because the -- the downside is the kid's going to
20 die. Okay? So. And we -- we -- it's also not
21 optimal, but remember that the A.H.A. data or the
22 ILCOR data actually on that, you know, does allow
23 joules per kilogram of ten per kilo up to ten per
24 kilo. So that if you have a, you know what, twenty-
25 kilogram kid, that's two hundred right there. You

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2 know, if you have a ten-kilogram kid, it is one
3 hundred, which is close to the, you know, the one-
4 fifty or so, whatever the Stryker, I think has.
5 **CHAIRMAN COOPER:** Ryan, is it
6 possible, do you think, for us to put together a --
7 some kind of advisory that would get this information
8 out there a little bit more broadly?
9 **MS. EISENHAUER:** I think that -- well,
10 I can shut this off if you want to or I can. So --
11 so there is an advisory and it's -- it's up on the
12 screen right now from NASEMSO. So I mean, we could
13 distribute it just as a general, hey, for awareness,
14 re-awareness, this has been issued by -- by NASEMSO.
15 It has been shared by other states for their pre-
16 hospital providers and hospital providers. Please be
17 aware that -- that this was put out. We certainly
18 could do that. There is already that information in
19 a document that we can share.
20 **MR. VAN DER JAGT:** You know, one
21 thing, Amy, that would be maybe, I don't know about
22 this advisory, what's in it, but it crosses my mind,
23 I'm thinking through this, is that if there is a
24 patient that's say, is younger, could you use the
25 length-based tape? And that needs to be manual

2 defibrillation rather than using the A.E.D. That's
3 what we would do in the hospital. We -- for years
4 had Lifepaks and there was -- we had signs on them,
5 do not use A.E.D. function for less than twenty-five
6 kilograms. They needed to be manually defibrillated
7 by weight. And so if there's a way to incorporate
8 that I don't know, but that would be beyond a lot of
9 the B.L.S., as I would guess, you know certainly.
10 **MS. EISENHAUER:** So certainly that --
11 that was Dr. Dailey's point, that his B.L.S. agencies
12 that also do B.L.S. 12-lead, where they can acquire
13 the 12-lead and then electronically transmit it, but
14 not read it because that's outside of their scope.
15 They again, I was not there when the sales were made.
16 I was not there when that clinical education was
17 given. Apparently, some of these agencies only have
18 these monitors. They do not have a separate
19 defibrillator anymore because they're under the
20 impression that this monitor could be used on the
21 B.L.S. level as an A.E.D. And so the issue is not so
22 much for paramedics or advanced E.M.T.s, but for the
23 B.L.S. only, that happened to also be using these
24 monitors.
25 **CHAIRMAN COOPER:** All right. I will

2 take it on myself working with Amy and Elise to put
3 together a one or two paragraph cover memo to go out
4 with the NASEMSO document really summarizing this
5 issue, you know, in a few bullet points so that the
6 word gets out there a little bit more generally.
7 Okay. Do I have the support of the committee in
8 doing that? Anybody disagree? Nobody's disagreeing.
9 Okay. So we'll take care of that. Procedural
10 sedation, anything on that, Amy? Elise?
11 **MR. VAN DER JAGT:** Yes. Yeah. This
12 came up this whole issue of procedural --.
13 **CHAIRMAN COOPER:** Excuse me, I'm
14 sorry. It is four o'clock. Can I -- can I ask for
15 the indulgence of the committee to go on for another
16 maybe fifteen minutes? That'd be all right? Okay.
17 Thank you.
18 **MR. VAN DER JAGT:** And then Dr.
19 Cooper, I think that we can probably discuss this a
20 little bit more fully in February. This I just want
21 to bring just a statement up here. I -- I serve on
22 the -- the quality assurance, quality improvement
23 committee for the Society for Pediatric Sedation.
24 And what that society deals with is procedural
25 sedation in emergency departments, in imaging areas,

2 in children's hospitals overall. But a lot of it's
3 in emergency departments. And the -- the question
4 came up is, how do we manage the need for sedation
5 for acute procedures in the E.D.? Is it being done
6 safely? Is it being done correctly? Is it being
7 done with the -- as minimal psychological and actual
8 nociceptive trauma? So that came up. And the
9 question then came up, shouldn't this be in the realm
10 of emergency medicine?
11 Especially in the smaller hospitals
12 where there may not be pediatric -- so many pediatric
13 folks. How do we get a handle on this? Are there
14 some ways that collaboration could be established
15 with the society to see how do we make this optimal?
16 And what I told them, I said, you know, I'm on this
17 group. I can certainly bring it up. And again,
18 under the umbrella of E.M.S.C. is -- is the whole
19 place. And this is usually sedations that are done
20 in the acute management of patients in the E.D. This
21 actually dovetails a bit also with the agitation
22 behavior area of, you know, with, you know, giving
23 very potent medications in the E.D. or even in the
24 pre-hospital care area. So just wanted to bring that
25 up.

2 But we can certainly do that in
3 February, and I can certainly prepare something a bit
4 more succinct that we might want to consider.
5 **CHAIRMAN COOPER:** Perfect. That's
6 what I was going to ask. If you could bring a
7 specific -- up a brief proposal, and again, bearing
8 in mind that we only have two months, the meeting's
9 February 1st. Okay. So that's actually less than
10 two months. It is virtual, but it still has to go
11 through the E.D.C.C. process. Which means pretty
12 much it's got to be ready by the first of the year, I
13 would guess. Right? Okay. We now have -- do we
14 have a report from Injury Prevention? Yes. Thank
15 you.
16 **MS. ALFONSO:** Hi, folks. So I'm Kris
17 Alfonso. I am with the State Department of Health,
18 Bureau of Occupational Health and Injury Prevention.
19 I have a couple of quick updates. The first thing I
20 wanted to do was intro -- introduce Susanne. So
21 Susanne is our new senior health program coordinator
22 specifically over child passenger safety and younger
23 driver safety. So you will see Susanne at these
24 meetings going forward. Susanne has over twenty
25 years' worth of experience in the field at a county

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2 level. So I think she's going to be a great asset to
3 this committee. Very quickly, I'll run down a couple
4 of our different updates.
5 So we have finished our C.N.B.C.
6 campaign intersections bookmark, that's available on
7 our website right now, as well as our K-5 pedestrian
8 safety video vignettes. So those are ten-second clip
9 video vignettes that are meant to teach children
10 different aspects of pedestrian safety and that can
11 be used in schools and with other agencies. We have
12 finished up a failure to yield P.S.A. in publication
13 that is available on our website. And we are going
14 through a pedestrian safety campaign media buy and
15 we're looking to raise awareness of and reduce
16 pedestrian related risks through education and
17 awareness on a pedestrian level.
18 I don't know if folks have recently
19 seen in the news, there were a couple of different
20 pedestrian related crashes that happened just in the
21 last two weeks. Two of them being on Central Avenue.
22 So it's something that we are aware of and we're
23 looking to get a lot of our publications out to
24 different groups of people through outreach. We have
25 been working with the New York State P.T.A. to do

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2 outreach at their different events so that we can
3 provide our materials and resources to parents and to
4 that group in general. Beyond that, we -- for our
5 younger driver safety, we have a publication on
6 shared risk and protective factors that's been
7 developed and approved, and that's going to be
8 available on our web -- our website, as well as the
9 Driver Education Research and Innovation Center
10 project, DERIC.
11 So there's going to be three more
12 pilot trainings within the scheduled grant cycle, and
13 that's going to support the DERIC curriculum and
14 supplemental resources. So yeah, if folks have any
15 questions about any of those different projects or
16 campaigns that we have going on, please let us know.
17 **CHAIRMAN COOPER:** Thank you so much.
18 Any questions for our -- our colleagues from the --
19 from BOHIP as it's called? Hearing none. Thank you
20 so much for coming. We appreciate it. And welcome,
21 we look forward to seeing you in the future meetings.
22 Again, our next meeting's February 1st. Next Kate
23 Butler from -- I know you spoke a little bit
24 previously, but I'm sure you have more exciting news
25 for us.

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2 **MS. BUTLER:** Wouldn't necessarily say
3 it's exciting, but yeah. Kate Butler as a party from
4 the Office of Health Emergency Preparedness. As Amy
5 had noted before, we do have a number of -- of
6 federal grants that our office operates which is the
7 Hospital Preparedness Program and the Public Health
8 Emergency Preparedness Program. We are closing out
9 our five-year cooperative agreement in June. We will
10 be getting a new five-year cooperative agreement in
11 July. I'll be in close communication with Amy if
12 there's anything that is going to be a nice crossover
13 activity or if there's any new requirements that --
14 that would flag up for this group.
15 **CHAIRMAN COOPER:** This is the injury
16 community implementation program you're speaking of?
17 **MS. BUTLER:** No, Office of Health
18 Emergency Preparedness.
19 **CHAIRMAN COOPER:** Okay. I'm sorry.
20 **MS. BUTLER:** Sorry. But as I said,
21 looking at some of those crossover activities, we
22 have had the opportunity this year for our contract
23 hospitals. So the hospitals that we do provide a
24 small amount of funding to, we have a deliverable for
25 them all to do the National Pediatric Readiness

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2 Assessment for the E.D. We have started to get those
3 in. I will be getting those to Amy. I think it's a
4 really great -- we are offering, being able to offer
5 a little bit of a carrot to them all so that they can
6 actually complete that activity, have that data all
7 in there for the next time there is that formal
8 request. And we also get the luxury of having the
9 data. So I'm -- I'm -- I'm glad that we were able to
10 get that forward.
11 And the only other update that I did
12 have is that we, New York State Department of Health
13 has the Pediatric and Obstetric Preparedness toolkit
14 that was crafted in 2017. We will be looking to do a
15 review and refresh, and there's a number of folks
16 that are on this committee that will be involved in
17 that process as we move forward with that, with an
18 estimate of June of 2025 for that getting back out.
19 It's long. We got a little busy after 2017. So we -
20 - we -- we are aware that we should have been doing
21 that refresh a little bit earlier, but it is in
22 progress. And barring any questions, that was all I
23 had for today.
24 **CHAIRMAN COOPER:** Thank you. Any
25 questions for Kate? Kate, thank you. We again as

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2 also is the case with BOHIP, we deeply appreciate you
3 coming to these meetings every time. And I -- I hope
4 that, you know, the information that you learn from
5 us is at least helpful to bring back to your -- to
6 your colleagues in -- in the hospital preparedness
7 program. We're -- we're deeply appreciative of your
8 participation. And, you know, disaster preparation
9 and preparedness is deeply important to this
10 committee, even though you know, somehow you always
11 end up at the end of the agenda with little time.
12 But it, it is very to me -- for me, particularly,
13 it's an area in which I spend a lot of my
14 professional hours. In any event, thank you so much
15 for coming.
16 All right. Mike McEvoy is -- has not
17 been able to be with us this afternoon. He was
18 earlier, but he had other responsibilities that have
19 taken him away. And so now the last item on our
20 agenda is a report from Kim Wallenstein. Kim, please
21 take it away.
22 **MS. WALLENSTEIN:** Hey, thank you. Kim
23 Wallenstein. So I'm standing between you and the
24 door, so I'll make this brief.
25 **CHAIRMAN COOPER:** That's okay. I'll

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2 block the door until you're done, I promise.
3 **MS. WALLENSTEIN:** So we had our last
4 STAC meeting back in October. The next one's coming
5 up in January. We discussed a few different topics
6 at the pediatric subcommittee one being related to
7 our (unintelligible), New York State Collaborative.
8 And looking at our recent data and seeing where we're
9 outliers, we really were only outliers in one area,
10 which was fifteen to nineteen-year-old traumatic
11 brain injury mortalities. And so we're drilling down
12 into that. The data doesn't look quite right to us,
13 so we're looking into it. We also sort of started
14 talking because of that, about the issue of those
15 older teenagers, the fifteen to nineteen year olds,
16 because we recognize that our centers are very
17 heterogeneous in how we treat children.
18 There are some centers that see kids
19 up to age fifteen, like A.C.S.s that children are
20 sort of less than fifteen, and some centers go higher
21 than that. And we don't really know where these
22 fifteen to nineteen year olds actually go when they
23 get transported to hospitals, what teams take care of
24 them, what ICUs they go to. So we're working on
25 getting some data on that from our -- our centers.

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2 The second big topic we talked about was pediatric
3 readiness, as Amy Eisenhauer talked about before, and
4 our discussion earlier was pretty robust. So I won't
5 go deeply into it. We definitely recognize that
6 there's a lot of data that children do better if they
7 are taken from the field to centers that are ready to
8 take care of them.
9 And there's a little bit of comfort on
10 -- on our part that, at least from the A.C.S.
11 Standards, that centers that are trauma centers have
12 to be -- have that gap analysis and fill out that
13 form of pediatric readiness. But as we know,
14 especially in Syracuse and in a lot of the up --
15 upper part of the State, we know that the centers
16 that transfer patients to us are not level -- A.C.S.
17 level centers that have to do that. So we are
18 looking into where exactly patients are transported
19 from the field, what level those centers are before
20 they come to us as pediatric, hopefully pediatric
21 ready trauma centers.
22 We identified most of the issues with
23 pediatric readiness that we talked about just a
24 little bit earlier. We also recognized that there's
25 an ideal world, and then there's what we have now.

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2 So we had actually had an ask for STAC -- previous
3 STAC, probably about a year ago now, to require
4 centers to turn in who their pediatric care
5 coordinator is. And that -- everybody said, yeah,
6 that's great. That was passed, but then it went
7 nowhere because there's no real ask that anybody has
8 to turn in anything about any information about
9 pediatric care coordinators. So we're currently in
10 the process of sort of developing an ask for what we
11 think would be the best organization of this concept,
12 because it's great, like we were talking about, it's
13 great to have that up on the website that this is
14 available, that you can be pediatric ready, or
15 pediatric champion, or whatever.
16 But if nobody -- first, nobody goes to
17 the website and sees that exists, and nobody actually
18 does it because there's no incentive for it. And
19 then if they do it, nobody either publicizes it or
20 tells anybody about it. And so you don't know who
21 those centers are, then it just becomes really
22 disorganized. So we are -- we're working closely
23 with Amy to try to get that a little bit better
24 organized. In an ideal world, we feel that obviously
25 you have all the centers, all the centers that take

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2 care of kids or that have kids transported to them,
3 do that gap analysis, get on the website, choose a
4 pediatric care coordinator, send that list in on a
5 rotating basis whenever it changes so that you know
6 who those people are in the State.
7 And then have some sort of incentive
8 so that they can kind of advertise themselves and --
9 and, you know, like you have a sign on your hospital
10 or your marketers put that out in your newsletter
11 that you're pediatric ready would be the best thing.
12 So we are still working on that.
13 **CHAIRMAN COOPER:** Okay. A full plate
14 for the pediatric subcommittee of STAC. Kim, I know
15 that's, you know, probably a little more than keeping
16 you a little busier than, you know, than past chairs
17 have been. But we appreciate your work and -- and
18 that of the -- that of the -- the PED subcommittee of
19 STAC. It's you know, obviously our sister
20 subcommittee, if you will, in terms of our -- the
21 bureau's you know advisory councils. And it's a very
22 important group because as we all know, you know,
23 trauma does remain the leading killer of children.
24 More than all other diseases combined in the
25 childhood age ranges and remains an unsolved public

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2 health problem because we have injury prevention
3 techniques at our disposal that we just don't use.
4 If kids voted and if they had money,
5 things would be different, but they don't and they
6 don't. And so, you know, that's our -- that's the
7 reason we're here is if we don't stand up for
8 children who will. Right? So that concludes our
9 formal agenda. Is there -- is there any other new
10 business that any members of the committee wish to
11 bring forward at this time? Well then, hearing none
12 I want to wish you all the happiest of holidays. And
13 I will ask for a motion to adjourn and we will see
14 you February 1st.
15 **MR. HARRIS:** Motion to adjourn.
16 **MR. ALBERT:** Second.
17 **CHAIRMAN COOPER:** Thank you, Matt, and
18 -- and Kevin, thank you very much. Safe travels
19 home, everyone.
20 **MS. EISENHAUER:** Thank you. We can go
21 off the record.
22 (The meeting concluded at 4:13 p.m.)
23
24
25

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2 STATE OF NEW YORK
3 I, BECKY FOSTER, do hereby certify that the foregoing was
4 reported by me, in the cause, at the time and place, as
5 stated in the caption hereto, at Page 1 hereof; that the
6 foregoing typewritten transcription consisting of pages 1
7 through 114, is a true record of all proceedings had at
8 the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 28th day of December, 2023.
11
12
13 BECKY FOSTER, Reporter
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