2/1/2024 – E.M.S. for Children – WebEx

NEW YORK STATE
DEPARTMENT OF HEALTH
E.M.S. FOR CHILDREN
ADVISORY COMMITTEE

DATE: February 1, 2024
TIME: 1:01 p.m. to 3:56 p.m.
CHAIR: ARTHUR COOPER
VENUE: WebEx

Reported by: Cari Roraback

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2 **APPEARANCES:**
3 Alexa Cappola
Alexander Bleau
4 Amy Eisenhauer
Arthur Cooper
5 Becky Baitsholts
Benjamin Kasper
6 Brandon Rosettie
Bruce Barry
7 Christina Akey
Daniel Clayton
8
Drew Fried
Edward Conway
9
Elise Van Der Jagt
10 Eric Rowe-Jones
George Stathidis
11 Gina Wierzbowski
Grace Hennessy
12 Kate Butler-Azzopardi
Katerina Gaylord
13 Kevin Albert
Kim Wallenstein
14 Kris Alfonso
Jason Haag
15
Jennifer Coldman
Joseph Pataky
16
Marilyn Kacica
Mike McEvoy
17
Nicole O'Toole
18 Pamela Feuer
Peter Brodie
19 Peter Dayan
Ryan Greenberg
20 Sharon Chiumento
Susan Stegich
21 Vincent J. Calleo
22
23
24
25

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2 (The meeting commenced at 1:01 p.m.)
3 **MS. EISENHAUER:** We're ready if you
4 are ready.
5 **CHAIR COOPER:** I am ready. I am
6 unfortunately not in my office though today, Amy.
7 I'm -- I'm over at Metropolitan Hospital. So I'm
8 going to ask you, if you don't mind, to sort of help
9 shepherd us through the agenda. But I'm sure that
10 the first thing on the agenda is the roll call
11 followed by approval of minutes. So you've indicated
12 we have a quorum. And I think you've -- I've gotten
13 everybody's name who is present, correct?
14 **MS. EISENHAUER:** Yep.
15 **CHAIR COOPER:** So I guess the next
16 item on our agenda would be approval of the minutes
17 from last time.
18 **MS. EISENHAUER:** Well, we have to do
19 the roll call.
20 **CHAIR COOPER:** Oh, that's -- that's
21 what I -- that's what I meant, but go ahead.
22 **MS. EISENHAUER:** Okay. So our court
23 reporter, Cari, is here. And as usual please
24 announce your name before you speak. And so yes. So
25 for the whole meeting. Dr. Cooper?

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2 **CHAIR COOPER:** Yes, I am here.
3 **MS. EISENHAUER:** Dr. Van Der Jagt?
4 **MR. VAN DER JAGT:** I am here. Sorry,
5 I was on mute.
6 **MS. EISENHAUER:** Oh, that's okay.
7 Bruce Barry? Dr. Albert? Sharon Chiumento?
8 **MS. CHIUMENTO:** I am here.
9 **MS. EISENHAUER:** Dr. Conway?
10 **MR. CONWAY:** Here.
11 **MS. EISENHAUER:** Dr. Pamela Feuer?
12 Dr. Calleo?
13 **MR. CALLEO:** Here.
14 **MS. EISENHAUER:** Doug Hexel --
15 **MS. FEUER:** Present.
16 **MS. EISENHAUER:** Oh, thank you, Dr.
17 Feuer. Doug Hexel had a conflict and he will not be
18 attending today. Nickol O'Toole? Hang on, Nickol,
19 we're unmuting your phone. I muted you. So you
20 might be double muted. There you go. Okay. Nickol,
21 your phone is unmuted.
22 **MR. VAN DER JAGT:** It looks like on
23 the (unintelligible) it doesn't look like she's
24 hooked up to audio.
25 **MS. EISENHAUER:** She has a separate

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2 audio phone call in.
3 **MR. VAN DER JAGT:** Oh, okay. Got it.
4 **MS. EISENHAUER:** Yeah. Okay. We'll go
5 on. Dr. Bombard? Dr. Harris? Chief Pataky?
6 **MR. PATAKY:** Good afternoon. I'm
7 here.
8 **MS. EISENHAUER:** Jason Haag?
9 **MR. HAAG:** Jason Haag here.
10 **MS. EISENHAUER:** And Ben Kasper?
11 **MR. KAPSER:** I'm here.
12 **MS. EISENHAUER:** Bruce Barry?
13 **MR. BARRY:** Bruce Barry is here.
14 **MS. EISENHAUER:** Thank you. Okay. I
15 will turn it back over to you, Dr. Cooper. We have a
16 quorum.
17 **CHAIR COOPER:** Great.
18 **MS. O'TOOLE:** Amy, I'm -- can you --?
19 **MS. EISENHAUER:** Oh, Nickol is here.
20 Awesome.
21 **MS. O'TOOLE:** Yep, I'm here. Got it.
22 **CHAIR COOPER:** Wonderful.
23 **MS. O'TOOLE:** Thank you.
24 **CHAIR COOPER:** Wonderful. Okay. I'm
25 glad -- glad to know that we have a quorum. And next

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2 on our agenda, as you all know, is approval of the
3 minutes from our December meeting. And I will ask if
4 someone would be willing to make a motion to approve,
5 presuming that there's no additions, deletions, or
6 corrections that need to be made.
7 **MR. PATAKY:** This is -- this is Joe.
8 **CHAIR COOPER:** Go ahead.
9 **MR. PATAKY:** I make a motion to
10 accept.
11 **CHAIR COOPER:** Thank you, Joe. And
12 second?
13 **MS. CHIUMENTO:** Sharon Chiumento,
14 second.
15 **CHAIR COOPER:** Thank you, Sharon.
16 Thank you. Any discussion, additions, deletions, or
17 corrections? Hearing none, any objection to
18 approving the minutes as written? Hearing none, the
19 minutes are approved. Okay. Amy, take it away.
20 **MS. EISENHAUER:** All right. So for
21 the E.M.S. for Children Grant Report the Always Ready
22 for Children Pediatric Recognition Program is still
23 accepting applications. We have six applicants. So
24 very exciting. And some of those are -- and we
25 talked about this at pediatric STAC subcommittee just

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2 last week. Some of those are local emergency
3 departments, which is really who the program is meant
4 to help the most. So we're very excited about that.
5 There was some discussion at Ped STAC and also at our
6 meeting last -- last year, I guess, if we want to
7 call it that, but in December about how to promote
8 the program, how to get the word out. Right. How to
9 reach people. So there are several people that are
10 interested in kind of forming a subcommittee between
11 two groups. So a co-joined subcommittee between Ped
12 STAC subcommittee and E.M.S. for Children Advisory
13 Committee.
14 So if you're interested in that and
15 you haven't already spoken to me please send me an
16 email. Probably in the next couple weeks we'll start
17 have -- having kind of brainstorming meetings and
18 coming up with a plan on how we can all help each
19 other, get the word out to best help kids in E.R.s.
20 **CHAIR COOPER:** Amy, I'll be happy to
21 participate in that as --.
22 **MR. EISENHAUER:** Awesome. Thank you,
23 Dr. Cooper.
24 **CHAIR COOPER:** Yeah.
25 **MS. WALLENSTEIN:** Yeah. I think you

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2 probably already have my name. Yeah.
3 **MS. EISENHAUER:** Yes.
4 **MS. WALLENSTEIN:** Yes.
5 **MS. EISENHAUER:** Yes. And I feel like
6 both of you were going to be volun-told at some point
7 anyway. Just --
8 **CHAIR COOPER:** Yes. That is fine
9 **MS. EISENHAUER:** -- just because
10 you've been interested and are in charge of these two
11 groups. So for the Pre-Hospital Pediatric Emergency
12 Care Coordinator Program that is ongoing, we have
13 some exciting things coming up. So I know a few -- a
14 few months ago, many months ago, we got a rural
15 supplement grant from E.M.S. for Children to build
16 some education and build some tools for E.M.S.
17 providers to use. So one of those things was a PECC
18 kit. So a little bag that can go on the ambulance.
19 It would have a pediatric agitation infographic with
20 information on how to deescalate children. And
21 really, I -- I think the tips are good for anybody.
22 And the E.M.S. for Children Innovation and
23 Improvement Center had developed that.
24 We brought it through the E.D.C.C.
25 process, public affairs group made a great new one

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2 with New York specific you know, logos and things on
3 it, and made it purple. Thanks much -- much thanks
4 to Kathy for making all my things match. So she made
5 it purple for me. So that will be printed soon. We
6 just looked at the last proofs last week, some
7 communication cards. So Florida, Minnesota, and I
8 want to say Kansas, all have been sharing these cards
9 with other programs. So we had some made with our
10 logo on it. And those, the proofs just went through
11 last week also. So hopefully those will be printed
12 soon. I already received --.
13 **CHAIR COOPER:** Are we able to show
14 that to the committee on -- online at the moment?
15 **MS. EISENHAUER:** They are not up
16 online yet.
17 **CHAIR COOPER:** No, I meant -- I meant
18 if it's on your computer, I don't know if you're
19 allowed to do that.
20 **MS. EISENHAUER:** I do not know if I'm
21 allowed to share them yet.
22 **CHAIR COOPER:** Okay.
23 **MS. EISENHAUER:** Because they have --
24 I'm sorry?
25 **MS. GREENBERG:** Amy, if you want to

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2 give an example of what you have the ability to pull
3 up one or two of them or pull up the document --
4 **MS. EISENHAUER:** Yep.
5 **MR. GREENBERG:** -- and just
6 (unintelligible) do it. I -- I think we are good
7 with that.
8 **MS. EISENHAUER:** Okay.
9 **CHAIR COOPER:** Thanks, Ryan. I just
10 wanted the committee to get a sense of all the
11 incredible hard work that Amy's been giving that.
12 **MS. EISENHAUER:** Well, this certainly
13 was --.
14 **MR. GREENBERG:** Yeah. Also, you know
15 --.
16 **MS. EISENHAUER:** Go ahead, Ryan.
17 **MR. GREENBERG:** It -- it's a – it --
18 it's a little hard understand what they are unless
19 you're literally looking at them to a certain extent.
20 And -- and I think this will be an incredible tool
21 for a lot of E.M.S. providers as well as something
22 that they've never used before too. So it -- you
23 know, I think it will take a little getting used to,
24 a reminder that it's there, but, you know, have the
25 opportunity to, you know, really be helpful to them.

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2 Okay. With that being said, I think Amy and I are
3 both interested to see what the engagement of them
4 are. You know, do they end up, you know, collecting
5 dust in an -- someone's pocket somewhere, you know,
6 shelf somewhere, or do they find it to be a good tool
7 and, you know, something that, that really helps them
8 in that communication pathway?
9 So and -- and I also feel obligated to
10 say these were borrowed with pride. We don't steal
11 things. We borrow with pride from a -- from another
12 great E.M.S.C. program down from Florida, who we
13 spoke with and said, absolutely, you know, we -- we,
14 you know, it -- it is a good thing, and why recreate
15 the wheel? So here's our little piece of giving back
16 to -- to Florida who gave to us. And so if you do
17 get these and they're out there, remember to give
18 Florida some credit for it as well.
19 **CHAIR COOPER:** Sure. Nice.
20 **MR. GREENBERG:** This is just a little
21 bit, it will get printed into a card set. You'll see
22 the -- the round circle there. It will go in a kind
23 of a key chain. They're on a more durable -- it's
24 not just paper. They're on like a more durable
25 thing. I can't remember if we ended up plastic,

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2 right? I don't remember if we ended up plastic or
3 laminated, but on like a durable plastic thing. And
4 essentially it just looks like a card -- picture a
5 card set with a ring around it at one end, and, you
6 know, gives you the ability to, you know, look at a
7 picture. Obviously, you can see that in multiple
8 languages. And to -- to keep this on the ambulance
9 to help, you know, with communication or things of
10 that nature. You know, we talk about this from a
11 child point of view, but this is also pretty
12 interesting from a -- just the special needs
13 population.
14 I think, you know, we -- we think
15 children, when we -- we thought about this at first,
16 but when we talk about, you know, communication
17 barriers or other, you know, sensory things that are
18 going on, obviously in a complex situation that, you
19 know, these could also be effective in using and
20 communicating with. And Amy, correct me if I'm
21 wrong, although this is, you know, going out to our
22 E.M.S. communities, this could be a great tool for
23 our E.R.s as well.
24 **MS. EISENHAUER:** Yep.
25 **MR. GREENBERG:** And you know,

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2 something that we can consider helping in -- in that
3 part for anyone from an E.R. point of view that would
4 be looking forward. And credit where credit is due.
5 This is as well as Florida, but this is Amy who
6 brought it up here. So she found it, brought it, and
7 made it happen. And with the biggest list being,
8 getting to our public affairs group, so a -- a
9 credit, they did a tremendous amount of work to get
10 it through there, but it took a lot of shepherding
11 through and answering a lot of questions and -- and
12 getting the right approval staff to happen. So we'll
13 probably see this in -- by the time production and
14 everything else, Amy, do you have a thought on that?
15 **MS. EISENHAUER:** So these were
16 approved by us and Public Affairs Group has to get
17 quotes and do all of that. So they are telling me
18 that we will get them by the end of the grant period.
19 So we don't have to go through requesting grants for
20 it.
21 **MR. GREENBERG:** Which for everybody is
22 when? When's the end of our grant, Amy?
23 **MS. EISENHAUER:** March 31st.
24 **MR. GREENBERG:** Okay. We're hopeful.
25 **MS. EISENHAUER:** Yes.

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2 **MR. GREENBERG:** Once we have them,
3 we'll, you know, talk about that one.
4 **CHAIR COOPER:** That's great.
5 **MR. GREENBERG:** Thanks, Amy.
6 **MS. EISENHAUER:** Thanks. So also Dr.
7 van der Jagt had a question in the chat. I saw it
8 pop up and he asked, is there anything for the deaf
9 community? Not specifically for the deaf community,
10 but those cards could be used with the deaf community
11 right, with the pictures and the words. And then on
12 the back -- here, I'll just go back to that real
13 quick. They also branded a dry erase marker. So it
14 will say -- it'll be purple and it'll say E.M.S.C.
15 Pre-Hospital PECC. And this area is designed to be
16 where you could write on it or wipe it off with that
17 dry erase marker.
18 And this is the other recently -- this
19 is the other recently developed tool on calming peed
20 -- agitated pediatric patients. And so the root --
21 the root document for this was from the E.M.S.C.
22 Innovation and Improvement Center. And so New York
23 kind of put our own flavor on it, but all of the
24 content and information is from there. They made it
25 more plain language instead of more clinical

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2 language, but it still conveys the same message. And
3 my hope is that this will also be printed and put on
4 that laminate paper, just like the P.A.T. document,
5 but also this will be available via P.D.F. online and
6 our online resources for people to just print out or
7 access on their phones.
8 **MS. KACICA:** Amy?
9 **MS. EISENHAUER:** Yes.
10 **MS. KACICA:** This is Marilyn Kacica.
11 You know, as you know, we're updating the pediatric
12 and obstetrical toolkit.
13 **MS. EISENHAUER:** Yes.
14 **MS. KACICA:** And I think the resources
15 that you just showed are really great and should be
16 incorporated into that to make sure that they're
17 widely distributed.
18 **MS. EISENHAUER:** Oh, that would be
19 great. Thank you. I know Brielle from the Capital
20 Region Work Group has been keeping me up to date on
21 that. And my -- anytime there's been a meeting, I
22 have another, like E.M.S.C. specific meeting, kind of
23 the same time. So my hope is to be at the next
24 meeting to share with them as well. But I'll
25 definitely send all of those over to them.

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2 **MS. KACICA:** Yeah. And that group,
3 Amy, so it -- you know, there's a connection here.
4 And we have -- you should have been added to a team
5 site too, and all the material will be there.
6 **MS. EISENHAUER:** Okay. I'll -- I'll
7 double check. Thank you so much.
8 **CHAIR COOPER:** Marilyn, if you need
9 help from the committee, our committee in terms of
10 the vision of the toolkit, please let us know.
11 **MS. KACICA:** Oh, sure. Thank you.
12 **MS. EISENHAUER:** So other pre-hospital
13 tech things, let me go back to the agenda.
14 **CHAIR COOPER:** It's great work, Amy,
15 by the way. Thank you so much.
16 **MS. EISENHAUER:** Oh, thank you. So
17 also, just like we have Always Ready for Children
18 Pediatric Recognition Program for emergency
19 departments, this grant cycle, so this next four
20 years, one of the performance measures is to have a
21 similar program for E.M.S. agencies. I have been
22 working similarly that we did with the Always Ready
23 for Children Program. The whole Northeast, all of
24 our E.M.S.C. programs are working together to kind of
25 build a template that we can then bring back to each

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2 of our States and customize with our State's specific
3 needs and wants. So as soon as that template is
4 done, I will be looking to all of you to form a work
5 group to kind of flesh that out and then hopefully,
6 you know, put that through the process. And we will
7 update the PECC program to put it within that
8 pediatric recognition program for prehospital
9 agencies.
10 So it'll still be the same PECC
11 coordinators and all of that. It'll just be under a
12 larger overarching program. So the NASEMSO Pediatric
13 Restraint Device Testing Advisory Group. It's so
14 many words. So essentially for those of you who
15 weren't here last meeting, that is the work group
16 that is building testing standard recommendations for
17 S.A.E. and it's Tier test, the Pedi-Mates, the
18 A.C.R.4s, the adjust restraint device. All of the
19 different devices that are available out there would
20 be now made to test under this standard. So the end
21 of that to see who's -- who has been tested and who
22 hasn't, is not for at least another four to five
23 years. But we are working hard on the -- on the
24 advice on what should be tested and how it should be
25 tested.

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2 So that is ongoing. And I know that
3 May is kind of our target to have that document to
4 S.A.E. And then every year we have an E.M.S. for
5 Children Pre-Hospital Survey. And so typically that
6 is kicking off at this time of year. They have
7 updated the survey to reflect more of that pediatric
8 recognition hospital type survey. So this survey
9 will have two hundred questions, and I understand two
10 hundred questions sounds like a lot, but it's first
11 name, last name, address. So some of them are
12 demographic information. So probably I would say
13 twenty of those questions is just information about
14 the agency and the person filling it out. They have
15 provided some guidance. I have it. I will share.
16 To help E.M.S. agencies prepare for the survey.
17 So this is the preview that they --
18 that they have issued and is on the pediatric
19 readiness site. So it -- it explains what is pre-
20 hospital readiness which has not changed and also why
21 pediatric readiness is important. None of that has
22 changed. All of this comes from the research that
23 E.M.S.C. and the E.M.S.C. Innovation and Improvement
24 Center has been conducting all along. The difference
25 is the questions that they're asking. So this tool,

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2 just like the E.D. survey, is designed to see how --
3 not -- not punitively, but to see how your agency is
4 doing so that you can then form a plan to improve.
5 So the assessment -- there's a toolkit and this is
6 all available online. If you have difficulty finding
7 it, I'm happy to send it to you.
8 But the checklist as you can see here,
9 is divided into seven different sections. So that
10 would be education and competencies for providers,
11 which is the same thing we've been doing, providing
12 pediatric specific C.M.E. content and then providing
13 opportunity for E.M.S. providers to check their
14 skills by doing scenarios or simulations or even just
15 pulling equipment off the ambulance, going through
16 it, making sure they know how to use it. Kind of
17 those -- those skill simulations. Do you have the
18 right equipment and supplies, all different sizes for
19 -- all different size children. Patient and
20 medication safety? Do you have patient and family
21 centered care in your E.M.S. program? Policies,
22 procedures, and protocols, including medical
23 oversight?
24 So I think a lot of that is covered.
25 Quality improvement or performance improvement, and

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2 then interaction with systems of care. So do you
3 have interactions with the larger healthcare system?
4 So I think some of these things, there will be gaps.
5 But I think other things, they are things we're
6 already doing. They're just under a different name.
7 So a lot of the concern that the E.M.S.C. program
8 managers across the country have just been that
9 verbiage. So there will be, I think for the first
10 year, a lot of interaction, a lot of explanation, a
11 lot of discussion with agencies on exactly what are
12 they asking, what does this mean? And some of the
13 questions seem repetitive. And so we've been working
14 with E.M.S.C. and the E.M.S.C. data center to have
15 those questions be more clear before this survey
16 comes out.
17 So the assessment they estimated it'll
18 take thirty to forty-five minutes to complete. As I
19 mentioned, some of those questions are things like
20 your name, your agency address, what is the phone
21 number, what is the email, who should we contact?
22 Who are your pediatric emergency care coordinators?
23 Things like that, that are -- that are easy to fill
24 out. And some of the questions it's, if you said yes
25 on this one, then there's a few other questions. If

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2 you said no on this one, you might not need to answer
3 those questions. So there is some -- some tiers in
4 there. So after they complete the assessment they
5 will get a report, a gap report. Just like when we
6 do the hospital assessment every five years, you get
7 a reply with that gap report. And they'll see their
8 readiness scores.
9 Just like with the hospital survey, I
10 don't get -- I don't get these. Right. This goes
11 right to the E.D.C., the E.M.S.C. Data Center. And
12 they keep all of it. I only see if you completed it,
13 if you completed it halfway, or if you haven't
14 attempted it yet, I don't see specifics in there. So
15 they only share -- share that so that we can help
16 agencies complete the survey, answer any questions,
17 share the information, make sure the information got
18 to the right person. Maybe the agency changed hands
19 where there's different leadership now. So that's
20 how the E.M.S. for Children programs help in
21 deploying the survey.
22 So they -- they give more information
23 on how to -- how to get everything completed. And
24 then, of course, a Q.R. code. And you can find all
25 of this at this website. Does anybody have any

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2 questions on the upcoming E.M.S. survey in May of
3 2024?
4 **MR. VAN DER JAGT:** Amy, this is --
5 this is great. I had a question about how this pre-
6 hospital readiness survey will be communicated to our
7 State all the agencies in there. Because I think it
8 is really important and what crossed my mind, I don't
9 know how the communication will occur, but could
10 there be, or should there be, something to think
11 about, a letter from the advisory committee strongly
12 suggesting that everybody fill this out. I'm
13 wondering if that would be helpful. Just wondering
14 what your communication would be to the agencies that
15 we have, because I think it's pretty critical to have
16 them part of their readiness survey.
17 **CHAIR COOPER:** That's a great idea,
18 Elise. I totally support it. Amy?
19 **MS. EISENHAUER:** So just like the
20 previous E.M.S. for Children E.M.S. surveys, the --
21 the E.D.C. has a database. And so as part of our job
22 as program managers, part of our job is to help them
23 keep it up to date. So Jacob has been really great
24 at helping me keep that up to date, inputting new
25 information, making sure any agencies that closed are

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2 taken out, making sure new agencies are put in. And
3 so that is all available at the E.M.S.C. site. So
4 what happens is the E.D.C. will send out an email to
5 the people that are listed as the leadership at those
6 agencies. There is a first email, and then about a
7 week later there's a reminder, and then a couple
8 weeks later there's a reminder. So there's several
9 reminders throughout. And then as the program
10 managers, we can see on the backend of via Tableau
11 who responded and who hasn't.
12 And then they will only -- in
13 subsequent email blasts, they will only send out to
14 the people who haven't. So if your agency completed
15 it, you're not going to get fifteen emails. In
16 addition to that, I do send out notices to the
17 program agencies. I do send out notices to all the
18 PECCs. And really any other E.M.S. event I announce
19 the survey. So there -- there are quite a lot of
20 emails and communication related to completing it. I
21 think the best way that the committee could help is
22 in your areas. So if you are a medical director or
23 you work with E.M.S. agencies, or you work with
24 medical directors that work with E.M.S. agencies, or
25 you are an E.M.S. provider in a region because we do

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2 have a lot of pre-hospital folks here.
3 That grassroots piece is really
4 helpful because sometimes, right, the person who's
5 listed in there, especially because a lot of the
6 volunteer agencies turn over leadership in January,
7 right? We may have last year's chief, not this
8 year's chief. And even -- even in career agencies,
9 right? People leave for a variety of reasons, people
10 retire. So that information may not have made its
11 way to me to put it in the database. So that -- that
12 grassroots ability to provide outreach to your
13 specific areas is a huge help to me.
14 **MR. VAN DER JAGT:** That's very
15 helpful, Amy. I just -- I might -- I'm just trying
16 to think through this a little bit here because I --
17 it just seems to me that if we want this to really
18 happen in this State, we need to have, you know, us
19 as the committee endorsing this whole effort. So
20 because if you get something from the federal, from
21 the E.M.S.C., the Innovation Center, it's like, okay,
22 this is another thing that we have to do or we think
23 of doing. But I think if we say, you know, basically
24 your State, this committee, you know, along with
25 program management that you're dealing with, you

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2 know, is being strongly encouraging you to do this, I
3 just wonder whether it might be a little bit more
4 likely that we get better participation.
5 The other, the other part of that,
6 that's sort of the second point of that is sort of
7 indirectly I think it would be helpful for, maybe it
8 would be helpful for E.M.S. agencies to recognize
9 that there is an E.M.S.C. Advisory Committee that
10 looks at this rather than it is just you. Or I don't
11 mean to be derogative here, just, I mean, just one
12 person or the State Health Department, you know, but
13 there is a committee that specifically deals with
14 pediatrics. And that's what I was just wanting to
15 make sure that, is there a way to -- to do that?
16 Anyway, I --
17 **CHAIR COOPER:** Yeah. Amy, I want to
18 support -- I want to support that as well. I -- you
19 know, I think it's as Elise has pointed out when
20 something comes through on State letterhead, you
21 know, particularly if it's from the committee, I
22 think people tend to pay a little bit more attention
23 than if it's just something coming from the E.I.I.C.
24 or some other group that they may or may not
25 recognize. So I -- I think that Elise's point is

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2 good, and I personally would support it if -- if you
3 and Ryan, you know, would be willing to go along with
4 that.
5 **MS. EISENHAUER:** Yeah. I think the
6 more awareness the better for us.
7 **CHAIR COOPER:** Exactly. All right.
8 So I'll take it upon myself to get together a letter
9 with Elise and (unintelligible).
10 **MR. GREENBERG:** Sure. I think -- I
11 think I heard that, that it really is just you or I,
12 our -- our names are nothing. Our names are nothing.
13 I think that's what Elise is trying to say. We need
14 Dr. Cooper's signature at the bottom in order to get
15 the engagement. I'm okay with that. I'm okay with
16 that.
17 **CHAIR COOPER:** Well, it's not my
18 signature. It's that big picture of the State of New
19 York, I think that does it Ryan, but.
20 **MR. GREENBERG:** You know, I think the
21 one thing that would be interesting though, from this
22 committee that -- that we haven't done in the past
23 is, you know, you talk about, you know, this
24 communication going out to facilities to get the
25 facility buy-in. But if there are other groups or

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2 similar advisory groups and things like that, that
3 wouldn't necessarily get the survey, but would be
4 beneficial because of the people who sit on them get
5 the survey to maybe share with them. So, yeah. You
6 know, if there's a pediatric mental health advisory
7 council who, you know, all their council members sit,
8 you know, in hospitals or things like that, I think
9 this advisory body sending letters to other advisory
10 bodies like that to say, hey, we're putting this out.
11 If you, you know, have someone in there just to at
12 least be watching for it or watch for the spam.
13 I think that can be really a -- a
14 different approach and a valuable approach that each
15 of you really would know, because you probably sit on
16 something else that that might be relevant for. I
17 don't know what others think of that.
18 **CHAIR COOPER:** Well, certainly the
19 A.A.P. could be -- could be, you know, tapped to
20 assist with this. I don't know of any specific
21 pediatric mental health groups or advisory groups.
22 Maybe, I don't know, maybe -- maybe someone else
23 does. Certainly, maybe (unintelligible) --
24 **MR. GREENBERG:** And again, yeah, I
25 don't think we need to get into it today. And I

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2 think, you know, Art, I think even if we were to come
3 up with a -- a template letter that can go to other
4 bodies.
5 **CHAIR COOPER:** Sure.
6 **MR. GREENBERG:** And then if people
7 think of this would be good to go here and then, you
8 know, we will type in to them and you know, kind of
9 go.
10 **CHAIR COOPER:** Got it.
11 **MS. CHIUMENTO:** Amy, I know you
12 mentioned that you send it to the program agencies.
13 I don't -- didn't -- don't remember if you said read
14 the REMAC, but I think that might be a very good
15 place. Because obviously the -- the physicians are
16 in charge of each of the agencies and this way they
17 can bring back to their agency or at least endorse it
18 at their agency, encourage it.
19 **MS. EISENHAUER:** Absolutely. Yeah.
20 **MR. VAN DER JAGT:** Yeah. I had just
21 put that in the -- we're thinking alike I think,
22 Sharon, I just put that in the chat box as well about
23 the REMAC so that we can send them a letter. The
24 other thing, Art is that the -- the new president of
25 the A.A.P., I don't know if it's just Upstate is what

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2 Jeff Kaczorowski, who I happen to know here. He's
3 part of Rochester, Dr. Jeff Kaczorowski.
4 **CHAIR COOPER:** Sure.
5 **MR. VAN DER JAGT:** And I'm be happy to
6 talk with him, you know, about any -- about this
7 whole kind of project. Because I -- I can see him a
8 lot, you know, so if that would be helpful.
9 **CHAIR COOPER:** That'd be great.
10 **MR. VAN DER JAGT:** I'd be glad to do
11 that. He's -- he's -- he's the A.A.P. president just
12 elected, so.
13 **CHAIR COOPER:** For just your chapter,
14 Elise, or the whole district?
15 **MR. VAN DER JAGT:** Well, I -- it's the
16 -- you know, it's, he's president of, I -- I think
17 it's New York State A.A.P. chapter. So -- so I think
18 it's -- it might be the whole State, but it could
19 just be, you know how it's, I can't remember whether
20 it's -- there's an Upstate and a Downstate. I think
21 there is an Upstate and Downstate. So I'll have to
22 ask him. But I think he's certainly for the Upstate
23 part of it, I know he's present for that part.
24 **CHAIR COOPER:** Please, please, go
25 ahead. Yes, absolutely.

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2 **MR. VAN DER JAGT:** Okay. All right.
3 Because I'm happy to do that. So I'll talk with him
4 a little bit about this readiness project and -- and
5 -- and go from there. He is also very active in
6 vulnerable child populations disparities, things like
7 that. He's on the child health -- childhood health
8 agenda here in Rochester area. Very, very active.
9 So I think maybe we could even have him and come and
10 talk with us at some point to a little bit what the
11 A.A.P.'s doing, but also to familiarize him a little
12 bit about what this advisory committee is doing.
13 **CHAIR COOPER:** Sure. I, you know, and
14 as you speak with him, it might also be good to
15 mention Always Ready for Children as it is.
16 **MR. VAN DER JAGT:** Correct.
17 **CHAIR COOPER:** Okay. Anything else?
18 Anybody, any other comments from anyone? Okay. Amy,
19 do you have anything else?
20 **MS. EISENHAUER:** Nothing else from me.
21 **CHAIR COOPER:** Wow. Well, I guess --
22 I guess that's enough. Been busy, which is good. So
23 Ryan, I think you're next up, if I'm not mistaken.
24 **MS. EISENHAUER:** Next Ryan is later, I
25 think it's Nickol.

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2 **CHAIR COOPER:** Actually, Nickol
3 O'Toole.
4 **MS. EISENHAUER:** Yes. Nickol O'Toole
5 is next.
6 **CHAIR COOPER:** Yes. Let's do Nickol.
7 **MS. O'TOOLE:** Okay. Hello everybody.
8 Good afternoon. So I'm just going to do a quick
9 presentation on what a FAN is and we're part of the
10 Family Advisory Network. Next slide.
11 **MS. EISENHAUER:** Sorry, I'm trying to
12 figure out how to use Ryan's computer.
13 **MS. O'TOOLE:** That's okay.
14 **MS. EISENHAUER:** There we go.
15 **MS. O'TOOLE:** Okay. So I'm just going
16 to go over who we are and what we do and what we
17 bring to the E.M.S.C. Next slide. So our mission,
18 vision, and values. Our mission was to ensure that
19 there's a family and patient perspective, and that
20 it's centered and integrated on all of the E.M.S.C.
21 activities. And then our vision, we want to be
22 indispensable to the E.M.S.C., be equal partners, and
23 improve the continuum -- continuum. Can't talk
24 today. Of pediatric emergency care. Also, our
25 values are advocacy, diversity, respect, equity, and

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2 most importantly, partnership. Next slide. Okay.
3 So what we do. So this all began back in 1999 when
4 E.M.S. for Children was created the Family Advisory
5 Network. And it's to include the family
6 representatives in the State E.M.S. for Children
7 Program.
8 So we can operate as chairs, co-chairs
9 of subcommittees and also members of the State
10 E.M.S.C., which I am as a parent advocate. Also
11 coordinating special community projects, assisting
12 with development of children's policies, and help
13 plan and promote educational offerings. Next slide.
14 So who can be a FAN? Anyone really. Parents,
15 grandparents, civil servants, E.M.S., police, fire,
16 healthcare professionals, teachers and
17 administrators. Next slide. I call this the ever-
18 evolving slide because an individual, we can see
19 ourselves as advocates and educators, also local and
20 national leaders. Next slide. So there's two
21 levels. The State level which is where I am at, and
22 I see us as liaisons almost with the E.M.S.C. and the
23 national level for the FAN network.
24 So we just facilitate a connection
25 between the State E.M.S.C. and the community, again,

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2 with the policy and decision makers. So we're
3 really, I just kind of connect you guys with the
4 E.I.I.C. Next slide. So the State partnership, the
5 Family Advisory Network, it's in all fifty states.
6 There's programs that work to achieve federally
7 defined performance measures, State partnership
8 programs that are at the forefront of improving
9 pediatric patient outcomes, which we are very lucky
10 because we have Amy and she does so much. And then
11 also support developing and -- and implementing
12 sharing resources and tools. And it's amazing when I
13 sit in the meetings through the Family Advocate
14 Network, just hearing what the other FANs are doing.
15 It's -- it's very -- just wonderful for our children
16 in the State. Next slide.
17 So the significance of the FAN, again,
18 it's the voices of the families and the patients, and
19 it helps providers understand all the way from pre-
20 hospital to hospital. the desired outcomes ensures
21 the patient concerns. And this is what I love about
22 being a FAN, as we bring life experiences to becoming
23 a representative. It just allows patients to
24 participate in shared decision making and also
25 parents that have been through something as I have

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2 with my children. So it's just nice to let providers
3 know that and understand it a little better coming
4 from a family. Next slide.
5 Family representation. Again, we're
6 just integrating the family and patient perspective
7 in the E.M.S.C. with the program manager efforts, and
8 again, I can't compliment Amy enough, she's doing so
9 much. Family representatives, we participate in the
10 E.M.S.C. advisory committee. And then we also -- the
11 FAN representatives will be involved in developing or
12 implementing the strategic plan and goals for the
13 different programs. Next slide. So as Amy has
14 mentioned it prior, so we have these performance
15 measures. So the four-year period began in April of
16 2023 for the grant cycle. There's nine performance
17 measures, two evaluative measures for all State
18 partnership grantees. And Amy is keeping us on task
19 with that. Next slide.
20 So our program goal for New York
21 State, we're increasing the percent that the FAN on
22 the E.M.S.C. Advisory Committee who represent the
23 emergency needs. The national target is a hundred
24 percent of the States have a FAN who represent them.
25 And then the State target is a hundred percent, which

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2 we're at. So check, you guys got me. Next slide.
3 So do you guys have any questions about this before I
4 go over just a quick report from the last FAN
5 meeting?
6 **CHAIR COOPER:** No questions, but this
7 is Art Cooper just want to say we are particularly
8 appreciative of your involvement with E.M.S.C. and
9 you know, certainly all other members of the -- of
10 the FAN. And anything that you can do to help us and
11 vice versa, please let us know. I think this is a
12 potentially a great partnership. Thank you.
13 **MS. O'TOOLE:** Thank you, Dr. Cooper.
14 And so just a -- just a quick update from our last
15 FAN meeting. It just, every State talked and I just
16 want to just highlight some of the ones that really
17 were inspiring. New Jersey is actually working on
18 school nurses getting Narcan into schools. And then
19 Texas is working on getting Narcans on school buses,
20 which I didn't even think about, but I -- I think
21 that's going to be a -- a really good program. And
22 then a lot of them are working on their pediatric
23 readiness for the hospitals as -- as we are their
24 program. And Wyoming, their E.M.S.C. has ordered
25 sensory kits for all of their ground ambulances. And

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2 the sensory kit includes a five-pound weighted
3 blanket, headphones, fidget toys, sunglasses, and a
4 simple communication card.
5 I know we have the cards coming out,
6 but maybe someday we can expand on the card set and
7 get some of these sensory items for our artistic --
8 or autistic children. And that's the end of my
9 report. Thank you.
10 **MS. EISENHAUER:** I forgot to mention
11 the -- the I know that there's more than just those
12 little popper things for the sensory items that are
13 available. But we have a little extra money from
14 leftover printing. And that was my thought to add --
15 add one of those popper things. Because they're easy
16 to wipe off versus some of the other items out there
17 for the PECC tool kit. But we can -- we can discuss
18 further about what might be good to include.
19 **MS. O'TOOLE:** Yeah. I -- I think that
20 would great. I mean, the blanket great idea, the
21 headphones great idea, but I just don't know about
22 washing them and getting them back in. So I think
23 that's a onetime use and that's a lot, lot of money.
24 So but there are different fidget toys and stuff like
25 that.

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2 **MS. EISENHAUER:** I mean, we might --.
3 **CHAIR COOPER:** It sounds like a good
4 idea. So I'm going to ask Nickol and Amy to pursue
5 this if it's doable, that'd be great.
6 **MS. O'TOOLE:** Okay. Amy and I will
7 talk.
8 **MS. EISENHAUER:** So Ryan is next with
9 the Bureau of E.M.S. and Trauma Systems Update.
10 **CHAIR COOPER:** Thank you, Ryan.
11 **MR. GREENBERG:** Hi, pleasure. So hi
12 everybody. There's a -- a lot going on right now and
13 I'm going to try and keep it brief. In the E.M.S.
14 world, you know, as far as the bureau goes, we are
15 hiring a number of positions. We have a number of
16 different things that have come to fruition, and so
17 we're excited to see that one. I -- I do always try
18 and post those on my social media, so on my LinkedIn
19 and my Facebook account. So if anybody is interested
20 in different jobs in the Bureau related to anything.
21 So if we have funding for E.M.S.C. to hire things or
22 anything like that, I always try and put those on my
23 social media as well as, you know, as well as we push
24 out to different groups and things of that nature.
25 I think the biggest thing though,

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2 that's going on right now is, do I have -- Amy, I'm
3 going to share something. Is that okay?
4 **CHAIR COOPER:** Please do.
5 **MR. GREENBERG:** Looks like I'm good.
6 I'm going to share something hot off the presses.
7 Making sure I'm sharing the right thing here. Just
8 bear with me one sec. So the biggest thing that's
9 going on right now for -- for E.M.S. is the budget.
10 And for the third year in a row, E.M.S. has made it
11 into the budget. This is a really exciting thing for
12 us. People have recognized that E.M.S. is, you know,
13 in a challenging spot at the moment, and you know, we
14 need to do things to help improve it and to make it
15 happen. So last year we got into the budget, we had
16 Part S as in Sam, and there were portions of that
17 that made it into the final budget and had some
18 statutory changes.
19 One of them is really to recruitment
20 and retention and, you know, bringing providers in
21 and -- and keeping them in the field. So we're, you
22 know, really excited about that one. This year we're
23 Part V as in Victor and there's a lot of, you know,
24 exciting stuff now. The budget just recently came
25 out. All these documents are going to be made

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2 available. We also have a number of -- we have a
3 PowerPoint presentation and things that we're going
4 to start doing to the E.M.S. community, probably
5 starting just after council, just because of timing
6 between now and then. But I just wanted for this
7 group to -- to have a little bit of background on --
8 on what is going on and -- and what's in there.
9 So within the budget, if you read the
10 budget book that came out a couple weeks ago, they
11 talk about making E.M.S. an essential service.
12 There's lots of parts of New York State right now
13 that if you call 911, you may get an ambulance, but
14 you may not. You know, it just depends on if there's
15 one available and there's no requirement for that
16 service to -- to -- to be there. And so most people
17 assume E.M.S. is required and that, you know, no
18 matter what, when you call 911, you get an ambulance.
19 That's just not the case. And so one of the things,
20 and we've heard about this for a while, is to make
21 E.M.S. essential. And so working on that one, this
22 legislative change would happen on that one. The --
23 one of the second big things that is in here is
24 related to the State E.M.S. task force.
25 And so this is related primarily to

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2 disaster response and community need. So we saw this
3 with Buffalo. We saw this throughout, saw this with
4 different initiatives. This would establish a State
5 E.M.S. task force made up of primarily ambulances
6 from local E.M.S. agencies around the State that
7 would be paid for readiness and -- and be able to
8 surge an area or be able to provide area in a time of
9 need in order to, you know, kind of meet different
10 demands. And so that's a second one. I'll talk
11 about that in a minute. Then the last initiative on,
12 not last, but a big one in the book was this
13 paramedic telemedicine urgent care.
14 This is looking into our rural
15 communities, the ones who have the most issues
16 getting access to -- to medical care, particularly,
17 you know, more emergent, but maybe not high acuity,
18 more low acuity. And can we put a paramedic in an
19 urgent care center and then have them use
20 telemedicine to get to a provider? You know, can
21 they -- can we -- can we bridge this gap? And so
22 instead of that person who lives in a rural community
23 driving an hour, an hour and a half via ambulance
24 maybe, or even by car to get to that local E.R. when
25 they don't really need one, but it's the only access

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2 to care that they have. Can we change that and say,
3 okay, we're going to have you drive locally to this
4 paramedic urgent care center?
5 They would do an initial assessment.
6 They'd be the hands-on the paramedic there. They
7 would then telemed to a physician maybe a
8 pediatrician or a mid-level, and then provide care to
9 that patient. You know, if the patient has an ear
10 infection, they'll use technology to look in the ear.
11 And at the same time that they're looking in the ear,
12 you know, bringing it across, over to that mid-level
13 or -- or provider to, you know, via telemedicine. So
14 taking things and starting to look at things in a
15 different light, right? So like, we know the system
16 today isn't work -- isn't fully, you know, working.
17 And so the goal of this, and why we look at it from
18 the E.M.S. side is how do we help keep E.M.S.
19 resources in communities for when they're really
20 needed, that cardiac arrest and other things that,
21 you know, needs to stay in that E.M.S. community.
22 So as we go down one of the big things
23 is defining E.M.S. that we saw this in last year's
24 proposal. It didn't get into the budget but it's
25 redefining E.M.S. So currently today, E.M.S. is

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2 described as the initial care and treatment of an
3 emergency patient. This really expands it to what we
4 are today, which is beyond just the initial care. We
5 do emergency work, we do non-emergency work, we do
6 special event work, we do public outreach and really
7 just redefining the definition of who we are to -- to
8 represent what we really do today, not what was
9 essentially created in the 1970s. You know, it -- it
10 was Johnny and Roy and Rescue, you know is, you know,
11 it was a great hype. See, I got some smiles. Okay,
12 good. But, you know, it is a great show, and it was,
13 you know, indicative of the times and paramedics and
14 everything else. But -- but we're in a different
15 time now.
16 And so bringing that up to where we
17 are today. The next section down goes into community
18 paramedicine; last year it was in the budget to have
19 community paramedic. It actually didn't get in with
20 the budget, but it got into a legislative change.
21 But legislative change happened in -- happened during
22 the period of time. So it allowed community
23 paramedics to happen, but very constricted. And so
24 this actually just asked to expand that program from
25 the fifty-five that we have today, up to two hundred

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2 agencies if -- if permitted, and then to allow them
3 to do a couple more things than what they're doing
4 today.
5 The next one down goes into
6 demonstration projects for many of you who work for
7 hospitals and different things. The hospital
8 division has what's called a 2805-X demonstration
9 program project. And the issue is, it really is
10 isolated to Article Twenty-eight facilities and kind
11 of that framework. So we would create a similar
12 demonstration project, language, statutory language,
13 or it was created in Article Thirty, and then
14 hopefully collaboratively work with the 2805-X
15 programs and different programs out there to have
16 that synergy of E.M.S., nursing homes, and home care
17 agencies and -- and these different things.
18 So again, exciting to, you know, kind
19 of be able to look into the future and that
20 innovation. The big one that's in here is the E.M.S.
21 making E.M.S. an essential service. So this would,
22 you know, through some county responsibilities,
23 through some county programs would allow that county
24 to determine who the primary care responder is for
25 each part of their county. And then if they chose to

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2 set up a district for that. So, you know, counties
3 may choose to subcontract for different parts of the
4 county. They would choose to get into it and
5 supplement parts of the county, but all these
6 different things would -- would give them opportunity
7 to, you know, to do this.
8 And by the way, I'll share these
9 documents with you as well. So just for anyone who's
10 trying to read quickly or anything else, we'll make
11 sure to -- to share them with you. One of the big
12 things we learned from last year related to
13 recruitment and retention is E.M.S. providers one of
14 the biggest things we get asked is how come we're
15 called certified versus license. In the world of
16 healthcare, in the world of the Department of Health
17 and legalese point of view, they are licensed because
18 the -- the State has given them the authority to do
19 something. But that word means a lot to them. And
20 so this legislative change would give the Department
21 of Health the ability to license them or set
22 standards for, you know, licensing with that.
23 But credentialing part is related to
24 retention. So we learned a lot from other healthcare
25 professions. We've learned a lot from nursing. We

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2 learned a lot from different things that are out
3 there and -- and how do we create that ladder that
4 people can move up? How do we create the ladder
5 where they can, you know, continuously grow? And so
6 credentialing would allow for that. It allows them
7 to become a credential critical care paramedic, a
8 credentialed E.M.S. officer, credentialed field
9 training officer, things like that to allow them to
10 have their professional group. Maybe one of those
11 credentials in time is a credentialed pediatric care
12 program or pediatric emergency care coordinator. All
13 these credentials and things hopefully would give
14 them opportunity for growth.
15 Last part is paramedic urgent care
16 program. We spoke -- spoke about that, you know, a
17 little bit in the beginning and -- and really fairly
18 straightforward to -- to where to -- to what I was
19 saying, you know, before, which is just -- just that
20 paramedics in rural counties providing that. And
21 there's funding allocated to this too, for a pilot
22 program to have that happen. One last thing is that
23 you'll hear about is that State E.M.S. task force.
24 We spoke about it in the beginning but really
25 defining what that is. There'll be five zones to the

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2 E.M.S. task force that just isolates to make sure
3 each part of the State is -- has resources in that
4 given catchment area. It also allows us to identify
5 if there's a disaster happening in zone five. Let's
6 not pull resources from zone five. They need their
7 local resources where they are. Let's go from one
8 through four.
9 So this puts out that those resources
10 there's a series of -- of State staff who will be
11 hired in order to support the day-to-day readiness of
12 the of -- of the task force, and being able to make
13 sure that all the equipment and everything else is
14 ready to go, should it be needed. It would be made
15 up of ten which isn't a lot, ten Statewide, ten
16 paramedic readiness response units, which are
17 paramedic response units. They really are the day to
18 day helping make sure that everything's ready for the
19 task force. The real backbone in the task force is
20 the ground ambulances. The ground ambulances are
21 actually contracts with local agencies who have the
22 ability to deploy in times of disaster. And we pay
23 them for readiness with that. In addition, and
24 important to this group is our specialty care or
25 critical care strike team.

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2 We know during COVID, we had really
3 hard times moving patients, particularly pediatric
4 patients. It -- it's -- it's a unique skill. It's -
5 - it's not something that the average provider is
6 going to feel comfortable with. And so having
7 specialized teams out there with the focus, with, you
8 know, additional financial support in order to engage
9 them in additional training, such as, you know, let's
10 not only use practice, how to use events, let's
11 practice how to set up events on a one-year-old. You
12 know, this is -- this is different in the grand
13 scheme of things. As well as some specialty pathogen
14 units and then some specialized equipment as well.
15 Mass casualty buses and alternative support.
16 So we think of Buffalo last year. The
17 E.M.S. system shut down for almost two days. This is
18 about day and a half. And so how do we help them in
19 being able to -- to stay operational and -- and have
20 some specialized equipment. So in addition to that
21 one, again, for this group our surge operation
22 center, which started during COVID, which helped us
23 in finding beds for patients, helped us in load
24 balancing that will become a permanent facility, a --
25 a permanent in -- initiative now. We actually

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2 started hiring on that one. And really just kind of
3 continuing to grow this based on needs and demands
4 that are out there.
5 So that was like a two-hour
6 presentation, shoved into, I think, ten minutes. I'm
7 happy to take any comments, questions, or concerns.
8 Like I said, I'm going to pass these off to Amy, and
9 Amy will share them out with the entire E.M.S. group.
10 These are public documents. They are not well out
11 there yet. We have not even shared them with the
12 CMAC or the SEMSCO yet. That's literally going to
13 happen in probably next hour or two. They just got
14 approved. I mean, just got approved right before
15 this meeting. So you're the first. Like I said,
16 happy to take any comments, questions, or concerns on
17 either one.
18 **CHAIR COOPER:** Well, Ryan, the child
19 is the father of the man, so there we are. Okay.
20 Thank you for letting us go first. Ryan, this is an
21 extraordinary amount of work that some of your
22 colleagues in the Bureau has, you know, put forward
23 and even more impressive that you've been able to do
24 the rest to get it into the budget. This is some
25 pretty amazing stuff. And I think we're all going to

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2 be very interested to see how this plays out. You
3 know, I -- I do encourage all of you to visit with
4 your own constituencies about, you know, what's in
5 the budget and where appropriate and support it. And
6 I've seen that personally that there's things that is
7 not worthy of support. But I think that our
8 colleagues Statewide do need to let -- do need to let
9 the legislators know that this is a -- that this is a
10 great direction for E.M.S. and -- and you know,
11 building the infrastructure up is, you know, it is
12 just probably the hardest thing that we -- that we
13 do.
14 But Ryan, it looks like you've got
15 some great plans to make that happen, and hopefully
16 we'll be able to help you get there. Any other
17 questions from Ryan on the budget or anything else?
18 **MR. GREENBERG:** And also, I don't
19 know, it's just me, but Art, you seem to be breaking
20 up a little bit. So that could be my phone.
21 **CHAIR COOPER:** I don't know. I don't
22 know. I -- I can -- I'm on my cell phone. I can --
23 because I'm over at Metropolitan Hospital today.
24 Amy, if you need me to -- to log off and log, log
25 back in, I'll do it. Can you hear me okay, Amy?

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2 **MS. EISENHAUER:** I can hear you okay
3 right now. Sometimes you get a tiny bit garbly.
4 **CHAIR COOPER:** Okay. Well --.
5 **MR. GREENBERG:** And Art,
6 **CHAIR COOPER:** -- I don't know if it's
7 times.
8 **MR. GREENBERG:** It's several times. I
9 don't know. And I – it -- I thought it was my phone.
10 I guess it's not part, I don't know if you want
11 Elise, maybe, you know, to take the lead for today's
12 and, you know, chime in as the components, but Amy
13 can, is that okay?
14 **CHAIR COOPER:** I -- I -- it's okay,
15 but I -- I -- I think I'm okay. Yeah. I mean, I'll
16 -- I'll -- if I get closer to the phone, I think that
17 works a little better. Yes?
18 **MR. GREENBERG:** Okay. Sounds good.
19 **CHAIR COOPER:** Okay. Thanks.
20 **MS. EISENHAUER:** So Dr. van der Jagt
21 did have a question about the E.M.S. task force. He
22 asked, is there a pediatric representation on the
23 E.M.S. task force?
24 **MR. GREENBERG:** This is the -- the
25 framework to the task force. It is just getting

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2 started right now. I -- I -- I don't think Amy would
3 let us not have a pediatric representation when we
4 start to get to that kind of planning component and
5 things of that. But this is the very early stages.
6 It hasn't set up yet, kind of the, you know, kind of
7 input and that stuff is, you know, still forthcoming
8 that will happen once some of those base positions
9 are higher and the preparation for the -- the more
10 long-term situations comes together.
11 **MR. VAN DER JAGT:** Yeah. I think just
12 to respond to that a little bit, I put it in there
13 because sometimes it really is -- it is helpful to
14 have, you know, if you're dealing with special
15 populations like pediatrics, and that's when you said
16 it was specially. So not everybody has those skills,
17 you know, that brings to mind, well, let's just make
18 sure that there is -- is adequate pediatric input for
19 these, you know, kinds of situations, especially in
20 rural areas, because it is a, shall we say, we
21 eliminate disparities of any kind. You know,
22 pediatrics is a minority compared to all the entire
23 population. You know, because it's only about ten
24 percent of the, you know, what E.M.S. sees. And so I
25 just wanted to make sure that in the planning of

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2 this, there was at least, you know, some solid
3 pediatric input, wherever that would be helpful.
4 **CHAIR COOPER:** Sure. That would be
5 great.
6 **MR. GREENBERG:** I totally agree.
7 **MR. VAN DER JAGT:** Could I ask one
8 more question, Ryan, because I –- I -- I'm a little
9 overwhelmed actually, because there's so many
10 components to this. Could you say something about
11 the E.M.S. staffing issues, which is such a crisis,
12 and yet we're -- there's now, if you make it an
13 essential E.M.S. service, how does that balance with
14 the staffing that you don't have? I mean, how does
15 that really work? And then if some of that staffing
16 is no longer riding ambulances, but are actually, you
17 know, they're doing telemedicine with providers and
18 things like that, you know how -- how -- I'm just a
19 little bit concerned about how you all, they -- the
20 task force is seeing that play out because it -- it
21 is such a difficulty.
22 I think the incentive program
23 obviously will be enormously important to do that,
24 that licensing and things like that. So but I'm just
25 curious how that was being addressed.

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2 **MR. GREENBERG:** Yeah. So I'll talk
3 about the essential portion first. So I think in the
4 essential portion in -- in where this helps with our
5 staffing crisis and things like that, there's often
6 today, you know, it -- we will have communities just
7 turn and say, yeah, well, you know, I'm -- I'm going
8 to cut that, or we can't -- we can no longer afford
9 that. Or you know, we -- the most we can afford is
10 to pay minimum wage. And, you know, because we're
11 not required to -- to provide it. And so I think
12 that's making it essential start to change some of
13 those dynamics and start to put stability into, you
14 know, when people are considering, you know, careers
15 in a system or even, you know, as volunteers, you
16 know, when they are looking for that financial
17 support, even just to have the right equipment, to
18 have the pediatric equipment that specialized stuff
19 that, you know, if a community is required to provide
20 a service, then hopefully they invest in that service
21 as well.
22 When they invest in that service and
23 the people are engaged in that service, when people
24 are engaged in that service, they want to stay in
25 that service. We see a tremendous amount of our

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2 people, and we know that, particularly at the E.M.T.
3 level, it's an entry level into healthcare. And so
4 they advance on to be nurses and P.A.s and -- and
5 doctors and everything else. But we -- we also are
6 looking to figure out how do we engage people to --
7 to advance onto a paramedic and want to stay there.
8 One -- one of the figures that most people don't know
9 is that, you know, related -- related to that. We
10 have about seventy-five thousand E.M.S. providers
11 Statewide. Only fifty percent of those providers
12 show up on a patient care report.
13 So thirty-five thousand of our E.M.S.
14 providers are -- are provide -- are providing direct
15 free hospital care, but then another thirty-five
16 thousand are somewhere, but we don't know where. And
17 you know, they -- they're -- they're not showing up
18 on patient core care report. Now, a portion of those
19 are going to be leadership. So right. So if you're
20 you know, Chief Pataky, like he's on this call, you
21 know, he might not show up on a patient care report,
22 but he's run, you know, mass incidents and, you know,
23 large scale incidents and things like that. But in
24 our world, if -- if you don't show up from P.C.R., we
25 don't have a way really to measure some of that.

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2 But there's also, we know there's a
3 large portion that -- that's not, we know that a
4 portion of our problem is -- is retention and giving
5 people, if I'm, you know, twenty-two years old, not
6 an E.M.T. and I'm looking to say, what does the rest
7 of my life look like? And I, you know, kind of look
8 and I say, I can go become a paramedic and I can go
9 make, you know, sixty or seventy grand a year, but I
10 can only ride the front of a truck, or I can go
11 become a nurse and I can make, you know, seventy to
12 eighty grand a year. And I have, you know, these
13 endless tiers of opportunities. You know, which path
14 do I choose to take?
15 And what we hear often is, it's not
16 always that they want to go into a different
17 profession, it's that they, you know, part of what
18 keeps them, you know, makes them go into another
19 profession is because of, you know, that -- that
20 shortfall, that -- that lack of opportunity, that
21 lack of advancement, that lack of, you know,
22 opportunity to -- to do something different. We look
23 at some of our, you know, larger agencies, and you'll
24 see upwards of seventy percent of their E.M.S. staff
25 is less than five years on, you know, working in

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2 E.M.S. before they leave completely. And so some of
3 these initiatives are moving towards that as well as,
4 you know, it's -- it's tough to see. It's tough to
5 see, well, how can we put paramedics in E.R.?
6 So we hear about this one often and
7 know that's not in the bill. You know, we hear about
8 this one often, well, how can we put paramedics in
9 E.R., it's just not possible because if we put a
10 paramedic in E.R., they're not on a truck, but
11 where's the other thirty-five thousand E.M.S.
12 providers who, you know, maybe they did ten or
13 fifteen years on ambulance and they just, you know,
14 body wise, health wise, whatever, can't continue to -
15 - to be in that same environment all the time. And
16 then what are opportunities for them and where can
17 they go to? And so looking at those and kind of
18 growing from there. Does that answer your question?
19 **MR. VAN DER JAGT:** In part, but
20 there's no talking. Obviously, this is a very big
21 area, you know, the staffing issues and all these
22 initiatives, which are great, you know, but I'm just
23 curious. But thanks for beginning to answer that
24 question. Okay, Ryan, thank you.
25 **MR. GREENBERG:** Yeah. If I remember

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2 correctly, Elise, I think you have a lot of kids. So
3 if you can get like, you know, seventy-five percent
4 of your children just to come into E.M.S., I think we
5 can solve it at least a local E.M.S. issue. So.
6 **MR. VAN DER JAGT:** Oh, six of them are
7 already in healthcare, but they're not in E.M.S., I'm
8 sorry to say. They could volunteer.
9 **MR. GREENBERG:** There's – there --
10 there's problem right there. You got six in
11 healthcare and we haven't even gotten one. You got
12 to figure out how to draw them in to E.M.S.
13 **MR. KAPSER:** Yeah. I -- I definitely
14 think that that diversification is a key thing
15 because a lot of times, paramedics, E.M.T.s, they are
16 just, can they -- they have to tunnel onto the
17 others, like a jack of all trades, but a master of
18 none. And that critical thinking and the ability and
19 the knowledge they have can be well versed in a lot
20 of different fields. I know that the union has been
21 (unintelligible) into the (unintelligible) in a
22 State, but anything broadens the scope of opportunity
23 would (unintelligible) people and if we're
24 considering it to be an essential service that then
25 that it's not going to be a profit generating entity

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2 like fire departments, right? You know, you can't go
3 to build a health service and be like, well, I can
4 put it out for you but (unintelligible) in a service
5 that's you know, provided with an attack and
6 everything else.
7 But I think it's great if we can make
8 it so E.M.S. has different avenues if their body does
9 kind of give up on them or -- or if they're just
10 realize mentally that they're like, oh, I -- I -- I
11 need a little bit of a change. I -- I think that's
12 great. I hope that that comes to fruition. That
13 would be amazing.
14 **MR. GREENBERG:** Okay. I agree.
15 **MS. EISENHAUER:** Okay. So --.
16 **CHAIR COOPER:** Okay. Ryan, are you --
17 do you have anything else for us?
18 **MR. GREENBERG:** I'm good.
19 **CHAIR COOPER:** You're good. Okay.
20 Any other questions for Ryan? Okay. Well, let's
21 move on to the next item on the agenda. Amy, I
22 believe it's the pediatric agitation test, right?
23 **MS. EISENHAUER:** So we -- we have some
24 guests that are here to present at two. So my hope
25 was that we would be able to jump to them and then

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2 come back to old business.
3 **CHAIR COOPER:** Okay, Amy, that's fine.
4 Let's go to the tests then. Okay?
5 **MS. EISENHAUER:** Excellent. So Alexa
6 Coppola, Kathryn Wright, Dr. Goldman, Dr. Hennessy,
7 and Katerina Gaylord are here from the Office of
8 Mental Health. And they are going to share with us
9 about the Crisis Stabilization Center overview. So
10 Alexa, Peter passed you the control, so you should be
11 able to share your screen. There you go. And I will
12 let you take over.
13 **MS. COPPOLA:** Thank you so much. Are
14 you able to hear me?
15 **MS. EISENHAUER:** It looks like closed
16 for a moment. Yes, I can hear you, but it's -- it's
17 a little bit low.
18 **MS. COPPOLA:** Okay. I'll talk louder.
19 It's -- it's not too hard for me to do that. But
20 thank you so much, Amy for helping us coordinate this
21 as well as Ryan and shout out to Dr. Cooper for
22 inviting us to this event. So we'll be giving a
23 general overview of Crisis Stabilization Centers.
24 They are a new program that I -- that are developing
25 across New York State as we speak. So I'm going to

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2 pass it over. We have -- I'll pass it over to Dr.
3 Goldman, Dr. Hennessy, and Kathryn to just introduce
4 themselves, real fa -- real fast, if you will.
5 **MS. GOLDMAN:** Sure. Hi everyone. I'm
6 Jennifer Goldman. I am with O.M.H. Medical Director
7 for Crisis and Community Services.
8 **MS. HENNESSY:** Hi, everyone. I am
9 Grace Hennessy. I'm actually not with O.M.H. I am
10 with OASAS, the Office of Addiction Services and
11 Supports, and I'm the Associate Chief of Addiction
12 Psychiatry.
13 **MS. WRIGHT:** Hi everybody. I'm Kathy
14 Wright. I'm with the Office of Mental Health. I'm
15 the Unit Director for the Crisis Unit on the kids'
16 side.
17 **MS. COPPOLA:** And we also have our
18 special guest today, Katerina Gaylord. Kat, if you
19 want to introduce yourself.
20 **MS. GAYLORD:** Sure. Hi, everybody.
21 My name's Kat Gaylord. I'm the Deputy Director for
22 the Bureau of Crisis Emergency and Stabilization
23 Initiatives at the Office of Mental Health. Crisis
24 Stabilization Centers amenities, mobile crisis CPEPs
25 are under our purview. Thanks for having us.

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2 **MS. COPPOLA:** Awesome. And I am Alexa
3 Coppola. I also am within the Bureau of Crisis
4 Emergency and Stabilization Initiatives at O.M.H. and
5 I am our lead program specialist for the Crisis
6 Stabilization Center development. And I'll also give
7 a shout out on the call, we do have Rebecca Baitholts
8 who is a part of our kids division here, as well as
9 Keith McCarthy the Associate Commissioner of Quality
10 Assurance and Performance, who are both on the call
11 today, but will not be presenting. So just we'll --
12 we'll go through a quick agenda. We'll briefly touch
13 on the comprehensive crisis response system. So you
14 can just see how Crisis Stabilization Centers have
15 been built into this model.
16 We will go into some details of the
17 Crisis Stabilization Centers appropriateness for use,
18 the type of services that they offer, and where
19 they'll be developing. And then we'll also just talk
20 about how they intersect or will intersect with
21 E.M.S. paramedics. And then we -- I just want to
22 give a brief -- I will -- I -- I guess I should say
23 it now, that there will be, if it has not already
24 been circulated, a one-pager sent to this group that
25 kind of describes where that we -- what we're

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2 describing today, it'll provide a brief overview of
3 the Crisis Stabilization Centers, and that'll also
4 come along with a spreadsheet so that you can see
5 where each center is being developed and a contact
6 for each center so that if you would like to have a
7 conversation about collaboration or partnerships
8 moving forward, that you have their information as
9 well. So I will pass it over to Dr. Goldman.
10 **MS. GOLDMAN:** Thanks, Alexa. Yeah.
11 So thank you for having us here. And I can tell you
12 guys have a very packed agenda, so we will try to
13 keep it brief. But just to give you an overview that
14 O.M.H. and OASAS have been collaborating on trying to
15 think about a Statewide kind of coordinated crisis
16 system, rather than these piecemeal services, really
17 connecting them with kind of the heart of this, as
18 Kat had mentioned through nine eight eight, the --
19 the New National, but, you know, in New York State
20 crisis call line linkages to mobile crisis response,
21 mobile crisis residences, our -- our comprehensive
22 psychiatric emergency programs and then the new
23 program that's being developed between O.M.H. and
24 OASAS, these Crisis Stabilization Centers.
25 So we'll just -- we have like a visual

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2 kind of, to give you a sense of where this fits into
3 the system, if you want to do the next slide, Alexa.
4 Perfect. So I mean, I think the overall vision is it
5 falls under these kind of three frameworks. Someone
6 having -- when -- when someone is experiencing a
7 behavioral health crisis, we want them to have
8 someone to call, that being nine eight eight, someone
9 to come, that being mobile crisis response. And then
10 somewhere to go crisis residences, Crisis
11 Stabilization Centers, or these psychiatric emergency
12 rooms. We recognize that, you know, current State,
13 we -- some areas of New York State have this, others
14 do not. And that you -- you all working in emergency
15 medical services, you know, are oftentimes are
16 involved and in the someone to come, certainly and --
17 and helping with somewhere to go for individuals that
18 are experiencing behavioral health crisis.
19 So our hope is that with the
20 development of these centers, that Alexa will go into
21 greater detail. they offer additional options and
22 hopefully will help to divert and -- and offset some
23 of the challenges that are being felt by medical
24 E.D.s, psych E.D.s across the State. So I forget if
25 the next slide is, oh yeah, this is -- this is more

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2 of an individual. But studies have shown that up to
3 eighty percent of crisis calls coming into crisis
4 lines can be actually resolved on the phone. So
5 that's sort of where the development of nine eight
6 eight has come in. For those of you that are not
7 familiar, nine eight eight was rolled out nationally
8 with the hopes as it being an alternative to 911 for
9 behavioral health crisis calls.
10 There are individuals, trained crisis
11 counselors that are able to connect with callers,
12 potentially make referrals to services. And then as
13 you can see here, you know, having these other pieces
14 of the puzzle, mobile crisis teams, crisis receiving
15 facilities, and certainly of course, like prevention
16 or post-crisis follow-up will be critical. So I
17 think we can move on. Okay. So -- so in this -- you
18 know, in this picture of the Crisis Stabilization
19 Centers are the new program that are getting
20 developed as a community-based, voluntary, twenty-
21 four seven service that will be available to
22 individuals seeking behavioral health, mental health,
23 substance use crisis services. So I'll turn it over
24 to Alexa to go in a little bit greater detail of
25 those -- the program and the kind of two different

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2 types.
3 **MS. COPPOLA:** Thank you. All right.
4 So there are two different types of Crisis
5 Stabilization Centers, or at least two different
6 types that we are looking to certify within the
7 model. And it is if -- if you haven't seen by now,
8 this is a jointly certified program between the
9 Office of Mental Health and the Office of Addiction
10 Services and Supports. So this is a joint effort
11 through and through from early development on to
12 implementation. We also have our own joint
13 regulations for this program under Part 600 and
14 program guidance. And so I'll just talk more broadly
15 about what all Crisis Stabilization Centers should
16 look like. So you know what to expect when you start
17 to see them in communities. So regardless of them
18 being supportive or intensive, an important thing to
19 keep in mind is that they're a completely voluntary
20 program.
21 So if somebody would like services,
22 they can go to a Crisis Stabilization Center. There,
23 I guess a good example is for, in, with the case with
24 kids, if a child does not want to seek services, but
25 the family member would like some services to work

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2 with that child, then that family member would be the
3 ones who are voluntarily seeking services. But
4 another thing, important thing to note is that Crisis
5 Stabilization Centers are -- they're able to serve
6 the entire lifespan. So they're open twenty-four
7 seven, three hundred and sixty-five days a year with
8 the ability to serve individuals across the lifespan.
9 So minors all the way to late adulthood experiencing
10 both mental health and substance use crisis symptoms,
11 there is no age limit or any like other additional
12 criteria that you would need to receive services.
13 Typically, individuals who would also
14 receive services at a Crisis Stabilization Center
15 would be medically stable. And I guess that's --
16 that would be important to mention for this group.
17 So they are person centered. We really have a -- a
18 very strong focus and emphasis on that peer and
19 recovery-oriented support. It's deeply ingrained
20 within this model. We really wanted to build out
21 spaces that were trauma informed,, therapeutic and
22 welcoming. So when you walk into one, they won't
23 replicate an E.D. necessarily. They are meant to
24 have a safe therapeutic environment as you walk into
25 them. They do -- and -- and then we'll talk more

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2 about like the differences between the kid spaces and
3 the adult spaces and how we're kind of managing that
4 or how providers are going to be managing that across
5 the State.
6 But important to note here that they
7 are under an outpatient service. So the goal of them
8 is not for people to stay longer than twenty-four
9 hours but they do offer rapid access to care. So
10 unlike an emergency room where there usually are long
11 wait times to see someone, just because of the nature
12 of an emergency room, these centers are set up so
13 that somebody is available to -- there are staff
14 available to provide services as soon as somebody
15 walks in. So shorter wait times. It is a voluntary
16 program and they offer rapid access to services and
17 hopefully they assist with the diversion from higher
18 levels of care.
19 So I'll just kind of de -- you will
20 have access to these slides. So I'll talk about
21 primarily the di -- the differences between the
22 supportive and intensive by describing the services.
23 All Crisis Stabilization Centers will be able to
24 offer the services that you see on the left-hand
25 side. So that's triage, screening assessments,

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2 therapeutic interventions, peer support services,
3 ongoing observation, collaboration with a recipient's
4 friends, family, or providers, discharge aftercare.
5 And what we don't have listed here, but it's
6 important to note, is also follow up. So these are
7 services that you will find at any Crisis
8 Stabilization Center. Now based on, you know, if an
9 individual knows in their community, if it's a
10 supportive or intensive, that's probably less likely.
11 But it's important for U.S. providers
12 to know so that, you know, what services would be
13 accessible if somebody were to walk into them. And
14 Intensive Crisis Stabilization Center, and like I
15 said, I'll note that we are sending out the list so
16 you can see the distinction of where intensive are in
17 supportive for opening across the State. But the
18 difference between supportive and intensive are the
19 services here on that right-hand side. So you'll see
20 intensive are able to offer psychiatric diagnostic
21 evaluation and planning, medication management,
22 medication for addiction treatment, medication
23 therapy, and mild to traumatic detox services with
24 the note that supportives, while they don't offer
25 those services on site, they must contract to provide

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2 a direct linkage to a provider who can offer those
3 services that are specific to an intensive.
4 So their goal isn't just to kind of
5 give somebody a list of services and then send them
6 on their way. The goal is really to connect them
7 directly with what they need, especially if that's a
8 higher level of care. I just want to note here the
9 importance of care specialists and peer advocates.
10 Not only when we -- as the model was being developed
11 but we understand that peers have a shared experience
12 with individuals and family across the lifespan
13 navigating both mental health and substance use
14 crises. So we acknowledge them as the leading
15 experts on resiliency, resiliency and recovery-
16 oriented support. Therefore, we do you know, we've
17 been working with providers on how to incorporate
18 that peer philosophy into the program model, not just
19 through direct service but through administrative
20 oversight, training development, and overall service
21 delivery. And I will hand this slide off to my
22 colleague Kathy.
23 **MS. WRIGHT:** All right. Thanks. So
24 as Alexa said, the Crisis Stabilization Centers are a
25 lifespan service. So as such, all Crisis

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2 Stabilization Centers are expected to serve children
3 and adolescents. She also mentioned that one of the
4 main premises of the Crisis Stabilization Centers are
5 being comforting and welcoming places. And to that
6 end, all the Crisis Stabilization Centers are
7 expected to have designated waiting areas and
8 treatment areas that are separate for children and
9 families. And from adults. For the waiting areas
10 that may look a little different from Crisis
11 Stabilization Center to Crisis Stabilization Center,
12 it might look like separate entrances.
13 It might look like separate waiting
14 rooms, or it may look like a lot of space flexibility
15 so that if somebody needs to move directly from the
16 welcoming area to a separate room other than the
17 waiting area then there's that availability. Also,
18 the goal is very limited co-mingling between adults
19 and children. The treatment will never happen in the
20 same place for children and adults. So for example,
21 there's not going to be a group therapy session that
22 includes a child recipient and adult recipient. The
23 C.S.C.s must have staff with expertise and training
24 in child and adolescent developmental and behavioral
25 health, and they must be available twenty-four seven.

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2 Again, because the Crisis Stabilization Centers are
3 open twenty-four seven, these staff also have to be
4 available twenty-four seven.
5 And the Crisis Stabilization Centers
6 must collaborate with child serving providers. So
7 that might be schools, pediatricians, outpatient
8 providers, juvenile justice, child welfare. There
9 are also mental health programs for children and
10 adolescents throughout most of the State that are
11 designed for kids in crisis, or kids that need
12 intensive treatment might be case management,
13 H.B.C.I., which is Home-based Crisis Intervention
14 Youth Act, which is the assertive Community Treatment
15 Program for youth. And along the lines of
16 collaboration, Crisis Stabilization Centers are also
17 expected to collaborate with the families and the
18 guardians and the collaterals that are working with
19 the children and youth.
20 And along those lines, when Alexa said
21 earlier that this is a voluntary service that
22 includes for youth, a youth needs to agree to this
23 service, there may also be situations in addition to
24 maybe that disagreement about between the child and
25 their guardian about maybe the child wants to go but

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2 the guardian isn't so sure, or the guardian wants
3 them to go and the youth isn't so sure. What we
4 would say is to have a conversation with the parties
5 involved as E.M.S. staff, and to see if there's an
6 agreement that can be met with everybody that's
7 involved. And we'd also recommend reaching out to
8 the Crisis Stabilization Centers that are in
9 development in your area, and to talk with them about
10 what services or supports they might have in
11 situations like that, because the voluntary person-
12 centered trauma-informed nature of all this is
13 important for the kids and adolescents too.
14 And that's it for that slide. I think
15 we can do next slide and I'll pass it back to Alexa.
16 **MS. COPPOLA:** Perfect. Thank you,
17 Kathy. And I do want to note, and we'll go over the
18 funding sources for these and how they're being
19 developed across the State, but we wanted to provide
20 this general overview to this group because it is a
21 really good time to be having these conversations
22 with providers as the majority of them are still very
23 much well underway with development that they are not
24 operational yet. So if you're, I think as talking to
25 Ryan, I think the gears continue to turn on like how

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2 can E.M.S. be a part of this table -- be a part of
3 this conversation and sit at this table. And there
4 is a lot of room for that right now, which is why we
5 wanted to be able to share context with the centers
6 as soon as possible. And they're also aware of that
7 collaboration and you know us sitting in on these
8 calls. So they're more than happy individually to
9 have those regional discussions about how would this
10 be most appropriate and where we'll kind of E.M.S.
11 interact with this program. And then --.
12 **CHAIR COOPER:** This is Art Cooper. I
13 just wanted to jump in for one second.
14 **MS. COPPOLA:** Yeah. Of course.
15 **CHAIR COOPER:** Point -- point out that
16 you know, as I think, you know, you know, we've had
17 quite a bit of discussion recent months especially
18 the last year or so on pediatric agitation. And I
19 imagine that at least some of the patients that come
20 to, you know, the -- the crisis State adjacent
21 centers you know, particularly the -- the -- the --
22 the lower-level centers, not the higher-level centers
23 are going to be maybe therefore uncontrollable
24 agitation. The parents are kind of bringing them in.
25 We -- we're -- we're developing I think a lot of -- a

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2 lot of resources at the moment to assist our
3 emergency medical technicians in, you know, in
4 understanding how best to deal with agitated kids.
5 I wondered, you know, to what extent
6 do the -- do the folks that are going to be staffing
7 for the C.S.C.s, particularly the lower-level ones
8 you know, how are they going to be, you know, trained
9 in -- in dealing with pediatric agitation, you know,
10 and so on? And are some of the materials developing
11 potentially useful for you? Or -- or would your --
12 would your idea be that if -- if a child came in a
13 significant agitation that the response would be to
14 call 911 and get the E.M.T.s to come -- to come? I
15 just wondered if you had had any -- given any
16 thoughts of that and how -- how you might want to
17 address it, it's okay if not. Thank you.
18 **MS. GOLDMAN:** I think that's a great
19 question. And I do think that the idea, you know,
20 given the work that you and your council has done to
21 try to put together standardized practices --
22 practices or recommendations for the management of
23 pediatric agitation in the field, I think it would be
24 great for us to be talking and that as much as there
25 can be some consistency the better, especially if

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2 there's going to be interfaces where individuals may
3 be picked up from the Crisis Stabilization Center and
4 being brought to medical E.D.s because it's
5 determined they need a higher level of care. I think
6 that there -- there certainly are going to be
7 policies and procedures around management of
8 agitation.
9 I would say that part of what we've
10 heard from some of the centers that have been
11 operating not under this licensure, but have been
12 providing similar services in sort of a crisis
13 stabilization setting, is that it's important to be
14 working with communities to understand who would be -
15 - both communities and providers who would be the
16 types of appropriate cases or in individuals that are
17 most appropriate to be coming into the Crisis
18 Stabilization Centers. Because they are not
19 authorized to, for example, utilize restraints or do
20 things that the hospital settings and E.D. settings
21 do have the ability to do.
22 They operate more as, almost like more
23 of an outpatient clinic setting in that way where
24 they will use certainly a number of different
25 techniques to try to deescalate and try to engage and

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2 maybe offer medication or other kind of calming
3 options voluntarily. But because these are -- there
4 -- there's -- these are voluntary centers and there's
5 not, you know, the involuntary component, the staff
6 is not going to be -- have that expertise in terms of
7 or have that option to be laying hands on individuals
8 or utilizing restraints or things like that. So I
9 think the goal would be that those individuals,
10 depending obviously on the, like, you know, agitation
11 can mean a lot of different things to people, but
12 depending on the level of agitation and if it -- if
13 it is one where it may require more than verbal de-
14 escalation, that probably those individuals would be
15 best suited to still go onto the emergency room.
16 **CHAIR COOPER:** Well, I just -- yeah,
17 these are all -- thank you for your response. You
18 know, I do think that it might be worthwhile for you
19 especially and for other members of your team to
20 maybe participate in some of the planning sessions
21 for pediatric agitation that we're getting to that
22 together for our emergency medical technicians. Most
23 of that training is going to be focused as you would
24 -- as you would imagine, on verbal de-escalation
25 techniques. Our E.M.T.s are not going to have the

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2 capability to administer medications. Our paramedics
3 can do so under very, very limited circumstances and
4 under medical direction. But you know, your end
5 point, you know, because we are talking as you've
6 really pointed out so well, really talking about a
7 continuum of mental health care for -- in troubled
8 kids and -- and so the -- the extent to which we can
9 kind of work together mutually plan, I think would be
10 very, very helpful.
11 Particularly since, you know, as you
12 suggested, there are going to be instances where
13 children, you know, are, you know, are exhibiting
14 behavioral characteristics that are way beyond what
15 may be provided in a Crisis Stabilization Center and
16 trip to the hospital with emergency medical services
17 personnel may be, may be what's -- what's needed in
18 those cases. Thank you.
19 **MS. GOLDMAN:** Yeah. Thank you. That
20 is great. I would love to be able to, I'm sure you
21 know others from my team would love to be able to
22 follow up after this and -- and take part in some of
23 those discussions. And thank you for that, you know,
24 idea and that invitation. That would be great to
25 collaborate.

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2 **CHAIR COOPER:** We'll hear more about
3 it. And Jennifer, I hope you can stay on the call to
4 hear -- hear from Sharon Chiumento, who's leading our
5 efforts in terms of getting the curriculum together
6 for our E.M.T.s.
7 **MS. GOLDMAN:** Yeah. I would like
8 that. Thank you.
9 **MS. EISENHAUER:** There are few other
10 questions in the chat.
11 **MR. VAN DER JAGT:** Yes, I have. I
12 think I'm the first one and then Dr. Albert. So and
13 again, it relates to the same sort of similar kind of
14 questions, I think that Dr. Cooper had. The issue
15 of, you know, would ambulances be able to take
16 patients directly to a crisis, you know, a Crisis
17 Stabilization Center if they have a -- a child, an
18 adolescent on board? And then that of course brings
19 up really Dr. Albert's question too is, you know, is
20 medical clearance necessary? Or meaning, how do you
21 -- how do you triage if that would be the case? And
22 is there a triage tool that would need to be
23 developed? Because if the patient needs you know an
24 I.M. dose of Olanzapine, you know that's one thing,
25 you know, but I mean, where does it -- where does it

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2 go into more E.D. management versus the, you know,
3 other, I'm a little unclear on that, and I wonder how
4 that's being formulated.
5 **MS. GOLDMAN:** Yeah. It's a great
6 question. And I think there's -- there's a couple of
7 questions, both as you're mentioning, like
8 clinically, you know, both clinically, how does that,
9 and -- and then operationally like, you know, how do
10 you develop standards around that? And then there's
11 also the piece of billing, certainly.
12 **MR. VAN DER JAGT:** Yeah.
13 **MS. GOLDMAN:** Then there's also the
14 variability across the State in terms of how the
15 different regions work. So I think what we've -- we
16 presented at SEMAC in September, just to start the
17 conversation to say that, you know, as Alexa
18 highlighted, this is in the development phase right
19 now. And that we would like that to be an option
20 that, that if -- if -- if E.M.S. felt that they could
21 get guidance, clarity that would allow their E.M.T.s
22 to, you know, have that comfort to make those -- some
23 of those determinations that would be great.
24 But we would want to be working
25 closely with, you know, all of you here to be making

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2 those decisions and developing. And then also
3 recognizing that while there would want to be some,
4 you know, standards, State -- Statewide standards,
5 that then there may be regional variability. We have
6 in some areas where some centers ha -- have already
7 developed a protocol with their local E.M.S.
8 providers about, you know, the -- the individuals
9 that would be most appropriate, the types of cases,
10 or types of calls. And as Alexa was alluding to,
11 some of them even, you know, have a call between the
12 center and the team to -- to, you know, clarify some
13 of that. But it really, since the resources are so
14 variable, you know, across the State, I think that
15 will be most fruitful to happen at the more regional
16 levels.
17 So we can work on maybe some guidance
18 around like a standardized triage algorithm. You
19 know, what are those cutoffs or considerations for
20 medic -- you know, what's considered medically stable
21 for these centers, what's considered, you know,
22 imminent risk or like acute danger where they need to
23 go to the hospital. Like we can help definitely
24 develop those. But we -- we wanted to work more
25 collaboratively on -- on whether or not and where

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2 that would get embraced and where that would start to
3 get taken up by, you know, depending on the different
4 regions.
5 **MR. VAN DER JAGT:** Well, thank you
6 very much. It's a great -- great opportunity.
7 **MS. COPPOLA:** And I think until we
8 have those conversations at this point, it's just
9 good to know where they're going to be located. And
10 if, you know, the -- to collaborate with the center
11 and they may be reaching out themselves to their
12 various providers as that being part of their
13 development. But I think important to remember, you
14 know -- I think I lost my train of thought. I think
15 I lost my train of thought today. But they
16 definitely want to have emergency medical services at
17 the table. And then at this point where they are in
18 development, where E.M.S. may interact with them most
19 is maybe if that person does end up going to the
20 center walking in, and they do end up needing a
21 higher level of care, maybe they walk in and there
22 does end up needing to be a medical concern. They
23 may call E.M.S., 911, whatever their protocol is to
24 get that person to an E.D.
25 So that's, I think, at this point

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2 where a lot of centers are seeing where that
3 interaction is going to happen just in their early
4 stages of development as we continue to have
5 conversations, of course, where the interaction can
6 occur at different places to help with that diversion
7 over time.
8 **MS. GOLDMAN:** And the good news is
9 that what we've heard from some of these centers that
10 again, are not operating yet as licensed, but have
11 done -- have been doing the work, is the more work
12 they do on the front end to educate community
13 providers and community members about who is like an
14 appropriate, what -- what types of crises ARE best
15 suited for this center, the less that they're having
16 that happen, you know, it's actually not that common.
17 There's the DASH center out on Long Island. They say
18 it's -- it's actually rather rare that they have to
19 call 911 and say, oh, we've got someone here. And
20 now turns out, you know, they -- they -- they -- they
21 need more than we can give them. You know, they --
22 they have to be transported to the E.R.
23 So I think that the goal is that we
24 will try, you know, the centers, the providers are
25 being encouraged to really work with their

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2 communities to highlight the types of individuals
3 that would be most appropriate.
4 **MS. COPPOLA:** And we do have a
5 Statewide learning collaborative while we -- where
6 we're working with each provider that will be
7 operating a Crisis Stabilization Center. So we're
8 more than happy to also incorporate this conversation
9 into that group. If there are resources or anybody
10 would like to join and we can have a meeting
11 dedicated to this intersection and to this
12 collaboration. But what we're also talking about in
13 that group is, you know, Crisis Stabilization
14 Centers, for them to really be successful is the
15 importance of their relationships within the
16 community in order to get people to where they need
17 to be. So while you may be receiving services for
18 that crisis in the stabilization center, the goal is
19 to connect you with all of those wraparound services
20 so that you don't continue to need to go to the E.D.
21 so that you don't continue to need -- to don't
22 continue to fall into a crisis state.
23 So they will be working with law
24 enforcement as well as hopefully E.M.S., but we
25 wanted to definitely be able to help that

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2 conversation along. So anything we can do to be
3 helpful in bridging some of those gaps we're more
4 than happy to do.
5 **MS. GOLDMAN:** I'm glad you mentioned
6 that, Alexa. Yeah. That is something the centers
7 are designed to have the option for police drop off.
8 So for individuals that are -- are being maybe, you
9 know, potentially engaging with police and there's a
10 determination that they could use psychiatric or
11 mental health help, you know, as a diversion from
12 maybe further involvement with criminal justice, that
13 there's a specific, you know, in the program's
14 design, the actual center's design, that there's a
15 police drop off area and things like that. So.
16 **MS. COPPOLA:** I do have a few more
17 slides, but those will be shared with the group. And
18 I don't want to take up too much more time of your
19 meeting. So I was wondering, what do you think Amy
20 is the best to do?
21 **CHAIR COOPER:** I'm sorry, I'm -- I'm
22 not quite following -- what will you --?
23 **MS. EISENHAUER:** Yeah. You're welcome
24 to -- to share the last few.
25 **MS. COPPOLA:** Okay.

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2 **MS. EISENHAUER:** We do have two other,
3 we have a discussion and another presentation as
4 well, though.
5 **MS. COPPOLA:** Well, I -- yeah, I don't
6 want to -- I don't want to take that time up. We
7 will be sending out the information more detailed
8 from the slide so that you can see exactly where the
9 Crisis Stabilization Centers, it's broken out by
10 intensive and supportive, the counties they'll be
11 located in, and that contact information for each
12 center if you're interested in reaching out. And we
13 also have in the slides our general inbox if you
14 would like us to present anywhere to provide more
15 clarification, please feel free to reach out to that
16 as well.
17 **MS. EISENHAUER:** Yeah. And for --.
18 **CHAIR COOPER:** When do you anticipate
19 that these are going to be stood up?
20 **MS. COPPOLA:** They're at various
21 stages of development. So Helio Health in Syracuse
22 was the first to receive an operating certificate.
23 They began, I believe December 11th seeing recipients
24 at their intensive Crisis Stabilization Center. But
25 we do expect to see a few be -- you know, get to that

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2 stage throughout this year and some probably more
3 early 2025. So there are various stages at this
4 point, and we do have that in the spreadsheet, our
5 projections on where we -- when we think they will
6 open.
7 **CHAIR COOPER:** Okay. In the interest
8 of time, I'm going to ask that, is there any last
9 very quick questions for our guests and Jennifer,
10 Alexa, we really, really appreciate you coming. Any
11 last questions? Okay. And then Jen -- Jennifer, and
12 -- and Amy we'll look forward to figuring out a way
13 that we can get -- get everyone together in terms of
14 how we proceed with the pediatric agitation piece in
15 particular. Okay.
16 **MS. COPPOLA:** That's great. Thank
17 you.
18 **CHAIR COOPER:** So I -- I think we now
19 segue into and again, I hope with our agenda we can
20 stick with this you know, Elise van der Jagt talking
21 about the procedural sedation, and then on to Sharon
22 talking about our pediatric agitation education
23 program. Elise?
24 **MR. VAN DER JAGT:** Hi there. You want
25 me to talk about sedation now? Is that what you

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2 said?
3 **CHAIR COOPER:** Yes, please.
4 **MR. VAN DER JAGT:** Yeah. I'd be glad
5 to do that. Amy, I have the -- I can share my -- the
6 presentation that you -- that I sent to you, and then
7 you revise a little bit in terms of putting it in the
8 right format. Is that okay?
9 **MS. EISENHAUER:** Yes. And I think
10 Peter is giving you control to share.
11 **MR. VAN DER JAGT:** Okay. Let see if I
12 can --.
13 **MS. EISENHAUER:** You should have the
14 controls.
15 **MR. VAN DER JAGT:** Let's see. I think
16 this is still on here. Yeah. Can you all see that?
17 Yes, Amy. Okay. Great. All right. Okay. So the -
18 - I'm hoping to make this relatively brief, but I
19 just wanted to bring this up as based on our last
20 conversations when we had our last meeting and this
21 has to do with the questions of procedural sedation
22 in emergency rooms in particular. And this actually
23 came up initially at a quality subcommittee of the
24 Society for Pediatric Sedation that I attended. I
25 was been -- I've been involved with that society,

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2 which is a national organization of -- of providers
3 who provide comfort care, sedation, analgesia for
4 procedures, usually relatively short procedures.
5 And the question came up is, well,
6 what -- where are procedural sedations done? And are
7 we -- since the society is the one who is really
8 interested in making sure that there is high quality
9 of care, when it relates to procedures including
10 comfort including decreasing anxiety and decreasing
11 pain, we -- the -- it sort of became apparent that a
12 lot of these procedures are done not in children's
13 hospitals, but are actually done in community
14 hospitals. A large number of them in rural areas.
15 So as we discussed this then it became, well, this is
16 really an emergency medical services for children
17 kind of area and we should be talking actively about
18 this. And then I actually promised them that I would
19 do that at least in New York State being on the
20 forefront of this.
21 So these slides will give you a little
22 bit of my thoughts about it, and I will end up with a
23 number of questions that I would like to put before
24 this committee. I can advance this here. Okay. So
25 the idea here is to optimize pediatric procedural

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2 sedation or shall we say, comfort in emergency
3 departments. And the idea here is that can E.M.S.C.
4 work together with a society for pediatric sedation,
5 or at least conceptually have E.M.S.C. practice
6 coincide or relate also to the S.P.S. practice, which
7 the idea being that -- let's see if I can, this is
8 not advancing here. Let me see how -- there we go.
9 That both areas have a unique interest in doing the
10 very best they possibly can for the kids out there.
11 Now, when I looked at this, I thought I would first
12 start with the readiness project because I figured
13 that E.M.S.C. is probably already somewhat involved
14 in this.
15 And this actually comes from the
16 checklist on the E.M.S.C., the innovation site that
17 we used for the readiness project, which we've talked
18 about. And if you note here under this checklist,
19 which we have on there, which is part of the
20 readiness project and survey there -- this issue of
21 sedation analogy to procedures, including medical
22 imaging and a lot of areas of medications, and
23 equipment, and pain scale assessments are actually
24 need to be in place if you want to be considered a
25 high-quality emergency department. So this is

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2 already being addressed in that checklist and it
3 really coincides always with our always ready for
4 pediatric patients that we have in New York State,
5 that new program that has been generated now.
6 I then also looked also at the
7 E.M.S.C. website and realized that there are also
8 several videos and documents that are available on
9 that, again showing that this is an important area
10 that we should be paying attention to. So things
11 like needle related pain, I.V. insertions and a few
12 other ones that I'll show you slides on. So clearly
13 E.M.S.C. includes this kind of area already in what
14 they consider, you know, part of the scope of
15 practice for E.M.S.C. Here are the videos that you
16 can see here videos. This is on the E.M.S.C.I.C
17 website. Reduce your infant's pain during newborn
18 blood test, just in time infant I.V. placement,
19 communication card about this, pain management, this
20 kind of thing is clearly all there.
21 And in fact, Neil Scheckter, who used
22 to be in Connecticut, actually, psychological
23 strategies even for, how do you deal with this?
24 Oops, let me go back here. The Society for Pediatric
25 Sedation on the other hand its mission, if you don't

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2 know this, is striving to be the international
3 multidisciplinary leader in the advancement of
4 pediatric sedation by promoting safe, high-quality
5 care, innovative research, and quality professional
6 education. And the disciplines that are involved in
7 peds sedation membership are critical care, peds
8 anesthesia, peds emergency medicine. As you can see
9 here, pediatric nursing, which of course translates
10 across many different areas. Child life, dentistry,
11 vascular access, and really is an international area
12 that we practice in.
13 And so the committee of quality and
14 safety then their job is to develop metrics for
15 safety and quality, recommend standards and
16 guidelines. It's a collaborative kind of metrics
17 that we're looking at here, and broadly applicable to
18 all sedation providers, which obviously include those
19 who are practicing in the emergency department and
20 also in inpatient areas. The goal then is really to
21 optimize pediatric procedural sedation everywhere in
22 both emergency and elective settings, and for both
23 emergent and elective conditions. And there's been a
24 lot of progress been made in doing really high-
25 quality procedural sedation in these sort of non-

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2 emergent areas.
3 You know, a lot of imaging oncologic
4 procedures, burn dressings, inpatient vascular
5 access. A lot of procedures that are for children
6 are extremely uncomfortable, but that also include
7 things more in more things like I.V. insertions and
8 phlebotomy, especially in patients who have mental
9 health issues, needle phobias, and behavioral
10 management kinds of issues. So here are the things
11 that we see sedation being used for in the E.D.
12 Typically, obviously, I.V. insertions are really the
13 large part of this, imaging issues, C.T.s and
14 M.R.I.s, but also things like fracture reductions,
15 wound cleaning, add dressing changes, debridement
16 burn, including particularly burns, laceration
17 repair, abscess drainage, and -- and any kind of tube
18 insertions as you can see, catheterization or N.G.
19 tubes placement.
20 So when I -- this is our -- the last
21 couple slides, then, what I wanted to do then for our
22 committee here is and when I put these in sort of
23 questions that I'd like to sort of begin some
24 dialogue about this. Are there opportunities for
25 emergency departments to improve management of

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2 pediatric procedural pain and anxiety, especially in
3 small emergency departments, which are largely in
4 community hospitals? We're not really talking as
5 much about children's hospitals, larger medical
6 centers that have many of these things in place. But
7 we're really talking about smaller areas where there
8 are not as many pediatric patients seen, and there
9 may be opportunity for improving.
10 We don't know the quantity of these
11 procedures. We don't know where they're being
12 completed. We don't know what's being used to
13 alleviate pain, anxiety, sedation with E.M.S. and
14 emergency department procedures. And then obviously,
15 currently, especially, we want to make sure there are
16 no disparities so that patients who are in rural
17 areas where they really are having only access to
18 community hospitals with maybe minimal pediatric
19 expertise ,they are seeing -- they're not getting the
20 optimal care as compared to patients who are being
21 seen at a sort of a high-level children's hospital
22 pediatric emergency room.
23 The second point here is education
24 about procedural sedation, analgesia necessary.
25 That's something we should think about. Is that

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2 something that we need to talk about a little bit.
3 Should the E.M.S.C. Advisory Committee develop an
4 advisory related to procedural sedation and analgesia
5 for hospitals in New York State? And then number
6 four, the Always Ready for Children emergency
7 department recognition program, is there a way that
8 the pediatric emergency care coordinators potentially
9 could play a role in these kinds of things? So I'm
10 throwing these questions on, that's the end of my
11 slides here, but now I don't know how to get out of
12 this. How do I do this? So do I just stop sharing
13 somehow?
14 **MS. EISENHAUER:** So wherever you're --
15 .
16 **MR. VAN DER JAGT:** Hang on. Yeah. So
17 let me see. I go back to --.
18 **MS. EISENHAUER:** Yeah. hang on one
19 second, Dr. Van der Jagt.
20 **MR. VAN DER JAGT:** Yeah. Sure.
21 **MS. EISENHAUER:** There we go.
22 **MR. VAN DER JAGT:** Thank you very
23 much. That's great. So the last thing I want to say
24 you is -- just happened to be that yesterday I
25 received in my email inbox notice of a publication

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2 that had been published by Connecticut, a few folks
3 out there. And they actually did a regional
4 assessment of community hospitals about the use of
5 for I.V. insertions in community hospitals. And they
6 found out that only -- it was only being used two
7 percent of the time for the pediatric patients that
8 were seen there, and they were able to, through a
9 quality improvement project, to increase that to
10 forty-two percent.
11 So it was very timely, actually, to
12 recognize that this is an important area. There are
13 now, looks like some efforts being made to really
14 improve the care in particularly in community
15 hospitals relating to decreasing anxiety and
16 discomfort. And so I wanted to throw that out to the
17 committee, some of the thinking about that,
18 especially for those of you who are in -- directly in
19 pediatric emergency medicine. But obviously everyone
20 who is on this committee has -- I would love to hear
21 their thoughts about it. And including family
22 representation that's on the committee that would be
23 very helpful to do so. Thank you, Dr. Cooper. So.
24 **CHAIR COOPER:** Thank you. You know,
25 one thing that strikes me, Elise, that might be

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2 considered rather than developing a, you know, a
3 guideline ourselves might be to, if -- if the
4 committee chooses to do so, you know basically, you
5 know, call attention to existing guidelines that --
6 that, you know, are already nationally slash
7 internationally recognized, such as, you know, the
8 ones from in the Society for Procedure -- for
9 sedation in children that -- that you've alluded to,
10 that I seem to be, that rather than developing our
11 own guideline, you know, that might be easier unless
12 there's a, you see that there's a specific reason to
13 develop our own guideline, or -- or would it be
14 enough just to say, hey, we're concerned about
15 inconsistency and procedural sedation in emergency --
16 in emergency departments.
17 Were you aware of these guidelines? I
18 -- I -- something along those lines. I -- I'm not
19 sure, your thoughts on that.
20 **MR. VAN DER JAGT:** Yeah. I think, you
21 know, my -- my -- my thought thinking in general is,
22 I -- I don't know the extent of the issues here,
23 first of all, in New York State. My concern is, is
24 that, you know, is that -- that we don't know the
25 extent of the issues. We don't know what the

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2 education is out there. We don't know what's
3 actually being done. That is one of the -- one of
4 the things I think to think about. Can we, like you
5 said, I think your words, you know, draw attention to
6 this with endorsement by the emergency and by our --
7 our particular committee to start paying attention to
8 this. And this is, again, I -- I -- I'd like to hear
9 from some of the folks who are particularly who are
10 in emergency medicine. So yeah.
11 **CHAIR COOPER:** Ed Conway has a
12 comment, please. Ed Conway, hey.
13 **MR. CONWAY:** So this is quite a can of
14 worms, obviously. And again, the underlying concept
15 is who's doing what and how do we figure it out.
16 **MR. VAN DER JAGT:** Right.
17 **MR. CONWAY:** What most people don't
18 want is another massive survey coming their way. I
19 wonder if there's a way that somehow, we can tie this
20 in, perhaps as an appendix to the pediatric readiness
21 document that's going to go out there. There may
22 even be some way to look at some of the data on it.
23 I'm not familiar with all one hundred questions
24 currently. To give us a gestalt for like -- like a
25 starting point here. You, you know, again, that's

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2 just my two cents. But I think where we all could
3 use some guidance, in particular the children with
4 some -- some of the behavioral disorders that may
5 already be on some medications, as we know, even in
6 the children's hospitals are very difficult to
7 sedate. And a lot of times we'll have to either call
8 in our critical care, we have to do it ourselves or
9 get our anesthesia colleagues.
10 So -- so I think that this is a much
11 bigger issue. And I'm just putting it out there as
12 to a way without ma -- making yet another, or go
13 through some of the other organizations, you know,
14 the -- the peds for example, the peds, right, they do
15 a lot of research. There may be other ways to get
16 some of this information. Just sharing that and
17 don't have an answer. Just wanted to raise the
18 issue.
19 **CHAIR COOPER:** Thanks, Ed. Anybody
20 else?
21 **MS. FEUER:** Yeah. Hi, it's Pamela
22 Feuer. I agree with Ed's description can of worms
23 because the -- I think a lot of these studies and the
24 sedation organizations and stuff are made up of
25 people from the larger scale tertiary, quaternary

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2 children's hospitals who are very well versed and
3 experience numbers in the use of these medications.
4 So I didn't read that Connecticut publication, it's
5 great to increase your use of intranasal Versed to,
6 you know, by a certain percentage in the E.D. as long
7 as you don't have bad effects or bad outcomes of
8 that. And I'm not sure that when we're talking about
9 Statewide or some of these community centers, I think
10 awareness of even non-pharmacologic ways to improve
11 pain control and -- and comfort are -- are good.
12 But I -- it's more of an awareness. I
13 don't know that I'd want to see practitioners who
14 don't get the number of -- of procedures and don't
15 have the same awareness and -- and education and
16 other resources like the anesthesiologist or the
17 critical care docs be doing some of this sedation.
18 **MR. VAN DER JAGT:** I -- I -- if I
19 could respond to that just briefly, Pam. I think the
20 -- what we are trying to deal with, certainly in
21 Upstate New York is, you know, the kids coming in,
22 they don't need to be admitted. They're -- they have
23 -- have to undergo a procedure. Oftentimes they're
24 just simple as an I.V. insertion or some hydration,
25 but they're two or three hours away. And the -- the

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2 overarching concern is how do we manage the anxiety
3 and discomfort, you know, for those kinds of kids?
4 So we're not talking necessarily about here, you
5 know, using propofol in a kid who, you know, needs
6 some kind of, you know, fracture reduction. You
7 know, these are relatively small procedures, but, so
8 that's -- it's really, I like what you're saying
9 about the use of tools, you know, child -- typically
10 child life kind of tools that would be helpful in
11 kind of relatively minor procedure.
12 And then start thinking about ways to
13 reduce anxiety that have a fairly good positive
14 response, but a low-risk response. So anyway, I see
15 Dr. Calleo's hand up. I'd love to hear from you.
16 **MR. CALLEO:** Yeah thanks. This is
17 Vince Calleo. So pediatric sedation is something
18 that's near and dear to me. I do work in the P.C.D.
19 for the large number of my emergency department
20 shifts. And I think this is something that's come a
21 long way in the last, you know, five to ten years
22 since I've been here. And I will say that I
23 primarily work in an academic center with pediatrics.
24 So like Dr. van der Jagt said, I think there's a very
25 big difference between what we see in, you know, the

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2 -- the academia world compared to those who are
3 practicing in the community, knowing full well that
4 many people who work in smaller community emergency
5 departments are going to be trained either as
6 emergency medicine residents who may or may not have
7 a lot of pediatric experience.
8 Some only get a couple months during
9 their residency in total as opposed to others where
10 it's, you know, more continuously integrated. And in
11 other cases, for some smaller E.D.s, they may not
12 even have emergency medicine trained people, and they
13 may be, you know, other primary care providers like
14 family medicine or internal medicine that might not
15 have the same degree of familiarity. So I think
16 bringing awareness to this is really important. You
17 know, I'd be lying if I said I was fully well versed
18 in all of the, you know, most recent literature out
19 there in terms of, you know, the number of, you know,
20 people who are being sedated or having anxiolysis
21 control for something like peripheral I.V. insertion.
22 But I think it's certainly something that, you know,
23 would be worth looking into from this committee.
24 And I think that if we were to say,
25 you know, if we review what's out there and say we

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2 really like these guidelines, then yes, we would, you
3 know, endorse them. It might be a great way to help
4 try to provide that for the community. But there may
5 be even an opportunity for us to, you know, think
6 about something on our own if we think that there's
7 something that might be a little bit different for
8 the individual areas that we serve. I mean, even
9 using, you know, intranasal Versed as an example,
10 I'll be honest with you, as a pediatric emergency
11 medicine doc, I actually don't love that if I have
12 the option to give P.O. Versed, because if you dose
13 that appropriately, it actually is much less
14 irritating to the children. It tends to be a little
15 bit more well tolerated, but it takes a little bit
16 longer to work.
17 So I think a lot of it depends on the
18 situation, and this is something where a lot of
19 people might not have a lot of familiarity. So if we
20 can kind of, you know, pool our expertise to help
21 provide even some simple recommendations or simple,
22 you know, sets of information to people, it might
23 help to really improve the overall care they can
24 provide for kids. So Dr. van der Jagt, if this is
25 something that you think would benefit from having

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2 like a smaller focus group, you know, looking at to a
3 little bit more, I'd be more than happy to
4 participate in it as well. If that's something you
5 think would be helpful.
6 **MR. VAN DER JAGT:** Thanks very much,
7 Dr. Calleo. That is -- that is great. I thought I
8 see a lot of it as well. And I personally, I do not
9 like intranasal Versed as everybody knows. I usually
10 use P.O. if I can, but in the E.D. sometimes it does
11 depend on the situation and how fast you need to get
12 an I.V. in and how can you do this, you know, so I
13 totally understand that. Dr. Bombard, I think had
14 her hand had hand up as well, so please.
15 **CHAIR COOPER:** Tiff?
16 **MR. VAN DER JAGT:** Tiff?
17 **MS. BOMBARD:** Hi. Sorry, I just had
18 to get my volume, my --
19 **MR. VAN DER JAGT:** No, that's okay.
20 **MS. BOMBARD:** -- video going there.
21 So I'm Tiff Bombard. I absolutely agree that any
22 support that you can give to small E.D.s is awesome.
23 And I don't want to downplay that in one little bit.
24 I do want to hand you a little bit of reassurance
25 that we're not doing kind of wild west medicine

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2 anymore in these small E.D.s. It's really not as
3 grim as you may have heard, but working at larger
4 receiving centers, I -- I understand having trained
5 at something that was a big receiving center. I
6 understand sometimes it feels that way, right? When
7 we receive patients from these small E.D.s, sometimes
8 we think, oh my God, who's working out there? And
9 what are you doing out there? Why is it all so
10 messed up?
11 So I've seen it from both sides.
12 Right now, I'm working in an eight bed E.D. and a
13 twelve bed E.D., two different places. And also, in
14 a larger -- larger receiving center. I work in the
15 northern part of New York State. So I work in three
16 places. So I both receive kids from small E.D.s, and
17 I treat kids in very small E.D.s with zero resources.
18 And when I say zero resources, I mean zero resources.
19 There's no O.B.G.Y.N., there's no nursery, there's no
20 I.C.U. There's no surgery, there's no
21 anesthesiology, there's a lot of no, if it ends at
22 all just we don't have it. So what you end up being
23 as an E.D. doc in these small places is a pretty good
24 generalist. We're sort of throwback doctors in this
25 day and age, and we see actually a surprising number

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2 of children because they -- we're the only place to
3 go, right?
4 The pediatrician's offices are
5 overwhelmed during the day and closed at night. And
6 it's a two-hour drive to another hospital. So we
7 actually do see quite a few kids. The reassurance
8 I'll give you is that more and more and more, these
9 places are staffed by E.M. docs, not by family
10 practice docs as well has been in days of yore, and
11 that's changing really quickly. That's changed a lot
12 just over the last two or three years that we don't
13 have, you know, I think there's one E.D. in a two-
14 hundred-and-fifty-mile radius from me up here in
15 Saranac Lake that's staffed by E.D.P.s any amount of
16 the time. The rest are now staff -- staffed by
17 residency trained emergency physicians. And that's a
18 change just over the last three years. So this is
19 really new. What I will say is E.M. residencies also
20 have changed a lot.
21 And we're not seeing kids for two
22 months anymore. We are seeing kids all the way
23 through our residencies, and we're seeing a lot of
24 them. And, you know, I trained at Albany Med. We
25 spent a month -- a month in the PICU, and we were the

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2 only physician there at night as a resident including
3 there was not an attending on site when I was there.
4 Now that has changed. Albany Med now does have an
5 attending on site at night. However, they're not
6 next to the resident. The resident is out there, you
7 know, learning, right? And they do have some backup
8 if things go sideways. So, you know, lots of things
9 have changed really recently. What I will also say
10 to you is that, you know, I think sedation is
11 something we're really familiar with, and I agree
12 with you on the nasal medications, by the way. I
13 think they're not very effective.
14 But you know, we do a lot of both
15 procedural sedations and, you know, minor distractor,
16 child life kind of variety things where we're using,
17 you know, spinners, and flashy things, and toys, and
18 games, and sounds, and phones, and all of that stuff
19 is part of our daily practice out here in these tiny,
20 tiny E.R.s. So we're really, we're not on another
21 planet anymore, I promise. Again, I'm not trying to
22 discourage support. Support is support, right?
23 Like, you guys are seeing a ton more kids than we
24 are, and any suggestions you have are much, much
25 welcomed. But I, you know, again, I want to reassure

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2 you that it's not as bad as it might feel when you're
3 on the receiving end. Because you're just getting
4 the worst cases, not the best.
5 **MR. VAN DER JAGT:** Thanks very much,
6 Dr. Bombard. If I could just respond to that as
7 well. I -- I -- first of all, I -- I didn't mean to
8 imply that folks in smaller community hospitals that
9 it was going to be, it's a wild west out there. But
10 I do -- I'm relatively aware having been in this
11 region for many, many years, that things don't always
12 go as rapidly in those areas as they do in larger
13 children's hospitals. I think for those E.D.s that
14 are doing these things that you sounds like you're
15 doing really, really wonderful. I'm not sure that
16 everyone is on that same page. And I think it was
17 just more looking at it from a consistency.
18 And incidentally, this is not only my
19 opinion, and this has been said across the board,
20 this did come up in the Society for Pediatric
21 Sedation, where there are many pediatric emergency
22 medicine physicians who live in kind of rural areas.
23 Are not in rural areas, they -- they have an outreach
24 area to the rural areas. So -- so anyway, I -- I --
25 I don't want to take up too much time. Dr. Cooper, I

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2 know we have some other things on the agenda here,
3 but --
4 **CHAIR COOPER:** We do.
5 **MR. VAN DER JAGT:** I'm sorry?
6 **CHAIR COOPER:** We do.
7 **MR. VAN DER JAGT:** Yeah. Yeah. So --
8 so maybe if someone's interested in looking at this
9 for the State, maybe Art, maybe that would be the way
10 to go with this. This was to sort of -- sort of get
11 us sort of involved in this effort. And because two
12 national organizations, E.M.S.C. and S.P.S. are both
13 interested in these areas, it just seemed to me that
14 it would be so cool, so to speak, if New York State
15 was on the front lines here trying to work together
16 in this -- in this area that is, you know, finally
17 beginning to develop some traction on both sides
18 these last several years.
19 **CHAIR COOPER:** Well, at least, you
20 know -- you know, the rules of life as well as I do
21 Elise. You know, you brought this issue to us and I
22 think in a very elegant and worthy way. And I think
23 Alex and Tiff have both contributed, you know, to
24 this conversation. What I'd like to suggest is that
25 the three of you and anybody else who might be

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2 interested get together on a -- on a conference call
3 that I'm asking Amy to organize through us, you know,
4 and see where we -- see where we can go from here.
5 Does that make sense?
6 **MR. VAN DER JAGT:** It'd be wonderful
7 as far as I'm concerned, that is if Amy's willing to
8 help with that organizational piece. That would be
9 wonderful. So I've got Tiff and Vince and who else?
10 Pam, maybe I don't know other people.
11 **CHAIR COOPER:** And Conway was part of
12 it.
13 **MR. VAN DER JAGT:** And Conway was part
14 of that.
15 **MS. EISENHAUER:** Yep. Sure, sure.
16 **CHAIR COOPER:** Yeah. Okay.
17 **MR. VAN DER JAGT:** All right. Thanks
18 very much.
19 **CHAIR COOPER:** Okay. Great. Okay.
20 Sharon?
21 **MS. CHIUMENTO:** All right. So just a
22 very brief report. I do want to just mention how we
23 got into this for those who are on this call that
24 were not -- had not been part of in the past. So we
25 decided several years -- several months ago that we

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2 were going to develop some kind of an educational
3 tool for specifically for E.M.S. providers on dealing
4 with patients with pediatric agitation. And -- and
5 the issue was that there was a lot of tools out there
6 that we could find that addressed adult issues that
7 addressed it, or in hospital settings, but not in the
8 pre-hospital settings and specifically for
9 pediatrics.
10 So back in December after our last
11 E.M.S.C. meeting, we did -- we had a conference call
12 our little workforce. And they decided that they
13 would like to go forward with developing some
14 scenarios that could be developed in some videos.
15 And -- and then we were going to -- and we came up
16 with some basic ideas for those scenarios. We had
17 three that we were going to do. One a -- a male --
18 male adolescent having a new onset of a mental health
19 issue is very agitated and paranoid after a fight
20 with his sibling. One that was a -- a school child
21 with developmental delay autism that is, it becomes
22 agitated where there's a change in -- in what his
23 normal schedule is, normal activities. And then one
24 that was a female adolescent who has just broken up
25 with her boyfriend and is very agitated and -- and

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2 potentially suicidal.
3 So -- so we had different people who
4 said that they would like to work on those particular
5 scenarios and develop some scripts for the videos.
6 But as of January 25th, when we had our last call,
7 very few of them were on that call, and we would --
8 we have no idea what the progress on it is, with the
9 exception of the -- the child with autism. One of
10 Mark Philippi, who also sits on SEMAC has done some
11 work with that. So we do have a little bit of
12 progress on at least that one scenario. So Chief
13 Pataky was on from the fire department of New York
14 there was on the call on -- on last week. And he
15 said he might have some resources that he was going
16 to try to tap into that, to -- to move this project
17 forward. So Chief Pataky, if you can just kind of
18 let us know what your progress is, that would be
19 wonderful.
20 **MR. PATAKY:** Certainly. Thank you,
21 Sharon. So I had a conversation just yesterday with
22 some of the folks from the E.M.S. Academy for the
23 F.D.N.Y., and we discussed the next steps that would
24 be necessary to, you know, start the scripting for
25 these videos. They've asked for a -- a point person

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2 in each of the videos. If we can't get a point
3 person, I'll volunteer myself to do it knowing the
4 scenarios that we're looking for, and we want to go
5 ahead and immediately start getting some scripts
6 together. We'll vet that through this committee to
7 make sure that, you know, everybody is on board with
8 the direction that we're going.
9 And once we have those scripts, we are
10 all hands on board for shooting the video and editing
11 it with, you know, partners from the State or anyone
12 else who has the capabilities to get these videos
13 out. But we, you know, once we get the script
14 together, once we're all in agreement that this is
15 the direction that we want to go for pre-hospital
16 care providers we are ready to go.
17 **MS. CHIUMENTO:** Wonderful. I will
18 contact the people who had said that they wanted to
19 work on those scenarios, and then I'll email you the
20 contact information for the people who I think would
21 be good point for people for your -- to work with
22 your folks. Also --
23 **MR. PATAKY:** That's great.
24 **MS. CHIUMENTO:** -- just to mention --
25 just to mention that SKDNY also had a PowerPoint that

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2 they had used in their training on agitation and on
3 de-escalation. So we are also going to incorporate
4 some of the -- the data point of the points from that
5 into the training when we - when we finish it. So
6 the training won't just be the videos, but we'll --
7 we will incorporate information about de-escalation
8 and safely working with these -- these patients out
9 in the E.M.S. environment along with the -- the --
10 these -- the -- the videos. And what our hope is to
11 develop a one-hour program that can be used on the
12 E.M.S. Academy and as -- as well as and around the
13 State by instructors or at conferences, things like
14 that. So -- so that's our goal.
15 And so we've made at least one more
16 step forward here, so I will make sure that I get you
17 that information very quickly. Any questions? Oh,
18 also, yes. And we would love if somebody who was
19 presented earlier would like to potentially be
20 involved on our -- on our work group conference
21 calls, it might -- that might be a good way for us to
22 interact with each other and -- and, you know,
23 collaborate together. So.
24 **MS. GOLDMAN:** That sounds great.
25 Thank you. I'm -- I'm glad I was able to sit in and

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2 hear this overview, and I look forward to hopefully
3 taking part.
4 **MS. CHIUMENTO:** Great.
5 **CHAIR COOPER:** That's great. Thank
6 you, Jennifer.
7 **MS. CHIUMENTO:** Please add her, please
8 add her to our listing.
9 **CHAIR COOPER:** Okay. Any questions
10 for Sharon? Thank you for keeping the ball rolling,
11 Sharon. I know it's herding the cats is the reason,
12 but you seem to be doing it. So there we are. So we
13 are now, I think, done with all new business, we're
14 up to our updates from our State partners and sister
15 advisory committees. Is Dr. Alda Osinaga with us
16 from -- from Quality and -- and Safety Sepsis --
17 Sepsis Initiative.
18 **MS. EISENHAUER:** George Stathidis is
19 here.
20 **CHAIR COOPER:** Oh, George. Wonderful.
21 Can you -- can you tell us where we are and give us a
22 brief update?
23 **MR. STATHIDIS:** Absolutely. Yeah.
24 And thank you, Dr. Cooper, and thank you for having
25 me here today. Dr. Osinaga was not able to attend,

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2 but I can give -- absolutely, I can give a short
3 update on where we are with our Pediatric Sepsis
4 Initiative.
5 **CHAIR COOPER:** Sure.
6 **MR. STATHIDIS:** So the -- the main
7 update that I have right now to share is that we are
8 getting very close with our 2021 sepsis report that
9 is data from 2021 that we've been working to -- to
10 compile into a new format, an interactive report.
11 It's going to be a dashboard report. It will be
12 publicly posted on the New York State Department of
13 Health website. That report includes both adult and
14 pediatric data. We are going to be doing risk
15 adjusted mortality rates for adults for this year,
16 but not for the pediatric population. We just do not
17 have enough data to -- to do that risk adjusted
18 mortality work for the pediatric population.
19 That does not mean that we're not
20 going to do it in the future. We just need to get a
21 bigger sample size to be able to do that risk
22 adjustment work. We're getting very close, as I
23 mentioned, to releasing that report. And when we do
24 get the approval to release that report, we're going
25 to extend an invitation to, you know, anyone who

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2 would like to join us with -- with us on -- on a
3 walkthrough of that report. So we'll -- we would
4 love to show everyone kind of the -- the data that's
5 there, some of the key takeaways and -- and
6 essentially how to interpret some of the data there.
7 So that is coming soon. I don't have an exact
8 release date, but when we do get that release date,
9 we'll be letting all of our partners know. That
10 includes several of the members, I believe, on this
11 committee.
12 We'll be sharing that announcement.
13 And then, of course, you know, if -- if you would
14 like to share that beyond this group, we would be
15 happy for you to do so and -- and would welcome
16 anyone who would like to attend. So I -- I -- I
17 would say that's our biggest update right now.
18 There's been a lot of work going into this, and I
19 think a lot of data collection done across the State
20 on the Sepsis Care Improvement Initiative over the --
21 over the past few years. So we're excited to be able
22 to show the result of all that work.
23 **CHAIR COOPER:** Thank you, George.
24 **MR. STATHIDIS:** That is -- absolutely.
25 **CHAIR COOPER:** Yeah. I think, we'll -

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2 - we're all looking forward to -- to the report.
3 Amy, correct me if I'm wrong, we next meet in June,
4 correct?
5 **MS. EISENHAUER:** We next meet May 6th
6 and that will be in person at the Hilton Garden Inn,
7 and that meeting will be at twelve noon, so it'll be,
8 instead of our normal one to four, it's going to be
9 twelve to three. Because our meeting overlaps a
10 little bit with the program agency meeting, and I
11 have to be at both.
12 **CHAIR COOPER:** Okay. No problem. So
13 George, please make note of that date I hope that --
14 I'm presuming that, that there will be a -- a report
15 available by that date, May, early May and I'm hoping
16 that you or Alda or someone from the Sepsis
17 Initiative will be able to share that data with us at
18 that time. Sound good?
19 **MR. STATHIDIS:** Yes. Absolutely, Dr.
20 Cooper, that's my hope as well, and we would be happy
21 to -- to join you again in May.
22 **CHAIR COOPER:** Thank you so much.
23 **MR. STATHIDIS:** Thank you.
24 **CHAIR COOPER:** Questions for George?
25 Hearing none Peter Dayan, or -- and or Brian

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2 Clemency, are you on for the PECARN report?
3 **MS. EISENHAUER:** I don't believe so.
4 Dr. Dyan had emailed me earlier and said that he
5 would have to jump off early. So he was here
6 earlier, but he had to leave. He did say that their
7 projects are ongoing and they don't have any new
8 updates.
9 **CHAIR COOPER:** Okay. Thank you. Our
10 colleagues from Injury Prevention now, Susan Stegich,
11 if I'm saying that correctly and Kris Alfonso, are --
12 are you with us at the moment?
13 **MS. ALFONSO:** Yes. Thank you so much
14 for having us. I'm Kris Alfonso from the Bureau of
15 Occupational Health and Injury Prevention. So we do
16 have some updates. I'll start with our pedestrian
17 program. So we do have a pedestrian safety campaign
18 media buy happening. The goal of this is to raise
19 awareness and reduce pedestrian related risks through
20 education and outreach on pedestrian related vehicle
21 and traffic law. With that, we're developing a new
22 tip card to raise awareness on understanding traffic
23 control devices at crosswalks and how to use those
24 devices for crossing safely. And then we're really
25 excited about a project that we have going on right

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2 now. We're conducting three focus groups in Albany,
3 Rochester, and Yonkers to learn more about what
4 community members believe are barriers to vulnerable
5 road user safety.
6 And we define vulnerable road users as
7 road users who have less protection and are more at
8 risk in traffic. So that's pedestrians, bicyclists,
9 and other cyclists, so people who walk, bike, or
10 roll. So we're going to be conducting those focus
11 groups. We're starting in Albany. We're very
12 excited. We've been able to work with Albany's
13 Metropolitan Planning Organization, and we are
14 hopeful that our first focus group will be with folks
15 at Albany High School. So we'll be with high school
16 students who are, you know, likely to be walking,
17 cycling to school, using public transportation.
18 So we are -- we're excited to be able
19 to talk with those students and get some input and --
20 and figure out ways that we can kind of bridge the
21 gap for their safety. And then in addition for our
22 motorcycle safety program, we're continuing with our
23 ride drive care campaigns. That's targeting car
24 drivers and motorcycle riders. We're producing a
25 second public service announcement that's focusing on

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2 speed as a contributing factor to crashes. And we'll
3 have a P.S.A. that's going to focus on men ages
4 twenty-one to twenty-nine. And we also have a
5 publication that is going to be going along with
6 that, focusing on speed reduction for riders and
7 drivers. I'm going to turn it over to my colleague
8 Susan, who's also going to give some updates.
9 **MS. STEGICH:** All right. So under our
10 child passenger safety we have a pictorial video that
11 is still in the approval process, but we are
12 expecting to be able to produce that in the spring.
13 We are working on a counterfeit car seat publication.
14 The draft has been composed and approved by the
15 Governor's Traffic Safety Committee. We next are
16 meeting tomorrow with outreach and education and
17 that, yes, tomorrow. And then under our Younger
18 Driver Safety the publication, help younger drivers
19 stay alive. That is on our website, but it is
20 waiting to go to printing. Our health educator is
21 getting a group of products that need to be printed
22 at the same time so that it'll be done at that time.
23 Under our Driver Education Research
24 and Innovation Center, which is the DERIC program, we
25 have in the grant cycle we are setting up three

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2 scheduled trainings for this curriculum. The first
3 is already set for April 20th, and that's in
4 Fairport. And with hopes for the next one to be in
5 June, which will be in the Albany area, and then in
6 August, hopefully in Long Island. So that's where we
7 are with INOP.
8 **CHAIR COOPER:** Thank you so much. I -
9 - did I miss -- did I miss it -- announcement about
10 the Injured Community Implementation Group. I think
11 that is meeting this month, is it not?
12 **MS. STEGICH:** And sorry, say that
13 again.
14 **CHAIR COOPER:** The Injury Community
15 Implementation Group meeting, I think that's coming
16 up this month, is it not?
17 **MS. ALFONSO:** That is coming up, yes.
18 Let me just pull up the date on that for you quickly.
19 But we are having the I.C.I.G. meeting soon.
20 **MS. STEGICH:** Yeah. That's going to
21 be February 21st.
22 **CHAIR COOPER:** Thank you so much.
23 Great. Appreciate it.
24 **MS. STEGICH:** Thank you.
25 **CHAIR COOPER:** Any questions for our

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2 injury prevention colleagues? Okay. Marilyn Kacica,
3 do you have anything for us other than the -- the
4 toolkit update?
5 **MS. EISENHAUER:** Dr. Kacica, I believe
6 stepped off.
7 **CHAIR COOPER:** Okay. All right.
8 Well, certainly the toolkit update is a very
9 important piece. And you know, Amy, I just simply
10 ask that you stay in touch with her, see if she needs
11 any input from our group. Okay?
12 **MS. EISENHAUER:** Absolutely.
13 **CHAIR COOPER:** Thank you. Next Kate
14 Butler do you have a report from Health Emergency
15 Preparedness?
16 MS. BUTLER-AZZOPARDI: Thanks, Dr.
17 Cooper. I do still have, I have just a few things
18 that are germane to this group. As I briefed out
19 previously, we are -- we were able to leverage doing
20 the National Pediatric Readiness Assessment as a
21 deliverable for our acute care facilities that we
22 contract with. And I have been keeping Amy in the
23 loop and giving her all of those reports as they're
24 coming in. It's been a little bit slow, but it's
25 also in the middle of the year. So we -- we -- we

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2 anticipate that we'll get all of those in before the
3 -- the June deadline for that. We are working on our
4 additional deliverables for what would be our new
5 budget period for starting in July.
6 And I know that Amy and Drew Fried in
7 our mayoral region may have a -- some potential
8 proposed deliverables. Because I do really enjoy
9 that we've had those crossover activities between
10 these two groups. I'd like to continue to see that
11 happen. So we're working on that currently. And
12 then again, we have mentioned the peds and O.B.
13 toolkit pretty extensively already. And I did, for
14 the sake of the minutes, I did want to extend the
15 thanks to Dr. Kacica for helping us out with that.
16 And -- and if there's anything that we -- you need
17 from my side with that, because I will be sitting on
18 that -- that activity as well. Please just let me
19 know. I think that's all I have for today.
20 **CHAIR COOPER:** Thank you, Kate. Any
21 questions for Kate? Okay. Drew Fried?
22 **MR. FRIED:** Yeah. Good afternoon.
23 Can you hear me, okay?
24 **CHAIR COOPER:** We can.
25 **MR. FRIED:** Okay. Excellent. So I

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2 just asked Amy if I could talk real briefly about a -
3 - a project we started down here in Milan that we're
4 going to mirror in our Lower Hudson Valley region,
5 which is our southern county, north of New York City.
6 And that would be our threat and hazard assessment
7 program. One of the things we decided to do this
8 year was look at on the impact probability, not only
9 the risk, would it happen, but what the impact would
10 be and how likely different things would happen and
11 what charge within in O.H.A.P. looking at -- at risk
12 populations. And one of those, of course, is our
13 pediatric -- pediatric population. So we -- we
14 targeted in -- in the survey one particular question,
15 which was, to the best of your -- best of your
16 knowledge, how likely could these hazards, and we
17 list a bunch of hazards, have an impact on the
18 pediatric population?
19 So I just wanted to talk about a
20 couple of the hazards, not the whole list of things
21 that we did, but just a few that we're finding some
22 interesting results and things we're going to look at
23 more closely, maybe even do some tabletops in the
24 future. We, of course, do work with both our
25 hospital and pre-hospital folks when we do these --

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2 these tabletops, particularly the E.M.S. folks in the
3 different attachment areas. So one of them was
4 weather events, and we found that the likelihood was
5 pretty much middle of the road when we surveyed the
6 hospitals. You know, it's -- it's -- it's something
7 that's going to happen. We know it's going to
8 happen. These weather events can be from hurricane,
9 nor'easter, severe storms, both have summer, winter
10 types and -- and -- and we seem to get those all the
11 time.
12 So no one at this point is going
13 either way on them. We looked at electrical power
14 outages and it was felt, those are probably not
15 likely, although we did have that big one during
16 Superstorm Sandy a number of years ago. And during
17 the first time of COVID, we had a fairly major storm
18 that did cause some blackouts Downstate in the Nassau
19 Suffolk area. But again, they're not looking at that
20 being a likely thing that's going to happen to affect
21 the pediatric population. M.C.I. hazmat was not
22 overall likely. But hazmat itself affecting
23 pediatric patients. So of course, the M.C.I. one
24 would be a rail accident, a trucking accident, some
25 type.

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2 But they did feel that hazmat itself
3 would be and we are looking at mostly things like
4 plumes and we've had a couple of big box stores in
5 the past catch fire. one was a pool store, so we had
6 chlorine, one was a major pesticides big box store
7 nursery. And we had of course organic phosphate
8 plumes now in the air. And at both of those, there
9 were healthcare facilities and schools in that
10 particular area. So that one was kind of like very
11 likely, which was interesting. Extreme heat, again,
12 middle of the road, how it would affect the peed --
13 pediatric population as far as E.D. visits, primary
14 care visits, trauma center visits, and so on. Poor
15 air quality, although we just went through a -- a
16 very big poor air quality week when we had the
17 Canadian fires.
18 Again, it would seem to be a not
19 likely situation that we'd be looking at on a regular
20 basis. And then of course there was just a general
21 M.C.I. pediatric. Again, it was considered not
22 likely, although we do know we have school trips. We
23 did have, you know, a -- a large accident with a -- a
24 bus on I-84 up in the Hudson Valley region where we
25 did have a number of folks on board injured and or

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2 did unfortunately did pass away. Again, it -- it's
3 something that doesn't seem to be something they look
4 to as being something they need to plan for. And the
5 last thing was the active shooter and that was
6 somewhat likely, you know, we do drill all the time
7 with the -- the schools and the hospitals together in
8 E.M.S. works for a school and museum and children's -
9 - children activity centers and so on throughout the
10 region.
11 So that was considered somewhat
12 likely. So we're going to continue to flush this
13 out. Continue to put all this together. You know, I
14 continuously talk to you, Amy, about a lot of these
15 things and as we move forward, you know, we'll
16 definitely let this group know where, you know, our
17 pediatric hazards and threats, you know, may come
18 from and how, you know, the hospitals. Because
19 again, primary focus of my program is the hospitals
20 is looking at mitigating and training for, and also
21 reaching out to E.M.S. folks in the captured area.
22 So anyone has any questions I will take them.
23 **CHAIR COOPER:** Questions for -- for
24 Drew?
25 **MS. EISENHAUER:** I have a question.

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2 **CHAIR COOPER:** Sure.
3 **MS. EISENHAUER:** So you mentioned that
4 there was the feeling that many of these potential
5 disasters were not likely even though we have
6 recently had some of those incidents occur. Was this
7 database, was this kind of a survey where, you know,
8 the responses were how likely do they feel at their
9 facility? How was that information collected?
10 **MR. FRIED:** All right. So this was
11 put out in a SurveyMonkey format where the question
12 was asked. And there was a -- a rating scale of one
13 to five, five being most likely, one being of course
14 least likely. We then also looked at for some of the
15 events, how it would affect us over time. Would it
16 be less than two weeks of an impact, greater than two
17 weeks of impact? This is just a small sampling of
18 what we actually did. And this is only phase one,
19 phase two of our program is going to be looking at
20 the capability and capacity for these events.
21 Although, yes, you are right. We had a few of these
22 events that have happened when we look at
23 probability.
24 But when we do, when the hospitals do
25 a true H.V.A. where they're actually scaling it, they

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2 look at facets of the possibility of it happening in
3 that year one to twenty percent, twenty to forty
4 percent, forty to sixty percent, sixty to eighty
5 percent and eighty to a hundred percent. So it's not
6 based on history. Such as Superstorm Sandy, we told
7 everyone the following year, don't rate storms,
8 number one. Yes. And it happened. Just the
9 probability of it happening again. Hopefully not,
10 statistically we would say no. Although we had Irene
11 so we had two years in a row.
12 **MS. EISENHAUER:** Exactly.
13 **MR. FRIED:** (unintelligible) but when
14 we look at the H -- when you look at the
15 H.V.A .program, which Kaiser Permanente is one of the
16 biggest, it actually puts it out. The probability is
17 nothing. It's not history. It's do you think it can
18 happen? And you got to look at a number of things
19 for that could be the weather for the last ten years
20 when it comes to storms or the history of something
21 in for a particular thing. Active shooter. Yeah.
22 The probability, although it happens throughout the
23 country for us down here, has been kind of forty
24 percent. Because it can happen, but no one's looking
25 to gear it up and saying, hey, we know that's going

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2 to happen tomorrow.
3 **MS. EISENHAUER:** And then just one
4 follow-up question. You did mention weather
5 emergencies and you did mention Hurricane Sandy and
6 Irene and I did get to work in both of those storms
7 down in the New York City area. So yes, they were
8 quite something. However, over the past three to
9 four years, there's been major flooding incidents in
10 New York City and that surrounding area. Is that one
11 of the weather events that we're looking at, or?
12 **MR. FRIED:** I actually have flooding
13 kind of teased out separately. I did not include
14 that, you know, looking at that today for you, I was
15 looking more just at the storm first thing. Flood is
16 going to be pulled out separately because this, it is
17 happening more and more and it's happening more
18 because of the geography of the land is changing all
19 the time as we move forward with progress.
20 **MS. EISENHAUER:** Yeah. Okay. Thank
21 you.
22 **CHAIR COOPER:** Thank you, Drew. Any
23 other questions for Drew? Okay. Mike McEvoy, are
24 you with us? I know that -- that SEMAC did not meet
25 in December for lack of a quorum. But they are

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2 meeting next week. But State council did meet do you
3 have a -- an update for us from SEMSCO?
4 **MR. MCEVOY:** Yeah. So I can give you
5 a little bit of feedback on what's happening coming
6 up next week and what happened at the meetings in
7 December. So obviously you heard from Ryan earlier
8 about the budget and we're pretty excited to once
9 again be included in a big way with that. One of the
10 thing -- things that will come up at the meeting next
11 week is, as you know, the SEMSCO was charged in last
12 year's governor's budget legislation to develop
13 performance standards for E.M.S. agencies, dispatch
14 centers, and emergency departments.
15 We had a group that's been working on
16 that for the last several months. And they
17 consolidated the work that had been done by several
18 of the SEMSCO committees into four, four or five, I
19 don't remember off the top of my head,
20 recommendations to the SEMSCO for adoption. And from
21 those, the SEMSCO will probably pick two of those
22 that will then become legislated performance
23 standards Statewide. So that's to be continued. One
24 of the hot topics that was discussed in December and
25 May actually get moved with a motion next week, is

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2 the sunsetting of the E.M.T. critical care level
3 which exists only in New York State and nowhere else
4 in the United States.
5 There's been a lot of discussion about
6 the inability to continue to test at that level since
7 there really isn't a -- a valid curriculum. And as
8 these folks who do that are aging out, we're seeing a
9 -- a precipitous drop in the number of people who
10 remain cert -- certified at that level. For the last
11 three years, we've provided them an opportunity to
12 take an online bridge to go from critical care to
13 paramedic. And the numbers in those courses are
14 dropping now to just a handful each time that they
15 run them. So some date will probably be chosen at
16 the meeting next week to actually sunset that level
17 of certification.
18 There was in December, a significant
19 discussion on conflict of interests and for anyone
20 who was there at the meetings it was quite agitating,
21 I would say. So we're doing some presentations. We
22 did one this morning. We'll have one the Monday
23 night before SEMAC and SEMSCO to help do some ethics
24 training from the State ethics folks. And I think
25 that they'll also be in attendance at the SEMSCO

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2 meetings next week on Wednesday to help clarify
3 questions that members may have. You may know
4 already that there are a whole set of regulations out
5 for public comment on education and really minimal
6 comments have come in about those. So it is possible
7 that those regulations will be adopted once their
8 comment period closes, which is in about another week
9 or so.
10 And then, if necessary, they will go
11 out again for another round of public comment. I'm
12 not sure that any substantive comments have been
13 received, which would result in them having to go out
14 for another ninety-day comment period. But that
15 remains to be seen. And there are some good things
16 in education that have been incorporated into those
17 regulations, which would extend the certification
18 period, facilitate the use of other kinds of
19 education besides classroom, do some more virtual and
20 online training, and really revamp some of the
21 problem regulations that inhibit us from being able
22 to train the number of people that we need to train.
23 The Innovations Committee has a new
24 chairman and that's Dr. Michael Redlener, who many of
25 you may know from Mount Sinai. And he has been doing

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2 some work over the last month since he took over the
3 Committee on treatment in place and transport to
4 alternate destinations. Because of the success of
5 the E.M.S. community across New York State last year
6 in getting direct payment approved by the legislature
7 and then signed by the governor we have legislators
8 tripping over each other, coming to the E.M.S.
9 associations around the State to see what they can do
10 to help us this year. And the big push has been
11 approving payment for treatment in place and
12 transport to alternate destinations.
13 So the Innovations Committee has been
14 working on the -- the language for those and will
15 help facilitate the process once some of those things
16 are -- are put in place. As you know they were
17 included in -- in the governor's budget. And so I
18 think we'll definitely see something happen along
19 those lines. Innovations has also been involved with
20 the task force on Daniel's Law, which is a group that
21 was put together for helping to fix some of the
22 issues with response to mental health problems that
23 occur. And the impetus behind that was some adverse
24 interactions with law enforcement and people with
25 mental illness that did not end well.

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2 And so the -- we have a representative
3 from SEMSCO who's been serving on that committee. He
4 came to SEMSCO and to the Innovations Committee
5 somewhat concerned because one of the directions that
6 that group has been leaning towards is not to respond
7 by any law enforcement to any behavioral health
8 emergency that occurs. And we have a strong concern
9 about the protection of our providers when scenes
10 turn violent. And so we're in the process of
11 providing some feedback to that group so that we can
12 come to some equitable conclusions about how those
13 emergencies are best responded to. And then the last
14 piece is another very controversial work group that
15 has been meeting fairly regularly chaired by Dr. Paul
16 Barbara, who several of you probably know from the
17 New York City area.
18 And that's a group that's been working
19 on credentialing. And there has been a great deal of
20 discussion between the bureau and the regional
21 program agencies on their ability to credential
22 paramedics, how they do that, how they de-credential
23 people. And so that group has been working through
24 that, that whole controversy, and will ultimately
25 come out with recommendations to the bureau and

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2 perhaps recommendations for new regulations that will
3 help to facilitate that process -- process and
4 standardize it across the State. So kind of in a
5 nutshell, that's what's been happening and what will
6 happen. So to be continued. Happy to take any
7 questions.
8 **CHAIR COOPER:** Thank you, Mike.
9 Sounds more like a coconut shell than a nutshell if
10 that's where we are. Lot of -- lot of stuff has
11 happened. Any questions for Dr. McEvoy? Hearing
12 none. Let's move on to State trauma groups. Kim
13 Wallenstein, are you with us today?
14 **MS. WALLENSTEIN:** I am. So thank you,
15 Dr. Cooper. So the STAC met last week and the
16 pediatric subcommittee also met as well. And I'll
17 briefly go over what we talked about there. We sort
18 of focused on three different areas. One was our own
19 internal investigation of our quality reports. And
20 that was our T group reports that we went over to see
21 if we were truly high outliers in any areas. We
22 reviewed those things amongst ourselves. The more
23 robust conversations occurred around pediatric
24 readiness. We heard earlier from Amy Eisenhauer
25 about the Always Ready for Children program. And we

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2 talked a lot about that and how we are best suited to
3 help with that initiative and get the word out to
4 smaller hospitals.
5 I know from even my local region, I'm
6 up in the central New York region. We had our ARTEC
7 meeting recently too, also last week. And even after
8 Amy has come around and talked to that group, and
9 I've talked to that group still, the, you know, when
10 we mentioned the, the Always Ready for Children
11 program, there's a bunch of just crickets in the room
12 and wide eyes of people looking like they want to be
13 somewhere else, so. So I think that there's a lot --
14 there's a lot of challenges in -- in that program and
15 getting that out to, especially the smaller
16 hospitals. And we are looking forward to helping
17 with that initiative however we can. The third thing
18 that we talked about was we had a -- a little bit of
19 a discussion about apps, like phone apps and iPad
20 apps that exist for E.M.S. providers to take care of
21 children.
22 We had a brief presentation on, I
23 think an app that was previously supported, the
24 Handtevy app, but then it was mentioned that there's
25 a Muru app that is now the newest supported app. I

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2 am now updated on that app. I talked to one of the
3 people from that this week. And that seems like a
4 really important tool that E.M.S. providers can use.
5 And I'll be looking forward to sort of polling at
6 least my region and seeing how that is being used
7 among the E.M.S. providers and bringing that report
8 back to the STAC committee. And that briefly was
9 about it.
10 **CHAIR COOPER:** Thank you, Kim. Any
11 questions for Kim? I do have one small addition
12 after -- after you have questions for Kim from the
13 group. Hearing none, I think the -- probably the big
14 issues at the main STAC meeting, which affect Peds as
15 well have to do with some registry issues. The first
16 one, focusing on a -- a streamlined definition of
17 D.O.A. versus D.I.E. That's always been a bone of
18 contention. You know, among, you know, the trauma
19 registry community, not only Statewide but
20 nationwide. But the new definitions have been, you
21 know, have been suggested and approved by the STAC.
22 You know, which I won't get into now, except to say
23 that they make life a whole lot simpler.
24 The short and sweet is that if you
25 arrive in the E.D. with no vital signs and never get

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2 vital signs back, no matter what is done, you're
3 considered – you're considered D.O.A. If you arrive
4 in the E.D. with no vital signs and or, you know,
5 poor vital signs and work is undertaken to
6 resuscitate you which is unsuccessful, that counts as
7 the D.I.E. So that's the short and sweet of it. The
8 other big registry issue had to do with the fact that
9 there's the new vendor in town and, you know, there's
10 -- there's been a push to get everybody on board --
11 board with the new registry vendor you know, by
12 January 1st of next year.
13 And I think the registrar's uniformly
14 felt that that was too ambitious a timetable given
15 the fact that switching over from one register to
16 another always takes a very, very long time. So that
17 is in discussion with the department at the moment.
18 I don't have an update beyond the fact that the issue
19 was brought to the department. And you know I'm sure
20 there'll be further discussion on it. I think those
21 were the really big issues that came out of the --
22 the main STAC meeting. Of course, the -- the issues
23 that Kim mentioned, I think are of greater concern to
24 us than the STAC at large. But those two issues that
25 I mentioned will certainly affect the pediatric

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2 trauma centers as well. Any questions for me or Kim
3 on either of those items?
4 Okay. Well, wow. I did not -- I did
5 not think we would ever get this agenda finished in
6 three hours. We had a lot to discuss, a bunch of
7 different presentations from experts in various areas
8 and a lot of work to do over the next few months.
9 But the committee has really stepped up in the last
10 little bit here and, you know, we are on a roll, so
11 I'm looking forward to our meeting in May. I think
12 you said May 8th. Am I right, Amy? At the Troy
13 Hilton Garden Inn. Amy?
14 **MS. EISENHAUER:** Yes. Sorry, I had to
15 get to the mute button because I'm using Ryan's
16 computer set up and it's --
17 **CHAIR COOPER:** No problem.
18 **MS. EISENHAUER:** -- much different
19 than mine. So --
20 **CHAIR COOPER:** It's May 8th, still?
21 **MS. EISENHAUER:** No, no, that is
22 wrong. Hang on, I have it here. So --
23 **CHAIR COOPER:** Thank you for
24 correcting me.
25 **MS. EISENHAUER:** -- E.M.S. for

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2 Children meeting will be May 6th.
3 **CHAIR COOPER:** May 6th.
4 **MS. EISENHAUER:** On Monday. Yes. So
5 May 6th on Monday is the E.M.S. for Children meeting
6 at twelve noon till three p.m. The seventh is the
7 subcommittee meetings for SEMAC SEMSCO, and then the
8 eighth is SEMAC and SEMSCO.
9 **CHAIR COOPER:** Great. Thank you.
10 **MS. EISENHAUER:** Yes.
11 **CHAIR COOPER:** Okay. So does anybody
12 else have anything they want to bring up for the
13 children of New York State in their emergency care?
14 Hearing none, we got our tasks for today completed
15 with about five minutes to spare. I want to thank
16 everyone for their participation and specifically
17 their active participations. Been a great meeting.
18 A lot of -- a lot of information got -- got shared
19 and I'm really looking forward to the next few months
20 as we bring some of these projects -- projects to
21 fruition. So without further ado, I'll entertain a
22 motion for adjournment. I guess no one wants to
23 adjourn the meeting.
24 **MR. VAN DER JAGT:** Second.
25 **CHAIR COOPER:** Okay. All right. So

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2 all in favor of adjourning to say aye.
3 **MEMBERS:** Aye.
4 **CHAIR COOPER:** All right. Thank you.
5 Well, we'll see you all on May 6th at Hilton Garden
6 Inn in Troy at noon. Okay. And thanks again to
7 everybody, especially, especially to our committee
8 chairs most especially to Amy Eisenhauer from all the
9 work she does on behalf of -- of all of us. Thank
10 you so much. Take care everybody.
11 **MS. EISENHAUER:** Carrie, do you need
12 anything else from me?
13 (The meeting concluded at 3:56 p.m.)
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2 STATE OF NEW YORK
3 I, CARI RORABACK, 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 142, 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 16th day of February, 2024.
11
12
13 CARI RORABACK, Reporter
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