

5/6/2024 – E.M.S. for Children – Troy, New York
NEW YORK STATE
DEPARTMENT OF HEALTH
E.M.S. FOR CHILDREN
ADVISORY COMMITTEE

DATE: May 6, 2024
TIME: 12:11 p.m. to 2:51 p.m.
CHAIR: ARTHUR COOPER
LOCATION: Hilton Garden Inn
235 Hoosick Street
Troy, New York

Reported by: Danielle Christian

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- 2 **APPEARANCES:**
- 3 Amy Eisenhauer
- 4 Ben Sensenbach
- 5 Benjamin Kasper
- 6 Bruce Barry
- 7 Chief Joseph Pataky
- 8 Daniel Clayton
- 9 Deanna Ratigan
- 10 Douglas Hexel
- 11 Dr. Alda Osinaga
- 12 Dr. Brian Clemency
- 13 Dr. Edward Conway
- 14 Dr. Elise Van Der Jagt
- 15 Dr. Kevin Albert
- 16 Dr. Kim Wallenstein
- 17 Dr. Linda Efferen
- 18 Dr. Matthew Harris
- 19 Dr. Pamela Feuer
- 20 Dr. Peter Dayan
- 21 Dr. Tiffany Bombard
- 22 Dr. Vincent Calleo
- 23 Drew Fried
- 24 George Stathidis
- 25 Kate Butler-Azzopardi
- Kate Rose Bobseine
- Kris Alfonso
- Marilyn Kacica
- Meghan Williams
- Michael McEvoy
- Nichol O'Toole
- Ryan Greenberg
- Sharon Chiumento
- Steven Blocker
- Susan Stegich

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(The meeting commenced at 12:11 p.m.)
DR. COOPER: So, good afternoon, everyone. My name's Art Cooper. I have the honor of chairing the -- this committee, the Emergency Medical Services for Children Advisory Committee to the New York State Department of Health. And it's good to see you all here today for one of our quarterly meetings. It appears that we do have a quorum, but - but Amy Eisenhower will be formalizing that in just a moment.

But I just wanted to welcome, welcome you all. Good to see everyone again. And we have, of course, you know, a busy agenda today. So, without further ado, we'll get started. And the first item of the business is for Ms. Eisenhower to ensure quorum.

MS. EISENHOWER: Thank you, Dr. Cooper. And for our court reporter, if we're not already on the record, we can go on the record. Dr. Cooper?

DR. COOPER: Here.

MS. EISENHOWER: Dr. Van der Jagt?

DR. VAN DER JAGT: Here.

MS. EISENHOWER: Dr. Albert?

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DR. ALBERT: Yes, present.
MS. EISENHOWER: Bruce Berry.
MR. BARRY: Present.
MS. EISENHOWER: Sharon Chiumento.
MS. CHIUMENTO: Present.
MS. EISENHOWER: Dr. Conway.
DR. CONWAY: Present.
MS. EISENHOWER: Dr. Feuer.
DR. FEUER: Present.
MS. EISENHOWER: Dr. Calleo
DR. CALLEO: Present.
MS. EISENHOWER: Doug Hexel is excused, as he and his wife might be having a baby shortly. Nicole O'Toole.
MS. O'TOOLE: Present.
MS. EISENHOWER: Dr. Bombard? Dr. Harris is excused. He emailed me this morning. He is a little bit under the weather but wishes us well and is probably watching. So hello, Dr. Harris. Chief Pataky?
MR. PATAKY: Present.
MS. EISENHOWER: Jason Hague emailed me saying that he would not be here today. And Ben Kasper?

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 2 **MR. KASPER:** Present.
 3 **MS. EISENHOWER:** And we have quorum.
 4 **DR. COOPER:** Thank you. So, the next
 5 item on the agenda is approval of the minutes from
 6 our February meeting. I trust you've all had an
 7 opportunity to review them. They were distributed
 8 via email sometime prior to the meeting. And so,
 9 I'll ask at this time if there are any additions,
 10 deletions, or corrections to the minutes?
 11 **MS. CHIUMENTO:** There is one
 12 correction on page -- let me see -- this one, twelve.
 13 Somehow FDNY became SKDNY. So, it's -- it was S-K-D-
 14 N-Y instead of F-D-N-Y. So, it just needs to be
 15 changed.
 16 **MS. EISENHOWER:** Thank you.
 17 **DR. COOPER:** Thank you, Sharon. Any
 18 other comments? All right. Well, hearing none, I
 19 will ask for a motion to approve the minutes.
 20 **MS. CHIUMENTO:** I'll make the motion.
 21 **DR. COOPER:** Thank you, Sharon. A
 22 second, please.
 23 **DR. CONWAY:** Second.
 24 **DR. COOPER:** Thank you, Ed Conway.
 25 Any discussion? Hearing none. All in favor, please

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 2 signify by saying, aye.
 3 **THE COMMITTEE:** Aye.
 4 **DR. COOPER:** Opposed? Carries without
 5 dissent. Thank you so much. Okay. The minutes are
 6 approved. So, the next item on the agenda, of
 7 course, is from the very famous and accomplished Amy
 8 Eisenhower, our E.M.S.C. Program Manager, who will
 9 report on the status of the program and several items
 10 pertaining thereto. Amy?
 11 **MS. EISENHOWER:** Thank you, Dr.
 12 Cooper. So, the first part that I will talk about
 13 today is our Always Ready for Children Pediatric
 14 Recognition Program. I'm very excited to have been
 15 at several events, again, promoting the program. And
 16 first I'll share that much thanks to Piswa and Peg.
 17 Our website has been updated, and I will show you.
 18 So, we've had the page for -- since
 19 last June. However, they have now listed all the
 20 hospitals that have joined Always Ready for Children,
 21 and these are those so far. So, they are listed by
 22 county. And as we get more on the screen, you will
 23 be able to select by county and see which children's
 24 -- or which hospitals are participating in the
 25 program around the State. I also would like to give

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 2 a big shout out to the Monroe Livingston area,
 3 the -- the Finger Lakes RTAC. Lauren
 4 Pearson and Adam out there at -- at Strong have been
 5 doing great work, working with their hospitals in
 6 their region and their associated hospitals to get
 7 them to join and helping them with the survey and
 8 kind of mentoring the other hospitals in their
 9 system, which leads me to another really great
 10 announcement and partnership. Over the last month or
 11 so, the E.M.S. for Children Innovation and
 12 Improvement Center has -- has a grant from Toyota,
 13 which they are doing pilot programming in Michigan
 14 and in Texas right now.
 15 Having a nurse at the Emergency Nurses
 16 Association in those states come into each of their
 17 trauma regions to be kind of that mentor, right, and
 18 help them with the assessment of their E.R. With
 19 doing the -- the survey, going through things,
 20 finding out where they're at, getting that base
 21 level, and then what next steps are based on what's
 22 already there and -- and fulfilling the needs that
 23 those facilities might need.
 24 So, I'm very excited that there was a
 25 little bit of money left over. And I like -- I like

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 2 to think that they just love New York, but also, I
 3 understand I'm the squeaky wheel. And so, there's a
 4 little bit of money left, and we just got into
 5 conversations with New York State E.N.A. for having
 6 one, maybe two of our trauma regions have this nurse
 7 Pediatric Emergency Care mentor.
 8 So, that is just in the beginning
 9 stages. And much thanks to New York State E.N.A. and
 10 Patrick Byrne for partnering with E.I.I.C. and our
 11 State program to -- to get these resources out there
 12 to the trauma regions. And more information will be
 13 coming on that it really is like that brand new. But
 14 I went to the E.N.A. conference two weeks ago.
 15 There's state conference. I talked about Always
 16 Ready for Children and got a lot of interest from
 17 different programs, and they're very excited.
 18 So, that's great news. We also had a
 19 meeting between our group -- certain members of our
 20 group, and pediatric STACs, so certain members of Ped
 21 STAC on promotion and outreach for Always Ready for
 22 Children to hospitals and what can be done. And so,
 23 we had our first meeting. And so, kind of getting
 24 everybody on the same page and -- and we're going to
 25 continue that work. So more to come on that also in

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 2 the future.
 3 Let's see. Let's see. So, the
 4 NOSEMISO -- I'll go back to this. So, the NOSEMISO
 5 Pediatric Restraint Device Testing Advisory Group
 6 that is -- sorry. Okay. So, that work is almost
 7 complete, at least the advisory part. The final
 8 document, I think right now they're having their
 9 final meeting, so good luck to them on that. But
 10 they have been sending us back the completed
 11 documents. Everybody's been kind of leaving comments
 12 and edits. So, hopefully those documents will be
 13 complete shortly to go to S.A.E. to begin their
 14 review of it, and actually begin building the, you
 15 know, potential testing which is exciting. And
 16 NOSEMISO continues to work on finding funding for the
 17 testing process. So, if you guys have any
 18 connections, you know, we need a few million dollars.
 19 It's not a lot.
 20 Next is the E.M.S. for Children Data
 21 Center, or the E.D.C. Pre-Hospital Readiness Project
 22 st
 23 Survey. So, this started May 1, this was released.
 24 You may have gotten an email from a constant contact.
 25 Please fill out your survey. This will be -- you're
 just going to hear me like this for the next three

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 2 st
 3 months. So, it started May 1; I believe it goes to
 4 July 31st. They did redesign the survey this year a
 5 little bit, and here, let me find it and I'll show
 6 you. So, as you can see on here, they designed the
 7 E.M.S. survey to be more congruent with the hospital
 8 survey, to really provide an -- an assessment for
 9 your agency to look at and see how prepared are you
 10 for pediatrics, and then give you that next step of,
 11 okay, this is where you're at, this is what you can
 12 do next, this is how you can make that flourish. So,
 13 it's emspedsready.org. And it does have a lot of
 14 components right here just on this page. You can
 15 start your assessment, and I'll go through that in a
 16 moment. You can also print a copy of the assessment.
 17 It's in English and in Spanish if you're more
 18 comfortable with Spanish. And there are some links
 19 to a FAQ and then pediatricreadiness.org. Also,
 20 there's an email to the E.D.C. Center. You can also,
 21 of course, email me. So, more information all on
 22 this page.
 23 And at the -- down here resources,
 24 there's a toolkit and a checklist in case you want to
 25 read them, you need some extra information; that's
 there for that. Also, they built this map. So, I

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 2 will say New Jersey, right, New Jersey looks like
 3 they're super overachievers that in just a few days.
 4 So, New Jersey, North Carolina and one other -- one
 5 other program were the -- the guinea pigs. They were
 6 the beta testers.
 7 So, New Jersey has a hundred percent
 8 because they already did this. So, they started in
 9 January and ended, you know, in the beginning of
 10 April. So, they were the beta tester just to see how
 11 everything went to kind of fine tune the messaging
 12 and information that goes out to the E.M.S. agencies,
 13 to all the E.M.S. for Children programs.
 14 So, that's why some of these numbers
 15 are super high because they were the testing guinea
 16 pigs. So, that is ongoing. Also on Vital Signs
 17 Academy, there is a tutorial for -- for the survey
 18 where I went through it. I went through all the
 19 questions. A lot of it is similar, right, where
 20 we're asking about pediatric education, but it goes
 21 into a little more detail, like, okay, what -- what
 22 kind of pediatric education, how are you approaching
 23 that, what things are you using, right? Because we
 24 don't really have a comprehensive picture of E.M.S.
 25 pediatric readiness across the country. And so,

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 2 that's what this is meant to be, to kind of see,
 3 okay, where are we at? What resources do we need to
 4 build? What resources do we need to offer?
 5 So, please complete your survey
 6 because it will help the New York State program be
 7 able to know what resources our State needs, and how
 8 we can better serve you. But also, it helps the
 9 larger E.M.S.C. program know what is needed in the
 10 states and what is needed by the agencies. So,
 11 please do your survey. So, Nickol O'Toole, who is
 12 our Family Action Network member, we kind of chatted
 13 about this. Did anything come in the FAN meeting
 14 specific to this?
 15 MS. O'TOOLE: No. Just other than it
 16 was coming out May 1st, and we do have till July 31st
 17 to get it done. And they said that the biggest push
 18 is from our State reps. So, hopefully we can get it
 19 out there. And I was going to say, let's try to beat
 20 New Jersey, but that's not going to happen. We'll do
 21 our best.
 22 MS. EISENHOWER: Eric Hicken is
 23 persistent. Yes. And he has a large office team to
 24 help, yes. So, we also have some additions to our
 25 teams, speaking of E.M.S. for Children's teams. So,

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 2 I would like to introduce Allie Lynch. She's in the
 3 back. Wave your hand. So, this is Allie. We are
 4 very lucky to have her. She's really great and thank
 5 God. So, she will be handling the Pediatric
 6 Emergency Care coordinator for pre-hospital, kind of
 7 handling the administration of that, the updates, all
 8 of that, helping me with the survey and kind of
 9 making those things happen because I'm all over the
 10 place, and -- and other duties as assigned, which
 11 she's finding out about. And I'll tell you more
 12 about the other duties as assigned in just a few
 13 moments. So, welcome to Allie. You'll be hearing
 14 from her and, you know, if you can't find me, you can
 15 find her, and she'll be happy to help you or find
 16 somebody who can.

17 We also posted for our E.M.S. for
 18 children data position, and those resumes came back.
 19 Peter went through them. So, we're in the process of
 20 planning interviews. So, hopefully by our next
 21 meeting in September, we will have an E.M.S. for
 22 children data specialist. Peter, what is the actual
 23 title?

24 **MR. DAYAN:** The actual title is E.M.S.
 25 Data Coordinator, and in parentheses, Pediatric.

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 2 **MS. EISENHOWER:** Thank you. Yes.
 3 We've -- we changed the name so many times. I'm just
 4 like, it's a -- it's a data person for kids. I -- I
 5 don't know the actual official title, but that's what
 6 it is. So, we're hiring for that. I don't know if
 7 Ryan is going to cover this in his report.

8 **MR. GREENBERG:** I can cover it right
 9 now.

10 **MS. EISENHOWER:** Go ahead.

11 **MR. GREENBERG:** So, I'm guessing you
 12 didn't yet?

13 **MS. EISENHOWER:** No, not, I gave some
 14 people a pre-warning.

15 **MR. GREENBERG:** So, hi everybody.
 16 So, with promotions and -- and new staff members,
 17 like I said, a couple. We've had a lot of new staff
 18 members actually in the bureau overall. And there's
 19 also been different opportunities that have opened up
 20 with different grants as well. And so, last week we
 21 did officially announce that our own Amy Eisenhower
 22 is taking a promotion and is going to become the new
 23 vital sign, sorry, the Vital Signs Coordinator, which
 24 is a public Health Specialist, something, forgive me
 25 on the technical title of H.R.I. So, she'll be

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 2 taking on a new responsibility -- some new
 3 responsibilities, or a new role within the bureau.
 4 Dr. Cooper, don't worry, she's not drastically
 5 leaving quickly. We understand that there's a
 6 transition, but we are very excited for her to -- to
 7 have this promotional opportunity. And
 8 congratulations to you for all the hard work that --
 9 that got you there.

10 So, with that, I will add, we have
 11 been working on the job description for the new
 12 E.M.S.C. coordinator, and we hope to have that posted
 13 in the next couple of weeks. So, particularly for
 14 this -- committee members and things like that, we
 15 would say, please keep your eyes open. We'll make
 16 sure to share it, obviously with everyone. But it's
 17 an exciting opportunity.

18 And I think it's also the right time
 19 to talk a little bit, if it's okay with you, Amy, for
 20 what the future of that looks like too. E.M.S. for
 21 children for many years, you know, when Martha was
 22 here and -- and, you know, for the time that -- that
 23 the bulk of the time that I've been here has been a
 24 single person, because the way the E.M.S.C. grant
 25 works nationally is every state gets the same amount

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 2 of money. So, whether you're in the middle of
 3 Nebraska or you're -- no offense to Nebraska, whether
 4 you're in Nebraska or New York, whether you have ten
 5 hospitals in total, or two hundred, if you have fifty
 6 E.M.S. agencies or a thousand, you get the same
 7 amount of money. And so that's been challenging for
 8 New York, and we've always -- we continue to lobby to
 9 see if there's anything additional that can come of
 10 that additional funding or things of that nature.

11 But that's also led us with some
 12 restrictions in the past that, for the most part, has
 13 led us to only be able to have one person or one
 14 full-time person in the E.M.S. for Children Program.
 15 And that, of course, has its own challenges, as well,
 16 as when there is transition or change when Martha,
 17 you know, took another opportunity within H.R.I., or
 18 in this situation where Amy's moving up; that it
 19 leaves a void and a gap. And one that we would like
 20 to hopefully in the future try and avoid having that
 21 situation. So, the future of our grant arm or grant
 22 arm, including a number of different grants that
 23 we've run through the Bureau is to be more of a
 24 collaborative community approach and a community
 25 outreach approach. And so, looking at Vital Signs,

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2 looking at E.M.S. for children, looking at many of
3 these different roles and grants, and having a team
4 of people working together is one on several things
5 rather than just one person in a silo working on
6 things.

7 So, as transition happens, and there
8 will always be a primary E.M.S.C. person, there will
9 always be a primary Vital Signs person, but there
10 will also be shared knowledge amongst them, as well
11 as resources, as different times of the year tend to
12 have different demands on different programs and
13 different things that are out there. For this time
14 of the year, it's a survey demand.

15 So, we're excited about what the
16 future looks like. I -- I will tell you -- I can --
17 I can assure you, even you will continue to see Amy's
18 smiling face at -- at a lot of things, and, you know,
19 do -- helping us push forward the pediatric
20 initiatives in the State. But hopefully we'll start
21 to see that team grow even further with the data
22 analysts and with, you know, our student assistants
23 and a number of different roles that are coming and
24 seeing a more collaborative approach to it. So,
25 we're excited about what the future has to yield. We

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2 think it's going to be a number of really good
3 things, and that's the probably the big news of the
4 day.

5 **DR. COOPER:** Thank you, Ryan. Any --
6 **MS. EISENHOWER:** I have a few more
7 things too.

8 **DR. COOPER:** Any thoughts on that?
9 Well, I have some thoughts on that. I think Amy has
10 done an -- an extraordinary job in moving this
11 program forward. I think we all acknowledge that.
12 And I do hope that all of us can take a moment and
13 rise and thank Amy for an out -- for an incredible --
14 Thank you.

15 Now, if I know Amy, since she will
16 still be involved in the program, that means that she
17 will continue to do the job that she's been doing
18 even though she'll have some help doing it. But I do
19 imagine that that's -- as Director Greenberg has
20 pointed out, that that smiling face will be with us
21 for quite some time. And again, Amy, we are all so
22 grateful, but it's not our gratitude. It's the
23 children of New York State that are the ones who are
24 most grateful for all the work that you've done and
25 will continue to do, so thank you.

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2 **MS. EISENHOWER:** Thank you very much.
3 I'm a crier.

4 **DR. COOPER:** We noticed. So,
5 continue, please.

6 **MS. EISENHOWER:** Thank you, Doctor.
7 Thank you everybody. I really appreciate that. I
8 have a few other things as -- as usual. And so, Ryan
9 knows, right, I stalk him around the office and I'm
10 like, this thing, wait, it's just one small thing,
11 right? So, a few other things. So, some work that
12 we had done in two -- I believe two previous meetings
13 ago, discussing A.E.D. defibrillator pad
14 compatibility and use of Lifepak Twelve and Lifepak
15 Fifteen for B.L.S. agencies, right, those monitors
16 being only able to be used in manual mode for
17 patients eight and under. So that was recently
18 approved, like Friday. Let me find it.

19 So, we do have our health advisory was
20 approved. Just going over all of those points that
21 were in the original NOSEMSO Pediatric Emergency Care
22 Council Advisory. So, this is, right, highlighting
23 those important things so that people can then refer
24 to that advisory, make sure that they're in
25 compliance, have everything that they need to treat

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2 children that might need defibrillation.

3 So, all of that is here. And this is
4 in the process of being posted. It will be found I
5 believe shortly, because I've been here at the
6 meeting, on your H.C.S. account, and it'll go out to
7 E.M.S., to hospitals, to all healthcare
8 organizations. Also, I'm going to post it on our
9 website. I'm working with PISWA, so that, that will
10 be accessible there. And this will also go out to
11 all the listservs for E.M.S. stakeholders that our
12 office has. So, that will be coming out, you know,
13 now. As -- as we speak, it's being distributed. So,
14 I want to let you know, because your work and
15 interest really led to that. So, thank you.

16 Another thing that has been kind of a
17 long time coming, and we had discussed this at a
18 previous meeting. This is part of our rural -- our
19 E.M.S.C. Rural Health grant. So, we have these kits,
20 the PET kits that I've been talking about, and all
21 the pieces. And well, they're here. And so, Allie
22 and many of our student assistants and other health
23 through the office came, and we have put together
24 most of them. So, each E.M.S.C. PECC, so pre-
25 hospital PECC agency will get one. We're in the

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 2 process of mailing them and making sure that the
 3 listing contacts are correct. So, if your agency has
 4 had a change to the PECC or change to anything, and
 5 you're part of the PECC program, please go on our
 6 website and update your form, so that Allie can
 7 update that. We'll have the most recent contact
 8 information for your agency. Sadly, each agency only
 9 gets one, because the money was only so much money.
 10 But each will have one, and I'm compiling a list that
 11 will go out with them, so that you know where these
 12 things came from. And you can make as many more as
 13 you need if that's what you'd like to do. So, they
 14 come in a dry bag, and there's a lot of stuff in
 15 here. Oh, and I think something that you guys
 16 haven't seen already. All right, we'll get to the
 17 rest of that. So, we also have been working on that
 18 pediatric agitation document.
 19 So, this is also posted on our
 20 website. So, you can get this right now on the
 21 E.M.S.C. website. Much thanks to everybody who, you
 22 know, contributed to this program and this project
 23 and all your hard work. So now we have a New York
 24 State one. It's very cute. So go online and grab
 25 it. Also, our updated P.A.T. document that you guys

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 2 have been working on, and much thanks to Sharon for
 3 doing all the editing, because that really helped,
 4 because otherwise I would've been like, I -- I don't
 5 know, like, just fix it. So, this is up to date. So
 6 -- and I mean, release two months ago. So, if you
 7 have not gotten a new P.A.T. document in the last two
 8 months, it's online. But you can also go onto our
 9 website, fill out the order form, and you can order
 10 either of these documents or the badge buddies, and
 11 Allison and I are -- are working on getting them out.
 12 So, you'll get one of each of these in the kit.
 13 You'll also get badge buddies for your
 14 agency. In the kit, you'll get twenty-five, so if
 15 you need more than that, you have to email us.
 16 There's also medical communication cards. So much
 17 thanks to all the other E.M.S. for children programs.
 18 So, we do a lot of work here, but other states also
 19 benefit from that. So, these documents I share with
 20 other state programs, these badge buddies I share
 21 with other state programs, so that we're not all
 22 recreating the wheel, because just like for a long
 23 time, there's only been one of me, in many other
 24 states there's -- there's only one of them. And so,
 25 when we all create something, we share it with each

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 2 other so that other states get the benefit. So,
 3 these were -- I believe we got these from Florida,
 4 and they got them from Michigan, and they got them
 5 from Kansas. And so, we're all kind of on the same
 6 page.

7 So inside, I don't know if you can
 8 see, right, it has a picture, it has words. It's in
 9 English and Spanish, but there's great resources in
 10 here. And I believe that these are also going to be
 11 put on Muru as an accessory. So yes, Steve just
 12 nodded, yes. These are also available on Muru.

MR. BLOCKER: All right.

MS. EISENHOWER: Yeah. Great. So, he
 15 says they're already on there. So, if you're using
 16 the Muru app, you can also access these on Muru. On
 17 the back there is a place where you can write, it's
 18 small, but it's something, and there's a dry erase
 19 marker in here too, so you can wipe it off when
 20 you're done with that patient. You also get a -- a
 21 Peditape.

22 So it's Broselow Tape, but a Peditape
 23 that -- that brand. You get a Pedi-Wheel, so dosing
 24 for children. You get a Handtevy Tape. If you use
 25 Handtevy, you can use that with their system. And

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 2 then we also have some STEM Toys, because not just
 3 neurodivergent kids need a little something. Or
 4 people, right, because this doesn't have to be for,
 5 you know, just children. But if you're scared and
 6 you're in an ambulance and you're a little kid,
 7 right, fiddling with something helps.

8 So, these are all rubber. You don't
 9 want to get forcey. So, you might have to replace
 10 these in time, because you know you're not going to
 11 get it back. But these little men, they stick to
 12 stuff, right, which is kind of neat. And then of
 13 course, the little poppers that if you have children,
 14 these are all over your house also. So, you get all
 15 of that in a dry bag to keep all of this stuff safe.

16 And so, over the -- over the next
 17 several weeks, we'll be mailing them out to PECC
 18 agencies that are already signed up. But we also
 19 have many, many, many for all of you who are going to
 20 want to sign up, so you can get cool stuff like this
 21 and get our monthly update and all the other things
 22 that the PECC agencies get.

23 And then my last thing, because the
 24 federal government was working on their budget and
 25 they went a little bit over, as it happens every

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2 year, the E.M.S.C. funding from -- from HRSA, we got
3 part of our funding. I'm still awaiting a final
4 notice for when the rest of the money's coming. So
5 just so that you're aware, we have funding, but it's,
6 you know, held up in the process. And I believe
7 that's everything for me unless people have
8 questions.

9 **DR. COOPER:** Questions? All right.
10 Well, then, hearing none, so I think it's time to
11 hear from Nickol O'Toole about the E.M.S. for
12 Children Family Action Network. Nickol?

13 **MS. O'TOOLE:** Thank you, Dr. Cooper.
14 I think Amy pretty much covered everything in my
15 report from HRSA. The committee met on March 20th,
16 and it's still all held up. And then also about the
17 May 1st, the assessments that came out. The only
18 other thing I have is E.M.S. week is coming up May
19 19th to the 25th, with May 22nd being E.M.S. for
20 Children Day.

21 So, it's also the fortieth anniversary
22 of E.M.S. for Children Day. So very exciting. And
23 if anybody wants to download some promotional
24 material, you can go on the EIIC website. They have
25 a lot of free things. So, that's it for my report.

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2 **DR. COOPER:** Questions for Nickol?
3 All right, hearing none, it is time for Director Ryan
4 to give us the latest and greatest. Thank you.

5 **MR. GREENBERG:** I'm going to keep it
6 brief because Amy took so much time, but I think
7 that's a good thing. She's -- I'm okay with that.
8 So, I think the big things just for this group to be
9 aware of is, you know, we did make it into the budget
10 this year from a proposed, you know, both funding and
11 legislative changes. Unfortunately, at the end, none
12 of the E.M.S. portions remained, so they came out,
13 but it really fostered some great conversations, some
14 really good things moving forward. And there's a
15 number of bills that are continuing or that are up in
16 the Senate right now in the house. So, we're still
17 waiting to see what happens in the remainder of the
18 legislative session. We know last year a portion
19 made -- a portion of E.M.S. things made it in during
20 the budgetary process, and then another portion of
21 things made it in through the legislative process,
22 but with the house and the -- with the Assembly and
23 the Senate.

24 So, we're excited to -- to see where
25 this yields and where it goes to, you know -- and you

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2 know, we had a lot of good progress last year too.
3 We have the System and Agency Performance Standards
4 Program that was created. We had the, you know, task
5 force initiatives that were created. So, a number of
6 things. And there's a lot going on and -- and moving
7 in a really positive direction for E.M.S. in many
8 different ways. So, we'll, you know, kind of wait
9 and see where that brings us. But a lot is on our
10 table and a lot of things moving in a good direction.

11 There's also some regulatory changes
12 going on right now on the E.M.S. side, so the
13 education regs are completed. They've finished the
14 public comment period. They'll be coming out or
15 going to SEMSCO for the final approval and adoption
16 that, so that will probably happen next four to six
17 weeks. Well, it'll happen this week for the final
18 approval. And then if it goes through, it will
19 happen next four to six weeks.

20 But we also have several other
21 regulatory packet changes that are -- that are
22 changing, some that affect this committee as well,
23 including equipment standards, and the new equipment
24 standards have different things, because of Amy,
25 that, you know, focus on pediatric care and making

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2 sure that, you know, we're prepared to treat those
3 pediatric patients. There's another one for blood
4 regulations, community paramedicine coming down the
5 pike, and I'm leaving one out, I apologize. But --
6 so there's a number of different things happening on
7 regulatory changes as well. And so, we're seeing a
8 lot of really strong and good movement -- oh, the
9 system agent performance standards regulations. That
10 was the other one. Thank you.

11 So a lot of really good things moving
12 in that front. The Bureau has been really happy, it
13 can't complain on being able to get new staff
14 including, you know, a number of student assistants
15 who've been phenomenal additions to our team, being
16 able to help with particularly some special projects
17 that aren't always regulatory in nature, but, you
18 know, more grant funds or things of that nature. And
19 give us, you know, a little bit more bandwidth and
20 opportunity to run reports or do statistical analysis
21 on things that otherwise, you know, might have to sit
22 on a back burner. So, we're excited to -- to see
23 those movements moving forward as well. So that's
24 everything that I think I got for right now and pass
25 back to you.

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 2 **DR. COOPER:** Sure. One question, this
 3 will probably come up at CMAG a little bit later this
 4 week, but I wondered if you could enlighten our
 5 committee about the status of the hiring of a medical
 6 director for the Bureau.
 7 **MR. GREENBERG:** Yeah, so we've gone
 8 back and forth. We did go through one round of what
 9 was going to be a contracted medical director. It
 10 did not yield the subject matter expertise; I believe
 11 that the department was looking to hire. And so we
 12 are moving forward on a permanent position. And I
 13 think you'll see that in this fiscal year.
 14 **DR. COOPER:** Would that be a full-time
 15 position or part-time?
 16 **MR. GREENBERG:** It looks like it's
 17 going to be a full-time position.
 18 **DR. COOPER:** Wonderful.
 19 **MR. GREENBERG:** Yeah.
 20 **DR. COOPER:** Okay.
 21 **MR. GREENBERG:** Wonder -- wonderful
 22 in some ways and challenging in others because
 23 sometimes full-time opportunities is not --
 24 **DR. COOPER:** Yes. Understood.
 25 **MR. GREENBERG:** Yes.

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 2 **DR. COOPER:** I think I -- I, you know,
 3 can express the wishes of the committee that the
 4 individual who the department ultimately selects have
 5 a, you know, significant background in pediatrics so
 6 that, that individual can work with us and -- and
 7 ensure that we can continue to provide the best for
 8 the kids throughout New York State. Thank you.
 9 **MR. GREENBERG:** Wholeheartedly agree.
 10 **DR. COOPER:** Yeah. Okay. I think
 11 we're up to some old business at this particular
 12 point. And the first item of old business to cover
 13 is the Monroe Livingston Regionally E.M.S. regions.
 14 A Handtevy implementation project. And we're lucky
 15 to have Dr. Maia Dorsett here with us today, who's
 16 been leading the charge. Maia, please take it away.
 17 **DR. DORSETT:** Do it, yeah.
 18 **DR. COOPER:** There you go.
 19 **DR. DORSETT:** So red is on, it's good
 20 system design. All right. I'm very excited to be
 21 here, and I'm going to start off by acknowledging
 22 that this is not a project that I have done remotely
 23 alone. It's taken a lot of work, and it would not be
 24 possible without Amy Eisenhower, who was able to help
 25 us with this. So, what we took on was the challenge

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 2 of reducing pediatric medication error and improving
 3 peds medication safety. And we knew that this was
 4 likely a large problem within our region, just like
 5 it was in every single E.M.S. system that had ever
 6 been examined.
 7 And one of the things that we were
 8 looking for were potential solutions because even
 9 though that the problem had been described that
 10 anywhere in the literature, approximately fifty to
 11 seventy percent of the time, pediatric medications,
 12 including critical pediatric meds were dosed
 13 correctly, which is like flipping a coin and hoping
 14 that you get the right dose for a child. There
 15 hadn't been a lot of publications showing how to get
 16 it right.
 17 There was a lot describing the
 18 problem, but not a lot about solutions to the
 19 problem.
 20 And in 2020, an M.S.P. published a
 21 position statement on best practices for pediatric
 22 medication safety and E.M.S. And the most useful part
 23 of this document was the resource document, which was
 24 a systematic review of the literature about what
 25 really are the evidence-based best practices of how

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 2 to do this right. And this included a lot of best
 3 practices, including getting weights and kilograms
 4 and using validated things like length-based tape,
 5 which came with its own set of errors, to improve
 6 weight estimation. But one of the key things was
 7 that there was publications including one by Rapaport
 8 L. in Denver Health, saying that one of the key
 9 innovations was using a volume-based dosing method.
 10 So that essentially the elimination of math in the
 11 real time of taking care of sick children who are
 12 medication dosing to get it right.
 13 And so at the time, I had been
 14 developed a lot of interest. The Rappaport L. had
 15 used the Handtevy System, not currently the app, but
 16 at the time it was done, it was sort of paper cards
 17 within their system to implement volume-based dosing.
 18 And so, this was the thing that I had wanted to
 19 implement because I wanted a solution that had this
 20 particular feature. Not just like we're getting
 21 weights on kids, not just opportunities to practice,
 22 which are all really important. We'll talk about how
 23 we incorporated that into our implementation, but
 24 something that took the math out of it.
 25 And I was significantly more motivated

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 2 to do this when we implemented a medication
 3 crosscheck regional medication safety initiative in
 4 our system. And Sharon actually works at the -- is -
 5 - works with the agency where I'm a medical director.
 6 And I just happened to pick a scenario of a five-
 7 year-old with a seizure as our scenario to practice a
 8 medication crosscheck. And the difficulty and the
 9 time lag in coming up with the correct dose of
 10 midazolam for this simulated seizure patient while I
 11 was just standing there, right? Like it was a
 12 mannequin. There was no seizing child, no crying
 13 parent, none of this in that circumstance, it took
 14 forever for a bunch of the paramedics even. And the
 15 Broselow Tape was outdated, and it had diazepam in
 16 it, and so like I fixed all those things, but I mean,
 17 like, I need to have a system to help people take
 18 care of children in this circumstance and actually
 19 improve safety. So, the Handtevy system was one of
 20 the few that does that.
 21 So, this is what it looks like. This
 22 is a screenshot of the app and I'm happy to show
 23 anybody what it looks like. There's length-based
 24 tapes that go along with it, but there's also, you
 25 can just use patient age. So like when you get

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 2 dispatched to a six-month-old seizure, you can
 3 actually just like click on that and they show that
 4 you're actually pretty close to the correct, unless
 5 the kid has some other reason that they're going to
 6 be smaller than normal or larger than normal. And
 7 then it can take you through -- you have the list of
 8 medications and the key component of it is that it
 9 has, what is the concentration of the medication and
 10 the volume to be administered. So, you can click on
 11 that, and it'll pull it up. And even more
 12 importantly is you can link it directly to your
 13 protocol. So, if I'm dispatched to a seizure, I can
 14 search a protocol, and it will automatically -- it's
 15 integrated into the protocols, pull up the protocol,
 16 but pull up all medications, the correct dose for
 17 that weight child as part of the application.
 18 So, you can't see this, but it's in
 19 the report that was handed is we really felt that
 20 it's never just the tool, it's always about how you
 21 implement the tool. And so we thought this had to be
 22 coupled with education integration into normal
 23 practice. We had to get this right, including
 24 knowing the concentrations of the medications in our
 25 field. So, the first thing we did actually, because

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 2 we were doing a regional implementation. So, to
 3 describe our system, we have twelve A.L.S. agencies,
 4 a bunch of -- a couple A.L.S.F.R.S. This was
 5 initially an A.L.S. implementation. We've brought on
 6 some B.L.S. agencies as well.

MR. GREENBERG: I'm just going to
 pause you for one second. I know that's really far
 away. Anybody who would like to follow along, we
 both shared the PowerPoint, and the web broadcast is
 also shows live. What she -- what's up there. So,
 if anybody would -- can't see it or wants to see it,
 they can pull it up on their computer.

DR. DORSETT: Okay. So what we did is
 we did a survey of every single agency in our region
 that had every medication in the protocol and they
 had to tell us what concentration med they carried.
 And we found much to our surprise actually is that
 there was only one medication with a variable
 concentration amongst all the different agencies,
 which made our job a little bit easier. And because
 we all know medication shortages have made medication
 variation and concentration and using a volume-based
 dosing application, that's very dangerous, right?
 Because if I have a -- I can create errors by doing

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 2 that. So, the only medication with variation in
 3 dosing was ketamine, where some carried fifty mgs per
 4 ml, and some carried a hundred mgs per ml.

And so, we can -- I can show you on
 our application, we actually, that's highlighted in
 red, so that there's integration into the app of
 highlight of variable concentration we have both
 listed. Then we wrote a regional policy that we kept
 in our back pocket that wasn't a stick up front, but
 we wrote a clinical guideline for best for safe
 pediatric practices and made that a regional policy
 passed by our RMAC of these agencies operating within
 our region needed to comply with that.

And we basically took the -- the
 position statement from N.A.E.M.S.P., the evidence-
 based guideline and made that a regional policy. And
 then built -- like built the app with everything
 integrated into the protocol and then built an
 education system with tabletop exercises that
 included five separate cases. Three were pediatric,
 one was an infant cardiac arrest, a pediac like a
 one-year-old seizure, a five-year-old pain management
 scenario, but then also two adult cases so that
 people would actually go to the app and use this on a

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2 more regular basis, which was a Levophed drip
3 calculation for a septic shock patient and ketamine
4 for pain in an adult because we had a missed dosing
5 problem. And the goal was that all agencies would
6 implement this. It actually only took like an hour
7 and a half to do it.

8 We did it as part of like our regular
9 quarterly training at my agency. Not all agencies
10 implemented it that way, but the majority, like over
11 eighty percent of the people who got access to the
12 app ended up doing that education.

13 And then we pilot it with a small
14 group. But this is like an example of what the
15 tabletop exercise would look like is they'd have a
16 scenario, basic vital signs and a series of tasks
17 coupled with the psychomotor skill of actually
18 drawing up the medication using simulated medications
19 and doing a medication crosscheck with a partner.
20 And it didn't take like a whole lot of time to do,
21 but I think people found it very beneficial.

22 So right, we don't have just one
23 agency. We have a bunch of different agencies with
24 different structures, large private agencies, smaller
25 agencies, B.L.S.F.R.S. What this graph shows,

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2 essentially is the timeline of how we built users up.
3 So, in the orange we have about three hundred and
4 fifty paramedics within our region. So it was around
5 July or August where we had the majority of A.L.S.
6 providers in our region registered as users of the
7 app. So, from the perspective of the app
8 administrator, I have a list of every user of the app
9 that I can access: when did they get access to the
10 app and when was the last time they used it? The
11 little tick up in the middle, that is the last time
12 they accessed the app. So, this was pulled -- I have
13 more up to date data, but this was pulled like a week
14 into February, so a week into February, one hundred
15 and seventy-five of the four hundred and fifty-two
16 users had accessed the app within February.

17 So, there are some people who got
18 access early on and are not integrated into their
19 clinical practice, but somewhere around like thirty
20 to forty percent are accessing it every single week.
21 And I know that because I can see when was the last
22 time, they actually pulled up the application.

23 So, we have variable usage within the
24 group.

25 Medication error is a hard thing to

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2 pull system data on, because the definition of what
3 defines an error is a little bit different for every
4 medication. In the published literature, the -- it
5 said, and it always says like eighty to one hundred
6 and twenty percent of the calculated dose is a
7 correct dose. But it's a little bit different when,
8 for example, I'm looking at fentanyl and the protocol
9 range is one to one point five mics per kilo. And
10 I'd say one hundred and twenty percent of one point
11 five mics per kilo doesn't seem -- seems a little
12 more clinically significant than like twenty percent
13 over on some other medications. And some medications
14 top out, right? Like dexamethasone tops out very
15 easily at like ten milligrams. Same thing with
16 epinephrine.

17 So, this, it's in the report, this is
18 the table where I used to define what those were.
19 And thanks to Peter Brody who wrote a report using
20 the ImageTrend Data Bridge, we were able to pull
21 regional data for every child thirteen and under who
22 was transported to Monroe County Hospital, and every
23 single one of these medications on the list because
24 we have like many regions, three different E.P.C.Rs.
25 We don't have medical directions. So, this is how we

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2 did it and how the rules of how I process the data.
3 And one of the things we wondered is, if we're using
4 the weight that's documented in the P.C.R., is that
5 going to be accurate? And luckily, I have pediatric
6 emergency medicine fellows who needed quality
7 improvement projects. And they -- I gave them
8 essentially a year of data of thirteen and under
9 children transported to Strong Memorial Hospital who
10 got medications and they looked to see what was the
11 weight documented in the E.M.S. chart, what was the
12 date on that visit in the emergency department. And
13 greater than ninety percent of the time, that weight
14 is exactly the same.

15 So, I think they're actually writing
16 down the weight when they bring the patient to the
17 E.D. But for us, for calculating the metric, I think
18 we're very confident when we say there's an error or
19 not an error, that our weight denominator is correct.

20 All right. So, this is a control
21 chart, and I can tell you in the updated data, it
22 continues to improve. So, what is plotted here is
23 essentially four years on a monthly nearly thirty-day
24 basis of what is the percent correct dose. So, a
25 hundred percent would be a hundred percent correct

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 2 dosing and then below that, and I can't even see, but
 3 it was like seventy percent for years. You can see
 4 how much variability we had early on. A lot of that
 5 is because we didn't have that many meds administered
 6 to children. But that the -- you can see that the
 7 denominator as the control limits go narrow, we
 8 actually have bigger numbers, like more kids are
 9 getting things like pain management, which is a good
 10 thing.

11 But prior to implementation, only
 12 seventy percent of the time were we dosing children
 13 correctly by the definitions. And since
 14 implementation eighty-three, now eighty-five percent
 15 of the time on the most recent data, we are dosing
 16 children correctly, right? So, that's a fifteen
 17 percent improvement. The interesting thing is not
 18 all medications, I think this is sort of like not as
 19 important for all coming meds as it is for specific
 20 critical medications.

21 So, for example, ninety percent of the
 22 time we were dosing dexamethasone correctly. That's
 23 because it's hard to get it wrong, because once the
 24 kid hits two, the common dose is probably ten
 25 milligrams, right? And that's what you give. And a

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 2 lot of the fentanyl was actually like underdosing,
 3 not overdosing, on fentanyl, which is not great to
 4 undertreat pain, but much less concerning than like a
 5 two to threefold overdose of fentanyl. So, one of
 6 the most commonly mis dosed medications, which I did
 7 find quite disturbing, was Midazolam for seizure,
 8 which prior to implementation we only got correct
 9 sixty percent of the time, right? And like luckily,
 10 we're changing the dosing to more evidence-based
 11 dosing, but sixty percent of the time. So, this is
 12 only two quarters.

13 But what I'm going to show you is this
 14 graph. So, what this graph is this is called an X
 15 chart, which is individual administrations of
 16 midazolam over time from 2020 through to the end.
 17 And what is plotted here is the dose that the child
 18 received divided by the correct dose. So, if it'
 19 what your goal is that it's a one. If it's a one,
 20 it's essentially like a perfect administration. You
 21 can see how much variability we had and then you can
 22 see that the line narrows. And see all those little
 23 dots along one. Those are all correct doses; there's
 24 one outlier. And the one outlier is somebody I can
 25 look, and they were not a registered user of the app

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 2 at the time.

3 So, I contacted their agency, I made
 4 sure they got access and trained on the app. I now
 5 have three months more of data. We've only had two
 6 subsequent dosing errors, both from people who never
 7 got onboarded to use the application. So, for users
 8 of the application, we have had zero medication
 9 errors for midazolam dosing procedure. The test
 10 really will be, we are rolling out the protocol
 11 updates where we increase the dose. If you think
 12 about what is the work to change everybody's
 13 knowledge of what is the dose of midazolam versus
 14 flipping a switch and making it sure that everybody's
 15 app shows the correct dose, which is now going to
 16 point two, that'll be a real test of like, can we
 17 rapidly push out changes?

18 So those are all numbers, and I love
 19 numbers. I do quality improvement, like control
 20 charts feed my soul, but I think to me I get like
 21 emotional, right? Like these are the -- I get this
 22 kind of text messages like from providers all the
 23 time, and then I get ones like this, right? Like, I
 24 had to take care of a pediatric cardiac arrest this
 25 morning; like I felt more prepared to take care of a

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 2 -- a sick child. It was a cognitive offload.

3 We have a lot of barriers to improve.
 4 And in that report, I left the free text comments on
 5 people's perception of components of the app about
 6 app use and their clinical care, because I think that
 7 the way we make positive change is we hear from the
 8 people who are the end users. One of the things that
 9 we were asked for and we got from Handtevy because
 10 they were implementing it, is that there was only two
 11 weights for adults, which was really inconvenient.
 12 We now have the full spectrum of adults' weights
 13 including for ideal body weights dosed according to
 14 height, and those are all linked to the protocols.

15 We're working into integration into
 16 the E.P.C.R. directly because we've had a few
 17 documentation errors that are like documented the ml
 18 and so the milligram, which is a big problem when
 19 you're talking about epinephrine, but I can actually
 20 go down like, and drill down into the E.P.C.R. and
 21 see what was documented and speak with the providers.

22 And then the last component is
 23 improving the frequency and quality of pediatric care
 24 education opportunities. I don't think that this
 25 would've been successful without hands-on education

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 2 on how to use this and have people, like when we did
 3 that, I realized a bunch of people didn't know how to
 4 use a stop for pediatric dosing of pediatric
 5 epinephrine in the cause of a cardiac arrest. Like we
 6 need to integrate those. So, doing the checklist,
 7 one of the things that we're doing regionally because
 8 of the -- the readiness checklist is we've -- and I
 9 think this created the model for it, was how do we as
 10 a region, as a program agency, make it easier for
 11 agencies to be pediatric prepared? Because I think
 12 thinking of that, every single agency that has a
 13 limit of bandwidth, limit of people trying to create
 14 these opportunities is going to be successful in
 15 completing every element of this gap analysis is not
 16 really sort of realistic about what people -- the
 17 barriers that people experience every day.
 18 And the Handtevy project showed us
 19 that as a region we can actually come together and
 20 solve something by creating a system where it's
 21 easier to do the right thing, right? Like if they
 22 have an issue or suggestion, there's one email they
 23 send it to, me or our other administrator take care
 24 of it, follow up on those requests. I'm finding
 25 errors that agencies didn't know about. Because I'm

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 2 looking at regional data and every time I find a
 3 clinically significant error, every quarter when I
 4 look at the data, I email that agency and let them
 5 know so that they can look into it. And so, we've
 6 created a pediatric advisory council as a
 7 subcommittee of our RMAC. And one of the things that
 8 we're going to do is not only continue the work on
 9 quality control here because we still have
 10 opportunities, but also think about how do we create
 11 those continuing education opportunities that are
 12 going to like support safe pediatric medication
 13 dosing as well as care of critically ill children.
 14 Sorry. Thanks. That's it. Lots of people to thank.
 15 **DR. COOPER:** Thank you so much.
 16 That's incredibly thorough report and phenomenal
 17 work. And if a program like this could be, you know,
 18 exported statewide you know I think we could
 19 substantially reduce the rate of, you know,
 20 medication errors in children. I see Amy giving me
 21 the eye here because of course that -- that would be
 22 quite an enormous undertaking. But at the same time,
 23 it's a necessary undertaking to make sure that kids
 24 are being properly dosed, you know, when medications
 25 are utilized. And of course, I -- I also can't help

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 2 but comment that, you know, this is, you know, the
 3 first time we've heard from -- from Maia Dorsett.
 4 And that was just amazing. And we hope that you
 5 become part of our family here and going forward.
 6 And, you know, your -- your future participation in
 7 E.M.S.C. will be, you know, I'm sure a welcomed with
 8 open arms by all concerns. So that was just a great
 9 presentation and a great job. And thanks for your
 10 diligence in carrying this thing, carrying this
 11 through. Not easy. Questions for Dr. Dorsett? Dr.
 12 Van der Jagt? Of course. It's our microphone.
 13 **DR. VAN DER JAGT:** First of all, I
 14 think this is a great project that you've embarked on
 15 in my backyard, incidentally. Okay. And it's --
 16 it's absolutely wonderful. And I think that the --
 17 the examples of seizure management I think is
 18 especially noteworthy. You know, over the last ten
 19 years, you know, we've really, maybe even five years,
 20 the we've recognized the importance of rapid response
 21 to seizures. It never used -- I mean, it used to be
 22 when I was in training, it was like, okay, give them
 23 thirty minutes, then you call it status epilepticus
 24 and then you have another half hour.
 25 Now it's recognize it within five

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 2 minutes, get it under control within ten to fifteen
 3 minutes, and do it that way. And so, the midazolam
 4 intranasally, which is I presume you're talking
 5 about, is critical. And of course, the dose has to
 6 be right. So, if somebody is really, you know,
 7 having a problem with figuring out the doses, that is
 8 a really important thing. So that example,
 9 especially I think in my mind knowing how important
 10 it's to treat seizures and how often these occur in
 11 children, I think is especially important in terms of
 12 rolling something this out statewide.
 13 So, I think you've done the pilot
 14 project, which is -- which is absolutely wonderful in
 15 a much -- in a controlled, relatively controlled
 16 setting. But I've a couple questions, also. One of
 17 is of course, and you alluded to this, is the
 18 importance of that the concentrations of drugs are
 19 the same. Because if the concentrations vary then
 20 the volume-based dosing is a problem, right? That's
 21 number one. And then the second is a question that
 22 has to do more with in rural areas where you may not
 23 have the ability of, you know, there's no Wi-Fi, you
 24 don't have I internet, you can't do it because of
 25 some of the barriers geographically, will that affect

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2 your app and these dosing? And what then becomes a
3 substitute? And how are you -- would you be handling
4 that?

5 **DR. DORSETT:** So, to the first
6 question, that is the biggest issue. And so whatever
7 system you have, it's never like a set it and forget
8 it. There has to be education and vigilance for
9 monitoring the correct dose. One of the things that
10 we did in our system is though the B.L.S. providers
11 didn't have access yet because of the number of
12 licenses we had. We had, you know, like over a
13 thousand B.L.S. providers and three hundred and fifty
14 A.L.S. providers and five hundred licenses. So, we
15 now have B.L.S. providers on board, but we
16 incorporate it as part of our medication crosscheck.
17 And we have a regional email that's just like,
18 Handtevy@millrems.org that people -- that is sent to
19 me, it's sent to Benson's box and to Shane O'Donnell,
20 so that one of us can identify or respond and
21 immediately send out a message if there's anything
22 wrong. With concentration dosing, we haven't had to
23 come up with that yet, but there's mechanisms that we
24 can immediately let people know about that.

25 With regard to timing of medication,

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2 we saw an increased percentage of I.M. I.N. dosing of
3 midazolam, which was promising. And one of the
4 things I was hoping to see was a decrease in time to
5 midazolam administration, because that's actually one
6 of the fair measures like the Florida quality
7 measures.

8 They haven't been incorporated
9 nationally NAMSCO, but to me that was an important
10 measure is looking at time of administration of time
11 -- time to administering time of critical meds. The
12 issue is that the only thing I can pull is what was
13 your on-scene time and what was your med
14 administration time? And so, if the kid like
15 resealed, right? That could look like a thirty-
16 minute, and I can't -- I can't pull that out. With
17 regard to the rural question, I haven't tried to
18 access the app without access to I think it will just
19 pull up the most recent, and so it wouldn't
20 necessarily do an update, which is one of the
21 dangers. I think in a --

22 **MR. SENSENBACH:** I can answer that
23 one.

24 **DR. DORSETT:** Oh, okay.

25 **MR. SENSENBACH:** So, the -- the way

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2 the app is designed --

3 **DR. COOPER:** Can you identify
4 yourself?

5 **MR. SENSENBACH:** Ben Sensenbach,
6 Monroe-Livingston Program Agency.

7 **DR. COOPER:** Jeff sit down too.

8 **MR. SENSENBACH:** Which -- which button
9 then?

10 **DR. DORSETT:** Right there.

11 **MR. SENSENBACH:** Which button?

12 **DR. DORSETT:** Oh, why don't you just
13 sit next to me?

14 **MR. SENSENBACH:** Here you go.

15 **DR. DORSETT:** You don't want to sit
16 next to me?

17 **MR. SENSENBACH:** Which button guys?

18 **MS. EISENHOWER:** The face.

19 **DR. DORSETT:** The face. The theory.

20 **MR. SENSENBACH:** Thank you. Ben
21 Sensenbach, Monroe-Livingston Program Agency. So,
22 the way the app is designed is all of those updates,
23 all of those protocols, all of those concentrations
24 are initially loaded. So, when somebody installs
25 that app, it's loaded and ready to go, it

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2 periodically updates, and it forces the user to
3 update when those updates are available. So as soon
4 as they open the app, it's going to queue them up to
5 download those. If they are remote, so like when I -
6 - I was on the helicopter the other day and there's
7 no cell service, I can still access, use the
8 application. The only thing I wouldn't be able to do
9 is just upload directly to my charting platform.

10 **DR. VAN DER JAGT:** So, it doesn't have
11 to?

12 **MR. SENSENBACH:** No, no, it's a great
13 safety net.

14 **DR. VAN DER JAGT:** You don't have to
15 be online; you have to --

16 **MR. SENSENBACH:** Correct.

17 **DR. VAN DER JAGT:** You just have to
18 have it on your phone.

19 **MR. SENSENBACH:** Correct. Correct.

20 **DR. VAN DER JAGT:** Thank you.

21 **DR. DORSETT:** I mean people do need to
22 use it regularly to get the updates though. And so,
23 one of the benefits like when I'm done here, I'm
24 going to be sending an email because we have all the
25 protocol updates. Is we've never had a list of all

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2 our providers in the region of an email list that I
3 can directly send messages to, but now, because I
4 have all their emails as the registered users of the
5 app, I can directly message every single user by
6 email.

7 So, when we have updates or education
8 or their data, which I share right with them because
9 it's their data, I message the users of the app
10 directly through an email. And so I'm going to send
11 them a message saying like, you really need to -- if
12 you haven't opened it recently, you really need to
13 open it because we've updated a bunch of the
14 protocols and concentrations, and because I have to
15 figure out as I do the data analysis, what is our
16 drop dead date for the -- the dosing -- the midazolam
17 dosing change, so that I can account for that. But
18 to me I think that's going to be a very important
19 test of how can we like rapidly disseminate a
20 protocol change and concentrate, you know, like for
21 that because it's going to double.

22 **DR. VAN DER JAGT:** So -- so one more
23 question about this is, this has to do more with this
24 state rollout. Are you at a position at this point
25 in time where another region in the state could also

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2 trial this? You know, whether it's in Buffalo or
3 Syracuse or downstate New York City. I mean, because
4 the only way to do it it seems to me is this is one
5 region. You know that it's very successful, and you
6 obviously have a lot of energy around this, you know,
7 but then if it goes to another area, that might be
8 another opportunity for seeing whether this similar
9 use of the app would work there also. I don't know
10 what the potential for that is, but it seems to me
11 that that might be the -- one of the steps if we're
12 thinking about maybe rolling it out further than just
13 Monroe-Livingston County area.

14 **DR. DORSETT:** The big barrier there is
15 cost. There's no lie this app is expensive. And so,
16 the -- what we've done now is, right, we had a
17 certain amount of grant funding, thank you to all of
18 you, to do the initial rollout. We had to go
19 through, it's much cheaper if we continued as a
20 region. And so, we got our Monroe County Chiefs
21 Association to actually come together, because I did
22 a loan negotiation and got some like a regional
23 implementation for Handtevy, which I want anyway.
24 Because I want to be able to control the updates and
25 the administration because we know we have people

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2 that we know are going to do it in like a, a timely
3 manner and pay attention to all those things.

4 Because -- because we have stability
5 at the regional level that we don't have in an
6 individual agency level, and we have prorated costs
7 for each individual agency who are coming together to
8 fund this continually. But it's going to cost us a
9 fair amount of money in the region. There was a lot
10 of barriers until I, you know, compare -- put -- I
11 put it in the perspective of like number of IOs per
12 year versus the cost of a tenfold med error and also
13 the regional policy that we have. Like you have to
14 find a way to meet the regional policy. You can come
15 up with your own way or you can use this particular
16 way.

17 I think cost would be the greatest
18 barrier. The time is -- the time is tough and
19 getting individual agencies to find a way to do the
20 training and the rollout and everything else, like,
21 it was not all like hugs and roses, like the whole
22 way to get everybody to implement it. But I think
23 that's all doable, like with regional perspectives. I
24 think cost is a problem.

25 **DR. COOPER:** Thank you.

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2 **MR. SENSENBACH:** Yes.
3 **DR. COOPER:** Oh, go ahead.
4 **DR. DORSETT:** Sorry to roll over the
5 time.

6 **DR. COOPER:** Let McEvoy, please.
7 **MR. MCEVOY:** There's -- so you're
8 probably aware that there's research going on in peds
9 now looking at age-based dosing versus weight-based
10 dosing. And would this like be able to accommodate
11 that if that pans out?

12 **DR. DORSETT:** Yes, because there's
13 both length-based and estimated weight. So, you can
14 just click a different weight. One of the things
15 they don't have -- so I think they'd have the ability
16 to do it because on the adult side. On one side it
17 has kilograms, the other side has pounds, so it has
18 kilograms in the middle pounds and then height on the
19 left.

20 So, I can quickly say how many pounds
21 are you and pick the correct weight and kilograms. I
22 think they'd have the capability to do that,
23 specifically for like children, if it came to that.
24 Like, if you wanted to use like stated parent age or
25 length-based tape. But length-based tape in all the

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 2 critical children we've had the providers used the
 3 length-based tape, and we did even like little P.D.S.
 4 As like in my own agency, I gave the length-based
 5 tape to different people and said where are you going
 6 to actually use this? And so, agencies, I gave
 7 people to pilot like when it's going to be, so like
 8 the Handtevy tape is small, it's actually with our
 9 pediatric blood pressure cuff in our monitor because
 10 it's a pediatric vital sign. And so, I train the
 11 B.L.S. providers to think of it as a pediatric vital
 12 sign because they're the ones that are doing it and
 13 they all trained. But the key is like, I'm already
 14 thinking how I keep that because it's going to fade,
 15 right, if that's just the training component.

16 **DR. COOPER:** Other questions?
 17 **MR. GREENBERG:** I'd be interested to
 18 see the research on the age-based one, only from the
 19 point of view of my son's in like the ninety eighth
 20 percentile on the weight category, and his best
 21 friend is in like the fifth percentile. So, when you
 22 put them next to each other, it --it's a great comedy
 23 show for multitude of reasons but including size.
 24 So, it'd be interesting to see.

25 **MS. EISENHOWER:** So that research is

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 2 actually ongoing through PECARN, so E.M.S for
 3 children is funding it. In Buffalo, A.M.R. Buffalo
 4 is one of the twenty nodes across the country. So,
 5 Dr. Clemency has taken over that work from Dr. Brooke
 6 Lerner, and Dr. Peter Dayan is still participating.
 7 And so, it is -- I was actually going to bring that
 8 up because it is related to midazolam and this issue
 9 of, you know, incorrect dosing.

10 So, they're looking at it from a
 11 different perspective of if we change it from, you
 12 know, weight-based to age-based in children, what
 13 does that look like and what does it, -- like, will
 14 it significantly help or is it not going to help at
 15 all? So that is still ongoing through PECARN. And I
 16 did have one question, and you kind of mentioned some
 17 of that, in -- right, in your presentation you
 18 mentioned some of those errors were related to new
 19 people not being onboarded. So, in the future,
 20 what's your plan to address that?

21 **DR. DORSETT:** So that was actually old
 22 people who hadn't been onboarded because we're still
 23 catching people who like slipped through the cracks.
 24 So, our plan going forward, right, is we're in -- I
 25 would say we're still in the quality improvement.

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 2 We're also a little bit in the quality control phase.
 3 So, for -- I'm the medical director of the paramedic
 4 program at M.C.C. also conveniently who produces most
 5 of the paramedics who work in our region. So, it's
 6 already integrated into the program. Students get
 7 access to the app at the beginning. They are the
 8 most facile users of the app we have probably in the
 9 region because they integrate it into, like the
 10 scenarios, they do everything else.

11 Individual agencies, I've been
 12 encouraging them to include it as part of their
 13 onboarding. Some agencies for sure have, others have
 14 not, and so I have to continue to work on that. And
 15 as leadership changes that individual agencies have
 16 to remind them that should be part of their
 17 onboarding process. It's always going to be a co --
 18 all control phrase. Like, I know that every three
 19 months I'm going to be sitting down on a Friday night
 20 Ben's going to send me a pulled report and I'm going
 21 to be working on the data and finding every med error
 22 in our system, so that I can continue to monitor
 23 those things. Like because I'm never -- like, if you
 24 take your eye off the ball, I can create the system.
 25 It's -- there's always going to be some degree of

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 2 drift until it becomes like an automatic way that
 3 people approach this problem. But it's the newbies
 4 into the system are not the -- like the ones that we
 5 need to convince to use an app.

6 It's people -- there's -- I think if
 7 you read those comments, there's people who think
 8 it's unprofessional to pull out your phone in the
 9 context who think we just need to be better at
 10 teaching paramedics to do math. But I think like we
 11 make it; I can't do math with a seizing baby. And I
 12 think I'm pretty good at math when I don't have a
 13 seizing baby in front of me. So, like trying to
 14 create that system.

15 **MS. EISENHOWER:** So, and kind of as a
 16 follow up to that, obviously, and we talked about the
 17 cost of the app and those barriers and things, there
 18 are other apps out there. Do you think that this
 19 could be achieved with other tools but the priority
 20 being having an invested medical director, having
 21 agencies that are invested, having the education
 22 component, and then not just setting it and
 23 forgetting it, like I think sometimes we do in E.M.S.

24 **DR. DORSETT:** Yeah, I think this can
 25 be achieved with any tool that has the best, those

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 2 best practices. Like that's why I think that paper
 3 like outlines like what are the elements, and then
 4 you have to think about how do people integrate this
 5 tool. The problem with most of what we create for
 6 pediatrics is we act like it's special for pediatrics
 7 and then nobody pulls it out until they have a sick
 8 kid. And the last time they pulled it out was their
 9 training two years ago and they don't remember how to
 10 use it. Like, just think about like the straps on a
 11 pediatric transport device, right? Like, we have to
 12 integrate that. And I think that's one of the great
 13 things about the pre-hospital pediatric readiness
 14 project. It's making you ask like, when was the last
 15 time we did pediatric training? Are we doing it
 16 regular?
 17 I think the solution has to be
 18 something that people use every single day for adults
 19 that they then know how to use for a child, right?
 20 Like, if it's something absolutely special, they're
 21 not going to feel it's going to be foreign and weird
 22 and cognitively overloading in the context of the
 23 situation of where all those things are possible.
 24 So it can be literally like note cards
 25 as long as those note cards are used regularly for

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 2 adult medications, right? And that you're updating
 3 them accordingly. It could be another app, but I
 4 think it needs to be noted like math free is the
 5 solution.
 6 **MS. KACICA:** Hi.
 7 **MS. EISENHOWER:** Marilyn?
 8 **MS. KACICA:** Hi. Thanks for the
 9 outstanding presentation. And when I first heard --
 10 when I first heard volumetric dosing, of course my
 11 brain went to kind of quality projects in A.E.P.
 12 looking at -- oh, going away from volumetric dosing,
 13 but you sold me for this group. My question is, have
 14 you thought ahead to that doing the right thing pre-
 15 hospital, but then you get to the hospital and that
 16 handoff; how is that volumetric dosing going to be
 17 handed off accurately to the new providers,
 18 especially when hospitals may have different
 19 concentrations of drugs that are on the truck, et
 20 cetera?
 21 **DR. DORSETT:** Excellent question. So,
 22 the app, when you click on the medication, what shows
 23 up is the volume, but you also have the correct
 24 milligrams. So, you can actually pull up the patient
 25 report and when it gives you it does -- if I pull up

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 2 the patient data from my phone, it doesn't give me
 3 the M.L., it gives me the milligrams or grams or
 4 whatever that I administered. So, it shows me like
 5 when I pull it up, the actual dose, not the M.L.
 6 administered.
 7 **MS. KACICA:** So, in that handoff
 8 before, you know like the printed stuff that comes
 9 down the line afterwards, someone would be able to
 10 bring up their dosing on the app and show that to a
 11 provider in the handoff?
 12 **DR. DORSETT:** Yes. And even for like
 13 a cardiac arrest, there's a cardiac arrest component
 14 of the app that has like a -- a metronome
 15 ventilation. So, we have a default set to fifteen to
 16 two, right, because kids are, like, different than
 17 what we're used to doing. Every time you click on
 18 that, it creates a patient record. One of the things
 19 we're working on, with some barriers from some of the
 20 P.C.Rs who want to charge us more money to do the
 21 right thing, is direct integration into the app. So
 22 like when the provider is done with their chart, it
 23 automatically -- they can import that data with the
 24 times of administration as well as the correct dosing
 25 directly into their chart.

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 2 There's integrations with ImageTrend,
 3 E.M.S. charts. E.S.O. is a bit of a different
 4 integration. The hard part for us is that we're a
 5 region not an individual agency, which creates its
 6 own special circumstances and -- and difficulties.
 7 You know, my dream is someday we just have H.L.
 8 Seven, right? And the data flows to the hospital and
 9 everything is integrated, right? And what appears is
 10 I want to know what that kid got, I just like pull it
 11 up and it's one seamless thing where I can see
 12 exactly what it is that was sort of clicked in the
 13 context of the app. That doesn't exist today, but it
 14 doesn't mean it's not like the technology exists to
 15 make that happen.
 16 But for now, you can definitely pull
 17 up the -- like you can review within your chart and
 18 show that. And that's actually something that I
 19 think we have to be, once you roll something out, you
 20 realize all the things that you would've changed. I
 21 think how we integrate some of that into our handoff,
 22 and how they can use, they can see the milligrams,
 23 not the M.Ls;
 24 That was a deficiency in our education
 25 that as we roll out some of this other stuff is

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 2 something that we need to work on. Simply from the
 3 commentary we got where they're like, it only shows
 4 the M.L. I'm like, no, it definitely shows you the
 5 milligrams, but they weren't sort of clicking on the
 6 thing and -- and pulling it up.
 7 **MR. SENSENBACH:** Yeah, I definitely
 8 like that you eliminate math from the equation
 9 because a lot of people just really don't -- it's
 10 very awkward looking one way and talking the other.
 11 Taking math out of the equation because a lot of
 12 people yeah, they just don't get it right simply.
 13 And when you're in high moments like moments of high
 14 stress, you're not necessarily going to be, you know,
 15 able to necessarily function that way. So, I really
 16 like that. I know that you mentioned as well that
 17 there was -- it's all volume or it has the option for
 18 volume-based dosing based on common concentrations.
 19 I know one thing that is in like the hospital-based
 20 system where at least I'm a part of its similar where
 21 it pulls up, you can flip a binder to the appropriate
 22 weight. It gives all of the appropriate med or all
 23 the, you know, A.C.L. or PALS medications that you
 24 might be administering, and it gives you the -- the
 25 volumes of each of those. And actually, I have a

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 2 P.D.F. of all of those.
 3 One of the -- the worries that I have
 4 is like too many apps just by, because it would be
 5 nice to have a one shop or one stop shop like, and I
 6 noticed that I just pulled up like the Muru app, and
 7 I was like, okay, I went into the dose calculator and
 8 if you put in a particular dose but then you flop to
 9 a protocol, it doesn't do the -- the -- the math for
 10 you, and it gives you -- it usually kind of defaults
 11 to like a -- like adult dosing system. So that could
 12 be confusing with our current setup, but to have
 13 something where it can be integrated into a
 14 preexisting app, and the Muru app is a lot better
 15 than, you know, previous protocols that have existed.
 16 But it would just be really nice to have a one stop
 17 shop to be able to kind of accomplish all those
 18 goals. And I think it's great how you've reduced the
 19 medication administration errors by, you know,
 20 fifteen percent.
 21 **DR. DORSETT:** Yeah. So, the -- the
 22 app -- the protocols are in the app, so in our region
 23 it serves as the protocol app.
 24 **MR. SENSENBACH:** Got you. So, it
 25 would basically just go and it's in place of Muru.

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 2 **DR. DORSETT:** In our region, it's used
 3 in that way because we've integrated the drug dosing,
 4 yep.
 5 **MR. SENSENBACH:** Nice. And is there a
 6 hard stop too to like, so you can't supersede an
 7 adult dose? Did you like embed all those? Okay.
 8 **DR. DORSETT:** Yeah.
 9 **MR. SENSENBACH:** Yeah. Just signal
 10 that could be.
 11 **DR. DORSETT:** In the setup, we created
 12 the entire setup and then we had --we reviewed with a
 13 committee, we all like played around with the apps,
 14 made sure that we found a bunch of errors. Then we
 15 identified a group of clinicians to try and break all
 16 the things and find all the errors. And so, we
 17 piloted with a small group who found all the things
 18 and whenever somebody has brought up anything
 19 confusing, they message us immediately, and we fix
 20 it. The reason the app is expensive is because
 21 there's twenty-four-seven support, and they will fix
 22 any error that you identify usually within about
 23 twelve hours.
 24 **MR. SENSENBACH:** No, that's excellent.
 25 The -- the other thing that the -- well you -- you've

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 2 admitted that you -- you like statistics and quality
 3 qualimetric kind of initiatives. It's like
 4 determining the actual weight of a -- of a child. Me
 5 as a person, like they -- they make eight-year-olds
 6 many different sizes nowadays. I don't know what
 7 they feed them, and they also do math differently
 8 with the Common Core. But when we go ahead and kind
 9 of integrate for like actual weight, we actually did
 10 a local study in Buffalo where because we had some
 11 discrepancies and well, we oftentimes we as humans
 12 like to check a box; if we get information we take it
 13 as truth. And -- and also when -- when you kind of
 14 related the E.M.S. weight estimations to the -- the
 15 hospital course, they were pretty spot on. But you
 16 even admitted though too that they might have taken
 17 E.M.Ss estimations and we incorporated something with
 18 a -- a popper tape which takes into account like the
 19 body habitus of a kid. So, you can basically use, and
 20 you do arm circumference, and you can kind of have a
 21 little bit of a sliding scale based on your findings
 22 to get a little bit more of an accurate weight. And
 23 the actual weight for healthy non-acute, non-high
 24 acuity patients was then compared to a provider
 25 guess. And using the popper scale and then some type

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 2 of length-based resuscitative scale and the provider
 3 estimation without any of those tools was found to be
 4 grossly inaccurate. So, that's just maybe something,
 5 and -- and I could share those findings with you at
 6 some point too, like because it's interesting like,
 7 because especially when you're dealing with like --
 8 **DR. DORSETT:** When I said they're
 9 taking the weight the kids are weighed when they come
 10 to the E.D., and the E.M.S. providers are writing it
 11 into their chart.
 12 **MR. SENSENBACH:** Oh, okay.
 13 Understood.
 14 **DR. DORSETT:** Because I can -- because
 15 we can pull from the, right, epic rights whether or
 16 not it was an actual or stated. The act it's always
 17 an actual because our E.Ds have regulations that
 18 every patient eighteen and under must be weighed as
 19 part of their initial vital signs, like on a scale.
 20 So, it's not ideal body weight, but it's total body
 21 weight. I think the thing is, it led to clinically
 22 significant error. So, we have one that's
 23 technically an error on versa dosing where it was
 24 point seven five of the actual dose and it's because
 25 it was a one-year-old that weighed thirteen kilograms

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 2 and, they used an estimate of a one-year-old weighing
 3 ten kilograms, and it's point seven five. And I
 4 would say I'm not -- that does not keep me up at
 5 night, right? Like, you're close to the ballpark
 6 fivefold overdoses or children getting twenty five
 7 percent of the correct versa dose for their seizure
 8 and only getting redosed five minutes later. That
 9 keeps me up at night.
 10 **MR. SENSENBACH:** Definitely
 11 understood. Well, it's -- yeah. And -- and taking
 12 math out of the equation, you know, that pesky little
 13 decimal point, you know, you don't want to give ten
 14 times or one tenth of a medication, because that's
 15 not going to be therapeutic. Right. So no, I think
 16 that's great work. Thank you for sharing.
 17 **MS. EISENHOWER:** Yes. So, I did just
 18 want to address the medication calculation that Ben
 19 just brought up in the Muru app, because I have been
 20 able to calculate medications in the Muru app. And
 21 we -- actually, Steve Blocker is here. He came early
 22 for meetings. So, if nobody minds, he can talk to
 23 the specifics of that because I used it, but he knows
 24 how it works. So, if you want to just come up real
 25 quick and explain how that works for, you know,

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 2 maybe, you know, you're not the only one that has
 3 experienced that.
 4 **MR. SENSENBACH:** I -- I feel pretty
 5 strongly with my ability to do math, but yeah. Thank
 6 you.
 7 **MR. BLOCKER:** Hi, Steven Blocker, CEO
 8 of Muru. So just to answer, first of all, this study
 9 is amazing. So, rarely do we get to see anyone admit
 10 the -- to document a baseline to then watch the
 11 improvement. So like, thank you for all that
 12 incredible work.
 13 To answer your question about
 14 pediatric dosing, about twenty-five of all the doses
 15 done in Muru are for pediatrics. They also use it
 16 mainly for adult pain management and other things
 17 like that as well. But the way we have them do it is
 18 rather than focusing on pediatrics, when they either
 19 go into Dose Builder, they select an age, but in
 20 reality, just with search, they can say, I have a
 21 seven-year-old, and it knows that fifteen years old
 22 is the cutoff in New York. And then automatically
 23 starts calculating for pediatrics.
 24 So, if they say anything from barking
 25 cough for a kid, it'll know, right? We're going to

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 2 protocol that covers croup all the way through. So,
 3 the pediatric dosing is in there too for that
 4 purpose. And as far as the adaptability that was
 5 brought up before with regards to kind of weight-
 6 based testing, I totally agree, right? If it's not
 7 all in one place there, it's -- it's incredibly hard
 8 to get people to -- to remember which app to pick up
 9 for what thing. It does need to really be
 10 incorporated.
 11 **MR. SENSENBACH:** Thank you.
 12 **DR. COOPER:** Well, I want to thank
 13 everybody for their -- their questions and comments.
 14 And I want to thank Dr. Dorsett for, you know, an
 15 incredible presentation and for fielding these
 16 sometimes difficult questions with aplomb and, you
 17 know -- and in detail. So, thank you, Dr. Dorsett,
 18 and we hope we continue to see you here all the time.
 19 **DR. DORSETT:** Thank you.
 20 **DR. COOPER:** If I might add one last
 21 comment to the discussion here before we move on.
 22 You know I was part of the initial group that
 23 developed the initial set of pediatric protocols
 24 back, you know, in the thirteen hundreds. And --
 25 and, you know, the -- the truth of the matter is that

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 2 as we all know, nobody ever dies from the X, Y, Zs;
 3 they only ever die from the A, B, Cs. And building
 4 off Ben Kasper's comment a little bit earlier that we
 5 are flooded with apps and sitting there on our
 6 handhelds, you know, calculating this, that, and the
 7 other thing, you know, sometimes, you know, can take
 8 away from, you know, the -- the fundamental care that
 9 we're providing the patient.

10 You know, and -- and when we did
 11 design those protocols back in the day, we designed
 12 them according to a model that we referred to as
 13 conservative, yet permissive, conservative in the
 14 sense that the emphasis was always on basic life
 15 support, because that's the X, Y, Z as opposed to --
 16 or the A, B, Cs as opposed to the X, Y, Zs, you know.
 17 And to -- to cite the example that we've utilized so
 18 frequently in the last half hour or so, you know, the
 19 seizing child, okay, making sure that we maintain a
 20 good ventilation is, you know, really the -- really
 21 the -- the -- you know, the -- this -- the start and
 22 maybe not necessarily finish, but pretty darn close
 23 to the finish as well.

24 You know, I also want to, you know,
 25 point out that for the great majority of drugs that

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 2 we used in the prehospital environment, the
 3 therapeutic to toxic ratio is pretty wide. And
 4 that's especially true, you know, in the pediatric
 5 age group. It's not to say that as you were pointing
 6 out, Ben, that -- that, you know, a five times
 7 greater dose or a one tenth dose isn't -- isn't --
 8 isn't optimal. You know and in some cases it's going
 9 to be, you know, seriously problematic.

10 But in most cases, you know, even if
 11 the drug doses is off a little bit, you know, it's --
 12 it pales in comparison to, you know, making sure that
 13 the -- that the, you know -- the supportive airway,
 14 breathing and circulation, you know, it is -- is not
 15 being properly attended to. So this is -- I -- I
 16 want point out, you know, that -- that as always in -
 17 - in, you know, the kind of work that we do in -- in
 18 critical care environments, including E.M.S., we tend
 19 to focus on -- you know, on the itty bitty details,
 20 you know, at the sort of the end of the rainbow in
 21 terms of the -- you know, the -- the -- you know, the
 22 -- the level of support that those medications are
 23 provided and are providing. And as we all know, it's
 24 really the A, B, Cs that are really the part and
 25 parcel of everything we do, not just in the field,

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 2 but also the emergency department and in the I.C.U.
 3 So, while this work is really
 4 important, we want to make sure that the medication
 5 doses are -- are as close to -- as close to exact as
 6 we -- as we possibly can. At the same time, you
 7 know, we want to ensure that we're not neglecting the
 8 basics. And -- and -- and I -- and I think that it -
 9 - it's incumbent upon all of us to ensure in our
 10 educational programs and quality improvement programs
 11 that the -- that the major focus remains, you know,
 12 where it belongs: on supportive ventilation,
 13 oxygenation, and profusion while we get the kid to
 14 the hospital. So that's my -- that's my little
 15 soapbox editorial. Forgive me. But I can't help it.
 16 I'm a dinosaur, you know, and there we are. So --

17 **MS. EISENHOWER:** Jump to this since
 18 we're kind of talking --
 19 **DR. COOPER:** We can do that. And
 20 particularly -- and particularly because Meghan
 21 Williams is in the room. So, we are going to jump
 22 ahead at Amy's excellent suggestion to hear from
 23 Meghan Williams about the length-based resuscitation
 24 tape review project that has been led by our
 25 colleague Meghan Williams from Borough of Manhattan

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 2 Community College in New York City. Meghan, take it
 3 away.

4 **MS. WILLIAMS:** Absolutely. Thank you.
 5 And the presentation that Dr. Dorsett did absolutely
 6 tags right into this. And it's kind of the
 7 furthering along of this particular project where the
 8 paramedic students really compared multiple different
 9 resuscitation tape devices along with Handtevy. They
 10 had not yet implemented Muru as well into this, but
 11 it comes kind of a moot point in comparing the New
 12 York State Protocols and medications, medication
 13 dosages.

14 It becomes a moot point when you talk
 15 about apps, because they just upload what you want
 16 them to upload. So, there's no gap to analyze
 17 between Muru or Handtevy. As alluded the -- the cost
 18 is usually the factor when we're talking about the
 19 different apps. So, in particular, this document
 20 really compared the -- we did three different
 21 resuscitation tapes, and I think the takeaways -- you
 22 can read through the charts, you can read through the
 23 -- the gap that we analyzed and really highlighted
 24 the gaps that we saw between each one of these tapes.
 25 But the overarching thing that we ended up seeing was

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 2 that the apps have the exact information; there is no
 3 gap. And the other big thing that we saw was that
 4 there's a very big difference between resuscitation
 5 tapes that are focusing on literally resuscitation
 6 and excluding the other medications that you would
 7 give during an emergency.
 8 So that seemed to be the largest gap
 9 when we were talking about resuscitation tapes. They
 10 are focused on resuscitation. And as you look
 11 through this document and you look at the different
 12 resuscitation tapes as opposed to the apps, there are
 13 a large amount of medications that are just not on
 14 those tapes.
 15 So, they might be cheaper overall as
 16 we're looking to fill the gap of the medication
 17 errors and also what is out there for providers to
 18 use; they're missing a lot of medications. And it
 19 really comes down to their focus on resuscitation.
 20 And we've expanded from twenty, thirty, forty years
 21 ago on the amount of medications that we give, and
 22 certainly in the pediatric realm. So, resuscitation
 23 tapes are doing resuscitation and creating a very
 24 large gap in the rest of the drugs and forcing a lot
 25 of math, which we've talked about and lot no one

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 2 likes to do, especially in the stressful situations.
 3 So, closing that gap is a big thing.
 4 We talked last time in February about
 5 whether or not the providers had more difficulty or
 6 were taking longer to implement an app versus the
 7 actual paper, or just straight up memorizing. And
 8 like Dr. Dorsett also said, our students and our
 9 newer providers; technology is everything. So, the
 10 biggest gap to implementation was really the
 11 instructors and the evaluators learning, when they
 12 didn't have an app when they first started. The
 13 students on the other hand yeah, they were teaching
 14 us a lot of the time because it's just intuitive for
 15 them. That's we saw that they had much more time
 16 delays and much more of a problem not implementing an
 17 app and not relying on that. Obviously, we train
 18 them in proper technology etiquette.
 19 So not just sitting there and ignoring
 20 the person, not having eye contact, and just getting
 21 on their phone, and the person, the patient being
 22 able to assume, well, they're just taking a picture,
 23 or they're not interested, or they're checking their
 24 email or making dinner plans. We obviously address
 25 that very quickly into proper etiquette to make sure

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 2 that it doesn't cause more stress into the situation.
 3 So, we saw a lot with this gap
 4 analysis, really just highlighting the basics that
 5 the resuscitation tapes are exactly that; they're
 6 resuscitation, and we've expanded exponentially into
 7 the amount of medications that we can give. And
 8 there's a large gap there. And as Dr. Dorsett said
 9 again it's expensive. So, we did look at Handtevy.
 10 The cost for each one of these is listed on the three
 11 devices that we did look at whether or not it was the
 12 paper tapes or physical tapes or the apps. So, all
 13 of the prices are listed towards the end and Handtevy
 14 tends to be very expensive, as everyone talks about.
 15 Muru is another good option as far as
 16 coming along and giving or filling the gap here with
 17 medications and significantly cheaper if not free in
 18 some of these aspects. So, I think that it -- this
 19 gap, or this gap analysis really highlighted what are
 20 we doing with medications, and where have we come
 21 from and gone to, and what are the expectations? And
 22 it dovetails perfectly into Dr. Dorsett's research
 23 and implementation as well.
 24 **DR. COOPER:** Thank you, Megan. Where
 25 do you think you're going from here in terms of this

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 2 project?
 3 **MS. WILLIAMS:** I'm certainly looking
 4 at implementation over the next couple of months with
 5 both Muru and Handtevy into our paramedic students,
 6 and then into the fall semester with new paramedic
 7 students starting and hitting the ground running. I
 8 think the original question that caused this analysis
 9 to begin with was whether or not the protocols
 10 matched or whether or not the protocols had an
 11 adjunct to make sure that the providers were able to
 12 give the best care possible.
 13 This really just highlights that we
 14 don't have one particular system. And I know in the
 15 last meeting, we were talking about maybe having a
 16 document that was a quick down and dirty one page
 17 document for people to reference; that could be an
 18 option as well. But whether it's Dr. Dorsett's or
 19 this particular project, it really does highlight
 20 that there is a gap here that we need to fill in some
 21 way, shape, or form.
 22 **DR. COOPER:** I guess what I would wish
 23 for children of New York State is that you and Maia
 24 could get together and sort of, you know, dovetail
 25 your efforts so that, you know, we can, you know, if

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 2 you will, come up with a -- a process by which we can
 3 identify sort of a -- you know, a some kind of
 4 reasonable, you know, middle ground kind of solution
 5 that --that could -- you know, that could be broadly
 6 applicable throughout New York State. You know,
 7 because that's really what we need. As it's been
 8 pointed out, we have multiple systems, multiple
 9 tapes, multiple apps, you know, and all of them,
 10 well, shall we say, very similar in their -- in their
 11 content, all has some little, you know, differences
 12 around -- you know, around the edges. Those -- those
 13 -- those differences may not always be, you know, of
 14 a clinically serious nature.

15 But -- but as we all know, our
 16 paramedic colleagues you know, are kind of caught
 17 betwixt in between when there are, you know,
 18 multiple, you know, different approaches to the same
 19 problem. You know -- you know, those of us who've
 20 been involved in this process for a while probably
 21 recognize to some extent when there are multiple
 22 different solutions to the same problem that we don't
 23 really know what the correct answer is. And we have
 24 to, you know, come up with, you know, the -- our best
 25 educated guess as a community of experts as to, you

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 2 know, how to -- how to, you know, solve this problem.

3 So again, I would ask that for our
 4 next meeting, you and -- and Maia get together and
 5 think about what we could potentially do. I mean, it
 6 might -- I -- I -- not meaning in -- you know, in the
 7 anti-American way to foreclose any -- any competition
 8 between, you know, between groups of vendors that --
 9 that all of whom are doing their best to put out
 10 excellent products. But I'm thinking of something
 11 along the lines of the -- of the triage you know,
 12 algorithms that are out there where are different.
 13 And a colleague, nearly departed, Brooke Lerner, God
 14 rest her soul, led a project called MUCK, which is
 15 the -- the -- a document that ultimately said if
 16 you're going to, you know, have a triage, you know,
 17 algorithm that it needs to meet these particular
 18 requirements and if you will, a set of, you know,
 19 generic standards that -- that -- that need to be
 20 met. And perhaps something along those lines is
 21 something that you and -- and -- and Maia could come
 22 up with and bring back to the committee in the fall.

23 I think that would be, you know -- I
 24 recognize that would be a lot of work, but at the
 25 same time, I think there's a lot of value in pursuing

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 2 an approach like that, because we really do owe it to
 3 our, our, our paramedic colleagues to make sure that
 4 we are able to make a, you know -- a -- a
 5 scientifically informed recommendation as to what
 6 approach should best be taken. So, thank you as
 7 always for all your hard work, and -- and we look
 8 forward to hearing from you again soon.

9 **MS. WILLIAMS:** My absolute pleasure.
 10 And I think that you're right on, when you talk about
 11 a minimum standard being set, because this can be met
 12 with a large number of different applications or just
 13 physical guidelines. I think we would also be remiss,
 14 and I'll speak to Maia about this as well. If we
 15 didn't use the resources, then there were also
 16 available. So, in order to look at how many people in
 17 the state are already using apps, and just using,
 18 whether it's Handtevy, or how many users are actually
 19 on Muru, that's going to inform us as to where to
 20 really go with this. Because if we're looking at it
 21 and going sixty five percent are on Handtevy, or
 22 seventy five percent are on Muru, we can make any
 23 recommendation we want. But that would be very
 24 illogical to ask people to move or switch when it's
 25 already being done. So, we'll take a look at that as

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 2 well.

3 **DR. COOPER:** It reminds me, of course,
 4 the discussion that was taking place regarding
 5 technology one hundred and fifty years ago that has
 6 got us all stuck with a Cordy keyboard on our -- on
 7 our computers. But, you know, we -- to a certain
 8 extent the -- the marketplace does -- does end up
 9 setting the standard. But it would be very helpful,
 10 I think, to our marketplace, if we did provide them
 11 with some guidance that's scientifically evidence
 12 based. And look forward to your -- your -- your
 13 movement in that regard. So, thank you,

14 **MR. GREENBERG:** Mr. Chair?
 15 **DR. COOPER:** Sir.

16 **MR. GREENBERG:** So, I just want to
 17 point out something that I -- I think is fairly new,
 18 and -- and please by all means, feel free to correct
 19 me, is interview, have the historical side of it too,
 20 but the work that -- Meghan, hold on before you go.
 21 The work that Meghan and her students did is one of
 22 the first collaboratives that I've seen where there
 23 was an ask of a state council to look into something,
 24 and that the initiative was actually picked up by a
 25 body of students, paramedic students in this case, to

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 2 look into something and then come back and provide a
 3 report and some information from that. And I just
 4 think that that's a pretty incredible new kind of way
 5 of approaching it for us, both engaging our paramedic
 6 students who are the future of E.M.S., as well as,
 7 you know, having a need of something to be looked at.
 8 We often look and say, well, there's plenty of things
 9 we'd like to look at, but we don't have the time or
 10 the -- the bandwidth to do it. So, I would just like
 11 to -- to recognize also Meghan, her team and the
 12 initiative of taking an alternative pathway to -- to
 13 look into some research it because I think that's
 14 pretty amazing and -- and really appreciate
 15 everything that you've done and your students
 16 particularly
 17 **MS. WILLIAMS:** Greatly appreciated for
 18 that too. And to be honest, I did it to serve two
 19 purposes. One, it definitely benefited their
 20 education. and two, I didn't have a lot of time, so
 21 they certainly were able to help with that, to say
 22 the least. But I will say, just to add on to what
 23 you're saying and emphasize what you're saying, the
 24 small amount of additional time in putting together
 25 the rubric and the homework assignment paid off

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 2 tremendously. I have very passionate, interactive
 3 students, and they weren't necessarily like that
 4 before on this particular topic. They grumbled a
 5 whole heck of a lot on the extra work that they were
 6 doing, but now they're really invested, and they're
 7 really invested in getting down to the minutiae and
 8 asking the questions of, but why and why can't we do
 9 this? And that is really exciting going forward,
 10 because I haven't seen that level of engagement and
 11 involvement in the past fifteen years of running
 12 paramedic programs. And they are also participating
 13 and informed, not only on their county level, but on
 14 the state level.
 15 So, I'm getting a lot of questions,
 16 whether it's positive or negative with them saying,
 17 well, I heard from going to the state meetings that
 18 we're not going to have a practical skills exam
 19 anymore. Can you tell me? And I'm like, no, good,
 20 but roll it back a second. So, it is very exciting
 21 about what they can potentially do towards the
 22 future, and they're looking into how to get more
 23 involved, which is very exciting because we need more
 24 people doing more things.
 25 **MR. GREENBERG:** How many students

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 2 participated in this, roughly?

MS. WILLIAMS: Sixteen.**MR. GREENBERG:** Would you be able to get us a list of names of who they were?**MS. WILLIAMS:** Sure, I know them.**MR. GREENBERG:** Thank you.**MS. WILLIAMS:** Welcome.

DR. COOPER: Yes. We all have had an opportunity over the years to -- interface with our paramedics who always somehow find a way to ask us the tough questions that we hadn't necessarily have thought of the answers to. And the fact that, and thanks to Ryan and for pointing this out, and Megan for taking the lead on this, you know, our students are often, you know, the best people to present a solution to a longstanding problem since as we all know, engaging the front line. And so, solving any problem often turns out to be the best approach and unfortunately, often the least followed approach. So, thank you all who have thought about this and -- and we'll continue to think about it. And again Ryan, thanks for your comments. And Megan, thanks for your work. Okay, good.

Sharon, Chiumento, it is time to talk

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 2 about our favorite subject for which Dr. Van der Jagt
 3 has almost single handedly and assured us that no
 4 drugs will ever be needed, because we're going to be
 5 doing everything by de-escalation. Let's hear about
 6 the Pediatric Agitation Project. Thank you.
 7 **MS. CHIUMENTO:** Well, the work group
 8 has been very busy in the last couple of -- of
 9 months. We've actually started to develop the
 10 scenarios that we've been talking about doing.
 11 They've finally gotten some work done. Meghan has
 12 done a great job on one as well as Vera Foyer. So,
 13 the two of them have developed their -- their
 14 scenarios. I sent them all out. I believe everybody
 15 here should have received it on email last week from
 16 me with the -- with the scenarios in them, so that
 17 you can take a look and see. We would like any
 18 comments if anybody has any comments about the -- the
 19 current drafts of the scenarios so that we can go the
 20 next step and actually start to -- to get some of the
 21 videoing done.
 22 So, my goal would be if anybody can --
 23 has any comments, if they can send them to me by
 24 let's say Friday of this week, then I can get
 25 everything over to Chief Pataky and he can start to

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 2 work on the storyboards or wherever else he needs to
 3 do. The one issue is, is that the third case, the
 4 one on autism, Mark Philippi was -- was -- was in
 5 charge of, he's now going to have to withdraw from
 6 working on that case. He's -- he's gotten too busy
 7 with his job. He did send a PowerPoint of kind of
 8 the teaching points that would -- we would want to
 9 include in the scenario that he developed with his
 10 son who works with children with special needs. So,
 11 we -- I -- we would look to now to find another
 12 person to write that particular scenario. And
 13 Meghan, actually, yeah, she's coming up. I'll let
 14 her -- let her make her suggestion. Go ahead, sir.

15 **DR. COOPER:** Please, Meghan, go ahead.

16 **MS. WILLIAMS:** I have worked with
 17 Sarah Gover in the past, and she definitely presented
 18 last year at the Vital Signs Conference and has some
 19 really good knowledge on autism as well. So, she
 20 might be a great resource to tap into for that.

21 **MS. CHIUMENTO:** Okay. So --

22 **DR. COOPER:** Thank you. That would be
 23 great.

24 **MS. CHIUMENTO:** Okay, great. Yeah,
 25 that would be great. Because that would -- that --

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 2 that would be the second goal then, is to get that
 3 scenario developed in the next couple of weeks,
 4 maybe, hopefully by the -- let's say the end of June.
 5 From there, our timeframe is to get everything
 6 started to be put together so that at our September
 7 meeting, we would have to have everything in by July
 8 22nd in order to have everything available to put up
 9 on the screens in -- at -- at our September E.M.S.C.
 10 meeting. And then hopefully if any final edits could
 11 then be done by mid-October for approval December
 12 meeting, and then hopefully roll out the beginning of
 13 2025.

14 So that's kind of our -- our goal --
 15 goals going forward. I think the scenarios are
 16 really very well done. And I -- yes, I see your card
 17 there. That's the other thing. Yes, the -- I
 18 absolutely would like to use the -- some of that
 19 information for the PowerPoint that goes along with
 20 it, as well as handouts when we do do this particular
 21 scenario rollouts.

22 So that is with as excellent. Also, I
 23 think a lot of the points both in Mark's development
 24 we can put into, because we're going to need to
 25 develop the -- the slides that go before, after, in

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 2 between the scenarios as well, so that the
 3 information on that, the information on Mark -- on
 4 the information that Mark sent, as well as the
 5 previous PowerPoint that FDNY had done, I think we
 6 should be able to come together with some kind of a -
 7 - a flow of -- of slides to go in between the -- the
 8 slide sets as well as perhaps some -- some toolkit
 9 kinds of materials as well, and I see.

10 **DR. COOPER:** Yeah.

11 **MR. PATAKY:** Thank -- thank you,
 12 Sharon. So I spoke with Captain Randy Li from the
 13 F.D.N.Y. A.V. unit, and he's so graciously donated
 14 his time to help us produce these videos when the
 15 time comes. And he's given a timeframe per scenario,
 16 at worst case, about four weeks per scenario to
 17 shoot, edit, and have a product for us. So by our
 18 next meeting, we should have at least two videos
 19 ready. We're hoping to make that July deadline so we
 20 can actually show clips of it. And he's assured me
 21 that he can actually put together kind of a -- a -- a
 22 brief synopsis for this committee, and we might be
 23 able to show that at the next meeting. So, we're
 24 hopeful for that. But I just want to recognize
 25 Captain Li for his time that he's been donating to --

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 2 to get these videos produced.

3 **DR. COOPER:** Thank you, Chief. Dr.
 4 Van der Jagt?

5 **DR. VAN DER JAGT:** Thanks very much
 6 Sharon for heading this group here. I did have a
 7 chance to look at the -- what you sent out, and one
 8 thing that is kind of a big thing for that child with
 9 autism, if there's a way to incorporate the
 10 importance of the caregiver, whether it's a teacher
 11 or whether it's a parent in terms of the E.M.S.
 12 provider, really using that as a research, how to
 13 handle that child, I think that's really, really
 14 important. I handle these kids all the time, and we
 15 are totally dependent on the, you know, how the
 16 family understands how this child might best respond.
 17 So, I think that might be a really good educational
 18 piece for the E.M.S. provider that -- that would be -
 19 - even if it's a phone call, you know, away if the --
 20 if the parent isn't there, so.

21 **DR. COOPER:** Thank you, Elisa. I -- I
 22 might also add that recently was -- was exposed to a
 23 group in New Jersey, known as JoyDew, J-O-Y-D-E-W,
 24 that does a boatload of work in the -- in the, you
 25 know, autism spectrum space and a lot of work with

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 2 public education and so on might be worthwhile, you
 3 know, checking out their website and contacting them
 4 to see if there's any, you know, help that they could
 5 provide or information they could provide. I think
 6 it would be, you know, very useful as we, you know,
 7 finalize the development of these scenarios as -- as
 8 good as the scripts are at this point. And -- and
 9 our plans for the immediate future, JoyDew, J-O-Y-D-
 10 E-W. J-O-Y-D-E-W.org.com, I've forgotten which.
 11 Okay. Thank you. It should be pretty easy to find.
 12 Thank you. Any other? Yes, Ben?

13 **MR. SENSENBACH:** Yes, I -- I just
 14 wanted to second Dr. Van der Jagt's comments as far
 15 as incorporating the family members or just anybody
 16 that's able to provide supportive services for any
 17 agitated patient or anybody that has autism, mainly
 18 those that have autism, like the paraprofessionals,
 19 the teachers, if it's in a school-like setting. And
 20 also, when it comes to the agitated patient or the
 21 child possibly with autism to either exclude certain
 22 people from maybe that might be triggering that
 23 particular event. But I do think that the
 24 environment plays a -- like a pivotal role and how
 25 that all plays out just from my own personal

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 2 experience, because then you can deescalate
 3 situations a lot better when you don't have that
 4 triggering factor present. So, thanks.

5 **DR. COOPER:** Yeah, that's a great
 6 point, Ben. Thank you. And -- and I -- it just sort
 7 of a light bulb went off in my aging head, you know,
 8 the -- as you point out, the school environment is an
 9 incredibly important environment for us, those of us
 10 who deal with kids that we don't often talk about in
 11 terms of our interface, you know, with the E.M.S.
 12 system and so forth. I wonder, Amy, if it -- it
 13 would be worthwhile to reach out to -- to Department
 14 of Education and see if there might be some level of
 15 interest. We did reach out to our -- our colleagues
 16 with the, you know -- the -- the crisis stabilization
 17 centers that we spoke of last meeting, and it might
 18 be worthwhile to get some of the folks from S.E.D.
 19 and, you know, aware of what we're doing as well.
 20 I'm sure that they have already begun to develop some
 21 program -- programs and so forth. And it would -- it
 22 would be important for us to know about them at the
 23 very least so that if there is, you know, anything
 24 that we can learn from them and vice versa, you know,
 25 we could potentially include some information in the

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 2 -- you know, in the scenarios that are being
 3 developed about, you know, how to deal with the --
 4 the situation when the child is in school or what
 5 have you.

6 I -- I -- I leave that to folks who
 7 are far more expert in this area than I am, just to
 8 say I'm not an expert at all. And you know I think
 9 that -- but I think as many -- as many people that
 10 deal with this problem on a regular basis that we can
 11 -- that we can interface with, I think would be to
 12 the benefit of all. Thank you. Dr. Van der Jagt has
 13 another comment

14 **DR. VAN DER JAGT:** Since we're talking
 15 about resources. It just dawned on me, Sharon, you
 16 should contact Lynn Cole, C-O-L-E. She is the
 17 Clinical Director of the Department of Developmental
 18 Disabilities and Pediatrics as well as a Clinical
 19 Director of the Center for Autism Spectrum Disorders
 20 at Strong in Rochester. And I think that a - a
 21 person like that really would be very helpful in
 22 looking at the scenario and seeing whether it makes
 23 sense, because they deal with these kids all the
 24 time. That's where they go for the -- at least our
 25 entire region.

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 2 **DR. COOPER:** Thank you. Sharon?
 3 **MS. CHIUMENTO:** Dr. Van der Jagt,
 4 could you send me that contact information? Thank
 5 you.

6 **DR. COOPER:** Any other comments?
 7 Okay. Well, hearing none, it is time to hear from
 8 Dr. Van der Jagt yet again about the procedural
 9 sedation work group. Go ahead.

10 **DR. VAN DER JAGT:** Yeah. We have not
 11 met. I have to say that. I think Amy was really
 12 kind enough to send up a survey and asking whether
 13 people would be willing to meet with this, but there
 14 was only one response to that. So, I don't know
 15 whether this is a something that is not of interest.
 16 If there is, I would love to move forward with that.
 17 And for those who are volunteering, I think just the
 18 person, I think you were the only one from Syracuse
 19 that presented. And you would -- okay.

20 So, you would like to be part of that,
 21 too. I will unearth that, because I really do think
 22 that procedural sedation in the emergency department
 23 is really, really important, especially in the
 24 community hospital areas where there may be less
 25 expertise in dealing with procedures in pediatrics.

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2 So, this is a -- a national issue. And in fact, I
3 should say that this has become now also again,
4 moving in the sedation circles nationally, it's
5 become an international issue of how to manage short
6 procedures in E.D.s that are very painful, that are
7 very scary.

8 And how do you -- how do you do this?
9 So, I think that this is a wonderful conjunction of
10 E.M.S.C. in under the umbrella of what E.M.S.C.
11 means, which is the entire spectrum from E.M.S. to
12 E.D. to I.C.U and all the way through I think this is
13 a really important piece of it. So yes, I will. Dr.
14 Efferen, okay, as well, and if there's anyone else, I
15 will reorganize it. Oh, there we go. We'll do that
16 too. Thank you.

17 **DR. COOPER:** Okay. So, Dr. Pamela
18 Feuer, and Nickol too, that -- that group with Dr.
19 Van der Jagt, yes. Okay. So, we'll look forward to
20 a discussion over the summer and, you know, an update
21 in the fall. Thank you, Elise. So, the -- the next
22 item on the agenda is officer elections. And I'll
23 ask Amy if she would, you know, update us as to where
24 we are with that.

25 **MS. EISENHOWER:** Sure. So, there were

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2 some questions that were brought up about how do
3 officer elections work, when does that happen? Those
4 kinds of things. So, I did speak with our lawyer,
5 Wahija, who was great and reviewed the documents, and
6 also much thanks to Steve Desura. So, we looked at
7 the public health law, which doesn't say a lot. It
8 only says that the chair of the committee is
9 appointed by the commissioner. And then in looking
10 at our bylaws, a majority election. So essentially
11 when that election comes up, whoever is putting their
12 hat in the ring, whoever gets the most votes, then
13 that person would be submitted to the commissioner
14 for the commissioner to approve -- appoint the chair.
15 And so, according to the documents that happens every
16 four years on the revetting or -- yeah, revetting of
17 the chair.

18 So, Dr. Cooper's revetting letter is
19 sitting in process.

20 It's on its way. So once that letter
21 is approved, it will get sent to Dr. Cooper. And
22 then so I believe-- I hope they approve it before the
23 next meeting, because I have been waiting a little
24 bit. But once that is done and he is officially
25 reappointed to the committee, then we can start the

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2 process for elections. And whoever is interested can
3 say they're interested and then we'll have a vote at
4 the meeting.

5 **DR. COOPER:** Thank you. Just -- I'll
6 just take the opportunity to say that I would be more
7 than honored to continue as chair for one last term
8 if that -- if that is your wish. But of course, this
9 is a democracy and anyone else who wishes to serve as
10 chair, you know, should by all means, you know, not
11 hold their peace.

12 **MS. EISENHOWER:** I -- I forgot to
13 mention one thing. I'm sorry Dr. Cooper. The chair
14 has to be a physician according to our bylaws. So,
15 for those of you who are interested, it would have to
16 be a physician to be the chair.

17 **MS. CHIUMENTO:** It was also decided at
18 a previous meeting, years ago that the vice chair
19 would also have to be a physician, because that he
20 would need to be able to step -- he or she would need
21 to be able to step up into the president's role.

22 **DR. COOPER:** All that having been
23 said, we all need to remember that the law is quite
24 specific, that the commissioner does appoint the
25 chair, and he or she could appoint whoever he or she

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2 felt was the most qualified person to assume that
3 role, regardless of what, you know, advice this
4 committee, you know, put forward. But that is the,
5 you know -- the shall we say the -- the -- the
6 process that's followed for virtually all advisory
7 councils under state government. It's usually a
8 commissioner appointee and, or gubernatorial even in
9 the case of certain advisory councils. But the
10 commissioners in the past have been very gracious and
11 accepting our recommendations to going forward.
12 Thank you. Okay.

13 Any questions about that? All right,
14 well, hearing none, let's move on to our updates from
15 our, you know -- our partners in support of Emergency
16 Medical Services for Children. And begin with the
17 report from Alda Osinaga or -- and or Linda Efferen
18 from the Quality and Safety Sepsis Initiative. And I
19 have -- yes,

20 **MS. EISENHOWER:** I have their report.

21 **DR. COOPER:** Ah.

22 **MS. EISENHOWER:** Yes.

23 **DR. COOPER:** Okay, please.

24 **MS. EISENHOWER:** So, they could not be
25 here today, so George emailed me some of the updates.

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 2 So, I will read them to you. So, the New York State
 3 Department of Health Sepsis team will be presenting
 4 the results of the sepsis protocol and training
 5 requirements Heard survey that was completed last
 6 fall on June 5th, 2024, via Statewide Webinar to be
 7 hosted. And it will be on their announcement's page
 8 and their webinar link will be posted there in
 9 advance of the meeting.
 10 So, the survey was administered to
 11 assess how hospitals across New York State that
 12 report sepsis data are currently implementing sepsis
 13 protocols and sepsis training requirements in
 14 accordance with Title 10 Health of the New York State
 15 Codes Rules and Regulations Sections 405.2 and 405.4.
 16 The regulations have specific protocol requirements
 17 for infants and children, and we will be reviewing
 18 aggregate results from hospitals across the state and
 19 sharing key takeaways. They also mention that the
 20 sepsis team has continued to plan for the release of
 21 the 2021 sepsis public report. The report will be
 22 released in a dashboard format with previously
 23 unavailable features to allow users to interact with
 24 the data.
 25 The report is not yet available but

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 2 will be hosted on the New York State Department of
 3 Health Sepsis Webpage when approved. As stated in
 4 previous updates for our committee, the New York
 5 State Department of Health Sepsis Team will be happy
 6 to provide a more thorough update to the committee
 7 once the report is public.
 8 **DR. COOPER:** Thank you, Amy. And
 9 please express our thanks to George Stathidis who is
 10 assisting Dr. Osinaga and Efferen and, you know, in
 11 this arena. I do think that we should impress upon
 12 our colleagues in the quality and safety, you know
 13 area, how important it is to this committee that they
 14 be here in person to provide a report.
 15 You know, I think we all recognize
 16 that that -- that sepsis has become, you know, a
 17 leading cause of death in New York State's children,
 18 probably second only to trauma. And something that
 19 needs to be, you know, made exquisitely aware to this
 20 particular -- this particular group recognizing the
 21 signs of sepsis in the field remains a challenge for
 22 our colleagues in -- in E.M.S. but also in many
 23 emergency departments where the volume of -- the
 24 volume of patients with, you know, pediatric sepsis
 25 can be pretty low.

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 2 And therefore, the experience in
 3 identifying sepsis in its early stages, you know, not
 4 always as good as we might like. So, the help of our
 5 colleagues in the division of quality and patient
 6 safety will be very, very important as we, you know,
 7 think about how to really assist our E.M.S. providers
 8 in -- in getting the -- the -- in -- in getting the
 9 recognition done as -- as quickly and accurately as
 10 possible. So, thank you. Elise, please.
 11 **DR. VAN DER JAGT:** Yeah, I -- as you
 12 know, I've been very involved in sepsis. I'm on this
 13 committee actually, but I just wanted you to know is
 14 that the World Health Organization has put out some
 15 statements about this. There's been a recent, as you
 16 know world Health Organization International Day of
 17 Sepsis in these past few weeks, and I just crossed my
 18 -- some data across on their website is that almost
 19 half of all estimated sepsis cases worldwide occurred
 20 in children under five years of age. So, this is
 21 truly a pediatric problem. As you say, Dr. Cooper.
 22 This is something that we need to be very involved
 23 with, and I think this is important.
 24 **DR. COOPER:** Thank you, Dr. Van der
 25 Jagt. And of course, I -- I would be remiss if I

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 2 didn't acknowledge Dr. Conway's contributions to the
 3 international efforts in, you know -- in recognition
 4 and management of pediatric sepsis. So, Ed has been
 5 a, you know -- a real stalwart in that area and
 6 member of the -- the -- the committee that helped
 7 devise our national protocols. And you know Ed, I'd
 8 invite you to add anything you might want to add at
 9 this point. If you have anything to say, don't feel
 10 as though you do if you don't want to, but that's
 11 fine.
 12 **DR. CONWAY:** Thank you for the
 13 acknowledgement.
 14 **DR. COOPER:** Thank you. Okay. Now we
 15 move on to our colleagues Susan Stegich and Kate,
 16 Alfonso from what is affectionately known as BOHIP,
 17 the Bureau of Occupational Health and Injury
 18 Prevention from the department to tell us about
 19 current injury prevention activities.
 20 **MS. STEGICH:** Thanks so much. All
 21 right. A few updates that we have for pedestrian
 22 safety. We're continuing our pedestrian safety
 23 campaign media by. The Department of Health ran a
 24 visibility and winter campaign, as well as a
 25 distractions campaign in April. And so, our goal is

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 2 to raise awareness and reduce pedestrian related
 3 risks through education and outreach on pedestrian
 4 related vehicle and traffic law. We're continuing to
 5 develop new tip cards to raise awareness on the
 6 understanding of traffic control devices at
 7 crosswalks and how to use those devices for crossing
 8 safely. We're also conducting three focus groups,
 9 one of which we just finished conducting in Albany,
 10 Rochester, and Yonkers to learn more about what
 11 community members believe are barriers to vulnerable
 12 road user safety. And we define a vulnerable road
 13 user as a pedestrian, bicyclist, person using an e-
 14 bike or an e-scooter or other rollers. And this also
 15 includes pedestrians working in work zones. We did
 16 just finish our -- our first focus group that was in
 17 Albany, and it was at Albany High School.
 18 So, we spoke to kids that -- that go
 19 to Albany High School to see what some of their
 20 concerns were as it related to pedestrian safety and
 21 what we could do to help them in that area. For
 22 child passenger safety, we have a C.P.S. pictorial
 23 video that we're producing that's going to illustrate
 24 car seat installation instructions for limited
 25 English speaking and reading populations. So, it's

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 2 going to be very picture focused.
 3 Additionally, we have a counterfeit
 4 car seats publication that we're collaborating on
 5 with different subject matter -- experts, and it's
 6 going to be focused on the dangers of using
 7 counterfeit car seats. We're also going to be
 8 holding a safe travels for all children, or stack
 9 training June 19th and 20th at the Helen Hayes
 10 Hospital in Rockland County. For motorcycle safety,
 11 we are collaborating with Columbia University, the
 12 Governor's Traffic Safety Committee, and the
 13 Motorcycle Safety Foundation to join the Seneca
 14 Tribal Nation at their community fairs. And we
 15 conducted a motorcycle helmet fitting and shared our
 16 -- our safety publications at those fairs.
 17 In terms of micro mobility, we're
 18 going to be collaborating with the Bureau of E.M.S.
 19 and trauma systems, thank you to Amy, to develop a
 20 micro mobility tip card focusing on e-bikes and e-
 21 scooters. And we just intend to bring some
 22 familiarity to the topic for folks in E.M.S. for
 23 young driver safety, the Driver Education Research
 24 and Innovation Center, also known as DERIC. The
 25 first of three workshops for DERIC was held on April

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 2 20th in Rochester, and the training was conducted by
 3 members of the New York State Driver Training Safety
 4 Education Association, also known as NYSDTSE. We
 5 have two more trainings that are being planned. One
 6 in the Albany area and one in Long Island. And
 7 lastly the ACEs Prevention through Home Visiting
 8 Services publication. We're continuing to develop a
 9 questionnaire that is going to home visitors -- home
 10 visitor programs to get more information on their
 11 knowledge on domestic violence programs and to help
 12 reduce the number of ACEs in New York state. That's
 13 it for us.

DR. COOPER: Thank you so much. Any
 questions for our injury prevention colleagues?
 Okay, we're hearing none. It's now time to hear from
 our longstanding colleague Marilyn Kacica from the
 Division of Family Health. Thank you.

MS. KACICA: Thank you. So, I'm going
 to give you some updates on a wide variety of topics
 that we've been working on. I think you may be aware
 in 2019 legislation was passed called Elijah's Law,
 and it dealt with anaphylaxis in childcare
 facilities. So, we worked with the Office of Child
 and Family Services for a policy to implement this

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 2 law, which included guidelines on how to prevent,
 3 recognize, and respond to life-threatening
 4 anaphylactic reactions. So, the -- it's -- it was
 5 for the use of autoinjectors within daycare
 6 facilities.

So, the policy was issued in 2020, and
 since then they've gotten a couple questions about
 the policy that they had to do minor revisions. And
 one of the revisions of note was strengthening the
 language around calling nine one one first rather
 than calling the parent first. So, it's their
 automatic reaction to call the parent. So that's
 going to be strengthened. And also, to add
 documentation of the time epinephrine was given,
 because E.M.S. needs to know that, so we're going to
 strengthen that.

And we did learn from them that this
 policy has had an impact that on three separate
 occasions in three different daycares the auto-
 injectors had to be used. Two were on children, and
 one was on a staff person. So, it's good to hear
 that they're actually using the policy. As far as
 infants safe sleep, I think I talked about this
 previously, but more than one hundred and twenty

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 2 infants die of either sleep related causes or sudden
 3 infant death syndrome. So, in this year's budget the
 4 Office of Children and Family Services was given two
 5 million dollars to work on infant mortality. And
 6 what they're going to do is work with facilities to
 7 distribute Pack and Plays to families that are in
 8 need. And along with these Pack and Plays, there'll
 9 be a fitted sheet -- sheet and safe sleep materials
 10 to be included. So that's being worked on now.

11 We are working on the revision of the
 12 pediatric and obstetric toolkit. Amy's involved with
 13 that. We have subcommittees for each of the sections
 14 to review it. And I think, you know, a lot of the
 15 things, Amy, you talked about today really dovetail
 16 with that toolkit as far as resources and getting
 17 them connected. So that work is ongoing.

18 As far as early intervention, I
 19 thought I'd give you an update as far as the budget.
 20 There was a five percent rate increase for in-person
 21 services, which is one of the first rate increases in
 22 quite some time. There's a four percent rate
 23 modifier for rural areas and underserved communities
 24 for in-person services, and that will be implemented
 25 in fiscal year 2026. The methodology for that will

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 2 be worked on in the meantime. They are eliminating
 3 back-to-back group services for a child on the same
 4 day. They're limiting the size of a group session to
 5 six children and limiting the number of children
 6 having a one-to-one aid in group session to four.

7 They're reimbursing teletherapy at the
 8 existing facility rates. And consecutive extended
 9 home visits on the same day for the same service
 10 would be prohibited. That was in the budget.

11 The perinatal regionalization
 12 regulations are currently being worked on. The -- we
 13 received a hundred submissions and over five hundred
 14 comments.

15 So, we're currently under review by
 16 the department. And after that it'll be decided
 17 whether they need to go out again for comment or if
 18 you know what needs to be done next.

19 The other thing, we're beginning a New
 20 York State perinatal quality collaborative NICU
 21 project on equity. We are -- we have one now that's
 22 focused on maternal outcomes as far as the birth
 23 equity improvement project. But this will be
 24 specific in NICUs. And it's really to look at the
 25 experience of care that parents -- parents will rate

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 2 the experience of care through a survey when the
 3 child -- when they're discharged. So, sort of more
 4 qualitative things like do you feel like you were
 5 treated fairly, were you able to participate in the
 6 child's care, et cetera, as well as looking at
 7 policies and procedures within the NICU along equity
 8 and how individuals are treated. So currently we
 9 have forty NICUs signed up and are looking for more.
 10 And I think as we were here, the -- and you may
 11 already know this, the D.O.H. advisory went out as -
 12 - as with the proper use of automated external
 13 defibrillators and peds emergency care. So, I'm sure
 14 you were all very instrumental in that. So that's
 15 all.

16 **DR. COOPER:** Thank you, Marilyn. That
 17 -- that's unbelievable set of initiatives that you
 18 are working on at this particular point in time. And
 19 -- and wow, you're busy

20 **MS. KACICA:** We are busy, but it --
 21 but it's always -- it's good work and it's fun.

22 **DR. COOPER:** Yeah, absolutely. You
 23 know, any help we can provide, particularly with
 24 respect to the toolkit., you know, would be, you
 25 know, of course, freely offered and given. So let us

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 2 know if there's anything you need from us from that
 3 standpoint. Okay. Or anything else. Okay, good.
 4 Thank you. Questions for Dr. Kacica. Okay. Now it
 5 is time for hear Professor Dr. Michael McVoy to tell
 6 us about what's been going on at state council.

7 **MR. MCEVOY:** Well, the State Council
 8 meets in two days, and we did not have a -- a quorum
 9 in December for our physicians' group, the SEMAC.
 10 SEMSCO did meet then, and then we met again in
 11 February. A number of things, probably key things
 12 that are -- are happening. One is in the February
 13 meeting, they approved the -- what's been a seven-
 14 year process of sun setting the E.M.T. critical care
 15 level, and projected that that will end around 2027
 16 with kind of a phased decline in it, accompanying the
 17 phased decline in the number of providers since we've
 18 allowed them to bridge into paramedic level care.
 19 And then we also approved two performance standards.
 20 Over the summer last year, we had several of the
 21 committees work on performance standards and submit a
 22 wishlist to the State Council. And they approved a
 23 performance standard that would require agencies to
 24 conduct some quality improvement activities and
 25 monthly report those to the bureau and to their

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 2 REMSCOs.
 3 And the second performance standard
 4 that they approved was to track staffing and
 5 regularly report calls that are received, calls that
 6 are answered, calls that are turned over, and calls
 7 that are answered in other agencies jurisdictions,
 8 which will give us some data on performance of the
 9 system. And both of those are sustainability
 10 standards. So, the actual language of them needs to
 11 be worked out, and they'll end up in regulation
 12 basically at some point in the future.
 13 The other thing that did happen which
 14 didn't occur at SEMSCO, but SEMSCO was very excited
 15 about all the things that were added into the
 16 governor's budget for E.M.S. None of those made it
 17 through largely because the assembly doesn't believe
 18 in passing legislation as part of the budget. And
 19 so, they tend to veto everything that's legislative.
 20 However, if you look at the New York State
 21 Association of Counties website, there's a section on
 22 there called Rescuing E.M.S. And they list out ten
 23 bills that are currently one house bills, some of
 24 them with co-sponsors that take all of the language
 25 that got deleted from the -- the governor's budget

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 2 and put it into separate bills. And so, I would
 3 anticipate a significant number of those actually
 4 flying through before the end of the session in the
 5 next few weeks. So, I think most of us feel
 6 relatively comfortable about that. And I think the
 7 reason why is there's very little opposition.
 8 There's a lot of agreement between E.M.S.
 9 organizations, their associations, the Association of
 10 Counties, the Hospital Association of New York State,
 11 and -- and even the nurses in -- in a lot of those
 12 areas. So, I think we'll see some movement on a
 13 number of those things.
 14 I think that's -- that's primarily the
 15 key things that are happening. There's a -- a lot of
 16 work going on with the state council subcommittees in
 17 between meetings, and most of them meet at least
 18 monthly, if not more often. And we'll -- we'll
 19 probably have a whole bunch more news to give you at
 20 the next meeting after we meet in the next couple
 21 days. Unless there's any questions.
 22 **DR. COOPER:** Questions for Dr. McEvoy.
 23 Okay. Were, hearing none. I apologize to you all
 24 for inadvertently skipping over our report from the
 25 Healthcare Emergency Preparedness Central Office

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 2 Group. Deanna Ratigan is here with us today to give
 3 that report and we would love to hear from you.
 4 Thank you.

MS. RATIGAN: Thank you. Yeah, Kate
 wasn't able to be here today, so I'm stepping in for
 her. So just a couple quick --

DR. COOPER: We appreciate it.

MS. RATIGAN: A couple quick updates
 we have. The Hospital Preparedness Program, Notice
 of Funding Opportunity, which is for the next year
 cooperative five-year agreement, is still pending.
 It was supposed to be to us in January. And then
 there was supposed to be the deadline of March, and
 we are still waiting. So, once we receive that, any
 items that are pertinent to this group will be
 relaying to you Amy, for that.

As far as part of our current
 deliverables they contract hospitals outside of New
 York City continue to complete the National Pediatric
 Readiness Assessment as part of their -- their
 contract this year. And we've received the reports
 from the facilities. We've received eighteen so far,
 and I know Kate has passed those on to you, Amy. So,
 as we get those, we'll continue to send those along

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 2 as well.

And lastly via the Capital District
 Regional Office efforts to review and update the New
 York State Department of Health Pediatric and
 Obstetric Emergency Preparedness tool are underway.
 There are folks that are sitting on committees that
 are reviewing this different subject matter experts.
 So once that is completed, which the expected
 completion is Spring of 2025, that will be going out
 revised and updated as well. That's it.

DR. COOPER: Thank you. Questions for
 Deanna?

MS. EISENHOWER: I just wanted to make
 a point to say that the N.P.R. Pew survey that is
 part of the H.P.P. grant for hospitals outside of New
 York City, is the same survey that you can use to
 join Always Ready for Children. So, if you're
 already doing the H.P.P. survey, it's the same
 survey, please apply for Always Ready for Children,
 because you've just done the bulk of the work.

DR. COOPER: Thank you, Amy, this is,
 you know, an important bit of information. And for
 those of you who have not urged your emergency
 department directors to participate in the Always

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 2 Ready for Children Program, please do so. It's
 3 really a -- a very, very important program. And of
 4 course, Amy can help you, at least I hope she can now
 5 -- now that she's, you know, doing both jobs until
 6 she -- until she finds, you know, someone to assist
 7 with E.M.S.C. But until that time, which we hope
 8 won't take forever, please reach out to Amy for
 9 assistance in getting involved with that program.
 10 It's -- it's really so important. Thank you. Any
 11 other questions for Deanna? Okay. Thank you,
 12 Deanna. And give our regards to Kate. Thank you.
 13 Last but not least the Estate Trauma
 14 Advisory Committee and Pediatric Trauma Subcommittee
 15 did meet earlier this year. Really, the major issue
 16 that was on the -- on the agenda was in fact, the
 17 Always Ready for Children Program. There was some
 18 discussion about the -- about the the pediatric TQIP
 19 report as well, but most of the meeting focused on
 20 the Always Ready for Children Program because and it
 21 was, as most of you are aware, or many of you are
 22 aware, at least those -- those of us who are part of
 23 the trauma world realize that the New American
 24 College of Surgeons grade book standards do
 25 include a requirement that pediatric facilities

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 2 participate in the, you know -- in the National
 3 Pediatric Readiness Project. And of course, Always
 4 Ready for Children is a great way to do that. So,
 5 bear in mind that that is a requirement now if you
 6 are a trauma center.
 7 So please make sure that the folks who
 8 work with you are, you know, in the process of
 9 signing up for this program if they have not already
 10 done so. It -- it's relatively painless as many of
 11 these surveys go, you know. It's less painless
 12 than some others, or a lot more painless than some
 13 others, I should say. And it is really important
 14 that that New York State have an opportunity to
 15 really review this data in terms of where we are, you
 16 know, not just as individual facilities, but on a
 17 statewide basis. So please, please, please get your
 18 -- get your PGD folks to really participate in this.
 19 Of course, those of you who are working with E.M.S.
 20 agencies, please be sure that you're, that you're
 21 getting your E.M.S. agencies to participate in the --
 22 in the pre-hospital part of this project as well.
 23 The Stack will be meeting at the end
 24 of this month. Work, of course, remains ongoing in
 25 terms of getting everybody, you know, verified by the

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 2 college. And all of our pediatric trauma center --
 3 center statewide are in various stages of -- of
 4 reapplication. And you know the state regs, as you
 5 know, require us to be verified by the college in
 6 order to retain our trauma center designations. And
 7 we're all, you know, actively pursuing that aspect of
 8 things across the state.

9 So, we have now completed the formal
 10 agenda. I do have one item of whether you want to
 11 call it new business or a special request from the
 12 chair. I think that, you know, while we've done a
 13 lot of work today, covered a lot of ground, and we
 14 have a lot of really great projects that are -- that
 15 are ongoing, you know, it's a never ending, you know,
 16 opportunity to raise the standards of healthcare for
 17 pediatric patients particularly in the emergency
 18 arena. I -- I do think that it's important for every
 19 single one of us to think about projects that this
 20 committee could take on that, you know, not, -- you
 21 know, not shooting for the moon, but you know -- but
 22 that are limited projects that are eminently doable,
 23 that, you know, will take at least a reasonable sized
 24 bite at the apple, so that we can keep -- keep the --
 25 the wheels of progress turning.

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 2 Most of the projects that we're --
 3 that we're focusing on at the present time, you know,
 4 bubbled up in that exact way. So, for those of you
 5 that have, you know, special, you know, interests or
 6 special thoughts about projects that this committee
 7 could undertake, particularly as Ryan and Amy have
 8 been able to identify some, you know, potential
 9 research/statistical support for the, you know -- for
 10 the -- for the program, you know, I think we'll be
 11 very, very important, very useful.

12 So, I urge you to think about that.
 13 Please feel free to share the -- any thoughts you may
 14 have in that regard with me, Dr. Van der Jagt and of
 15 course, Amy and Ryan. And you know it's really
 16 important that we keep this -- we keep this going,
 17 you know, as -- as, you know, so often said, you
 18 know, children, you know, although they may represent
 19 only twenty five percent of the population are one
 20 hundred percent of our future. And you know, if we -
 21 - if we're to have a healthy future, it has to begin
 22 with healthy children. So please put your thinking
 23 caps on and let's see if we can come up with some new
 24 ideas for the -- for the immediate future. And you
 25 know that will be a great thing if we can think about

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 2 additional projects to focus on as a committee that
 3 will improve the -- the lives of children across New
 4 York State. So, with that, any final comments from
 5 any member of the committee? Well, thank you all for
 6 your attendance hearing. Then, Amy, we are meeting
 7 again in September --
 8 **MS. EISENHOWER:** September 16th.
 9 **DR. COOPER:** September 16th, I presume
 10 we are here, correct?
 11 **MS. EISENHOWER:** We are going to --
 12 **DR. COOPER:** You're not here.
 13 **MS. EISENHOWER:** -- be in Saratoga,
 14 **DR. COOPER:** Oh.
 15 **MS. EISENHOWER:** September 16th in
 16 Saratoga. And there is a time change, but --
 17 **DR. COOPER:** Microphone.
 18 **MS. EISENHOWER:** I was -- I -- sorry,
 19 I was telling Dr. Cooper so he could relay it, but so
 20 it will be in Saratoga. I know that there was some
 21 difficulty finding a place large enough for all of us
 22 to meet. So, we did find a place in Saratoga. I
 23 will relay that information as soon as all of that is
 24 confirmed because I work with Theresa so much thanks
 25 to Theresa who handles SEMAC and SEMSCO for also

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 2 helping with all the hotel stuff for E.M.S. for
 3 children because we work together on it to make both
 4 of our lives easier.
 5 So, once I have that I will send out
 6 all of that information. Also, the time is changing
 7 for the meeting because they had one room that fit
 8 all of us. So, we have to share Monday with the
 9 program agency meeting.
 10 So, we will, which is currently going
 11 on now, which is why some of the people here have
 12 left. So there -- here we can have an overlap
 13 because there's more rooms, but there, there's one
 14 room. So, we have to share, and I will let you know
 15 the time difference as soon as all of that is
 16 confirmed.
 17 **DR. COOPER:** Do you have -- do you
 18 have a guesstimate as to what the time might be at
 19 this point?
 20 **MS. EISENHOWER:** From off the top of
 21 my head, I think we said ten to one, because their
 22 meeting is two to five. And I -- I recognize that
 23 some people like to drive in in the morning, and I
 24 was not trying to make you wake up at two a.m.
 25 because I do that for the -- for the airlines, but I

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 2 can sleep on the plane. You can't do that while
 3 you're driving on Route Ninety. So, I recognize that
 4 some people do need to travel to get here. For those
 5 of you who do need to travel to get here, we will
 6 work on your travel information and, you know,
 7 obviously all the same stuff that applies to coming
 8 here, we'll apply for there.
 9 **DR. COOPER:** And Ryan, I presume that
 10 we can expect that SEMAC and SEMSCO will be meeting
 11 immediately thereafter, correct?
 12 **MR. GREENBERG:** They are.
 13 **DR. COOPER:** Thank you.
 14 **MR. GREENBERG:** And actually, it will
 15 come up, it is not definitive yet, but it looks like
 16 that Thursday after will be the E.M.S. memorial.
 17 Which had to be moved from May.
 18 **DR. COOPER:** Thank you very much.
 19 That's very important information. And then finally
 20 one other special thought for Amy and Ryan. It was
 21 stated earlier in this meeting that during E.M.S.
 22 week E.M.S.C. Day is May 22nd. I realize time is
 23 short, but I -- I wonder if there's anything special
 24 we could do to honor our, you know -- our program and
 25 its effect on, you know, sanitary effect on the

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 2 children of New York State. Ryan, any thoughts?
 3 **MR. GREENBERG:** So, I do know that
 4 information has passed -- been passed along to the
 5 governor's office related to that, and we would have
 6 to wait to see what their next steps are related to.
 7 So, we will advise everybody if it is.
 8 **DR. COOPER:** Okay. And, you know, if
 9 indeed there is a -- an opportunity for a, you know,
 10 some kind of press event or something along those
 11 lines, you know, I will certainly do my best to make
 12 myself available on that day. And perhaps Dr. Van
 13 der Jagt might be able to -- to -- to join you know,
 14 to represent the children of New York State and --
 15 and perhaps Nicole as -- as, you know, our family
 16 advisor committee network uh representative. So, we,
 17 you know -- we have the families represented as well.
 18 I think that would be a lovely moment. And you know,
 19 it would provide an opportunity for the governor to,
 20 you know, get this message out there in a very
 21 special way. So, Ryan, I get -- well, I -- I guess
 22 the -- the ball is in the governor's court. Perhaps
 23 you can -- you can lob the tennis ball again in her
 24 direction, letting her know that she'll have, you
 25 know, some support in doing that event should she

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2 choose to, you know, make herself available. Thank
3 you.

4 **MR. GREENBERG:** I appreciate it.

5 **DR. COOPER:** Thank you.

6 **MR. GREENBERG:** I'll relay the
7 message.

8 **DR. COOPER:** Thank you. So, that is
9 it. We have completed our -- our agenda for the day.
10 I -- I'm really surprised, I thought we were going to
11 go over by at least a half an hour given the -- given
12 the -- the, you know -- the -- the content of the
13 meeting. I just want to close -- I'd like to close on
14 a -- on a happy note, but on this particular issue, I
15 think I'm going to have to close on a somewhat sadder
16 note. We recently lost in New York State, a -- an
17 incredibly great champion for children, Dr. Michael
18 Frogel originally from, you know, the Northwell
19 Health System. But founder of the National Pediatric
20 Disaster Coalition who's worked extensively in the
21 pediatric disaster space nationally, regionally
22 nationally and worldwide for -- for many, many years.
23 He -- he recently passed this about -- about two or
24 three weeks ago. He was an incredibly healthy guy
25 until, you know, very, very close towards the end

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2 when he sadly, you know, developed a -- a rapidly
3 progressive fatal malignancy. And we've lost a great
4 champion for children. And you know I hope all of us
5 will keep him and his family in -- in -- in -- in
6 their prayers. And, you know, rather than a moment
7 of silence, I'll invite you all to have several
8 moments of silence in his honor as you -- as you wind
9 your way home.

10 So, thank you also very much for
11 coming today. And we look forward to seeing you on
12 September 16th in Saratoga, perhaps from ten to one,
13 perhaps at another time. But Amy or her soon-to-be
14 colleague will be letting us know when that will take
15 place.

16 **MR. GREENBERG:** And I will also
17 apologize just, and it should have come up earlier.
18 Phil Malini, for those of you who knew the name also
19 was a program agency director out of the Arams
20 region. A lot of a -- a rural part of New York. He
21 was a program agency director for forty-eight years,
22 from 1975 to literally 2023, just last March. He did
23 pass away last week, the week before, within the past
24 two weeks. And they just had a very nice, as nice as
25 it can be, service for him up where he's from. And

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2 so just his regards, and again, appreciation for
3 amazing work over, you know, nearly fifty years as a,
4 you know -- a leader in one of the regions. And so
5 just want to have you think about that one as well.
6 Thanks, everyone. Thank you, Mr. Chair.

7 **DR. COOPER:** Thank you. So, to return
8 to that happier note, summer is coming. The sun is
9 shining. You know all of our wonderful, you know,
10 holiday spots in New York State, Lake George, the
11 Finger Lakes, you know, two big lakes you know, Lake
12 Ontario, Lake Erie, all kinds of -- Long Island, all
13 kinds of wonderful places to spend time with your
14 families and particularly your kids. And may -- may
15 you all have a -- a restful blessed summer, and we'll
16 see you again in the Fall. Thank you all for coming.
17 Motion for adjourn -- of adjournment.

18 **DR. VAN DER JAGT:** Yes.

19 **DR. COOPER:** Yes, thank you, Dr. Van
20 der Jagt. Dr. McEvoy, I think. All in favor?

21 **THE COMMITTEE:** Aye.

22 **DR. COOPER:** Aye. Opposed? Thank
23 you. We'll see you in the Fall.

24 (The meeting concluded at 2:51 p.m.)
25

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2 STATE OF NEW YORK
3 I, DANIELLE CHRISTIAN, do hereby certify that the
4 foregoing was reported by me, in the cause, at the time
5 and place, as stated in the caption hereto, at Page 1
6 hereof; that the foregoing typewritten transcription
7 consisting of pages 1 through 127, is a true record of all
8 proceedings had at the hearing.

9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 10th day of May, 2024.

11
12
13 DANIELLE CHRISTIAN, Reporter
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