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

5/6/2024 – E.M.S. for Children – Troy, New York

APPEARANCES:

Amy Eisenhauer
Ben Sensenbach
Benjamin Kasper
Bruce Barry
Chief Joseph Pataky
Daniel Clayton
Deanna Ratigan
Douglas Hexel
Dr. Alda Osinaga
Dr. Brian Clemency
Dr. Edward Conway
Dr. Elise Van Der Jagt
Dr. Kevin Albert
Dr. Kim Wallenstein
Dr. Linda Efferen
Dr. Matthew Harris
Dr. Pamela Feuer
Dr. Peter Dayan
Dr. Tiffany Bombard
Dr. Vincent Calleo
Drew Fried
George Stathidis
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

5/6/2024 – E.M.S. for Children – Troy, New York

(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?

5/6/2024 – E.M.S. for Children – Troy, New York

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?

MR. KASPER: Present.

MS. EISENHOWER: And we have quorum.

DR. COOPER: Thank you. So, the next item on the agenda is approval of the minutes from our February meeting. I trust you've all had an opportunity to review them. They were distributed via email sometime prior to the meeting. And so, I'll ask at this time if there are any additions, deletions, or corrections to the minutes?

MS. CHIUMENTO: There is one correction on page -- let me see -- this one, twelve. Somehow FDNY became SKDNY. So, it's -- it was S-K-D-N-Y instead of F-D-N-Y. So, it just needs to be changed.

MS. EISENHOWER: Thank you.

DR. COOPER: Thank you, Sharon. Any other comments? All right. Well, hearing none, I will ask for a motion to approve the minutes.

MS. CHIUMENTO: I'll make the motion.

DR. COOPER: Thank you, Sharon. A second, please.

DR. CONWAY: Second.

DR. COOPER: Thank you, Ed Conway. Any discussion? Hearing none. All in favor, please

signify by saying, aye.

THE COMMITTEE: Aye.

DR. COOPER: Opposed? Carries without dissent. Thank you so much. Okay. The minutes are approved. So, the next item on the agenda, of course, is from the very famous and accomplished Amy Eisenhower, our E.M.S.C. Program Manager, who will report on the status of the program and several items pertaining thereto. Amy?

MS. EISENHOWER: Thank you, Dr. Cooper. So, the first part that I will talk about today is our Always Ready for Children Pediatric Recognition Program. I'm very excited to have been at several events, again, promoting the program. And first I'll share that much thanks to Piswa and Peg. Our website has been updated, and I will show you.

So, we've had the page for -- since last June. However, they have now listed all the hospitals that have joined Always Ready for Children, and these are those so far. So, they are listed by county. And as we get more on the screen, you will be able to select by county and see which children's -- or which hospitals are participating in the program around the State. I also would like to give

a big shout out to the Monroe Livingston area, the -- the Finger Lakes RTAC. Lauren Pearson and Adam out there at -- at Strong have been doing great work, working with their hospitals in their region and their associated hospitals to get them to join and helping them with the survey and kind of mentoring the other hospitals in their system, which leads me to another really great announcement and partnership. Over the last month or so, the E.M.S. for Children Innovation and Improvement Center has -- has a grant from Toyota, which they are doing pilot programming in Michigan and in Texas right now.

Having a nurse at the Emergency Nurses Association in those states come into each of their trauma regions to be kind of that mentor, right, and help them with the assessment of their E.R. With doing the -- the survey, going through things, finding out where they're at, getting that base level, and then what next steps are based on what's already there and -- and fulfilling the needs that those facilities might need.

So, I'm very excited that there was a little bit of money left over. And I like -- I like

to think that they just love New York, but also, I understand I'm the squeaky wheel. And so, there's a little bit of money left, and we just got into conversations with New York State E.N.A. for having one, maybe two of our trauma regions have this nurse Pediatric Emergency Care mentor.

So, that is just in the beginning stages. And much thanks to New York State E.N.A. and Patrick Byrne for partnering with E.I.I.C. and our State program to -- to get these resources out there to the trauma regions. And more information will be coming on that it really is like that brand new. But I went to the E.N.A. conference two weeks ago. There's state conference. I talked about Always Ready for Children and got a lot of interest from different programs, and they're very excited.

So, that's great news. We also had a meeting between our group -- certain members of our group, and pediatric STACs, so certain members of Ped STAC on promotion and outreach for Always Ready for Children to hospitals and what can be done. And so, we had our first meeting. And so, kind of getting everybody on the same page and -- and we're going to continue that work. So more to come on that also in

the future.

Let's see. Let's see. So, the NOSEMSO -- I'll go back to this. So, the NOSEMSO Pediatric Restraint Device Testing Advisory Group that is -- sorry. Okay. So, that work is almost complete, at least the advisory part. The final document, I think right now they're having their final meeting, so good luck to them on that. But they have been sending us back the completed documents. Everybody's been kind of leaving comments and edits. So, hopefully those documents will be complete shortly to go to S.A.E. to begin their review of it, and actually begin building the, you know, potential testing which is exciting. And NOSEMSO continues to work on finding funding for the testing process. So, if you guys have any connections, you know, we need a few million dollars. It's not a lot.

Next is the E.M.S. for Children Data Center, or the E.D.C. Pre-Hospital Readiness Project Survey. So, this started May 1st, this was released. You may have gotten an email from a constant contact. Please fill out your survey. This will be -- you're just going to hear me like this for the next three

months. So, it started May 1st; I believe it goes to July 31st. They did redesign the survey this year a little bit, and here, let me find it and I'll show you. So, as you can see on here, they designed the E.M.S. survey to be more congruent with the hospital survey, to really provide an -- an assessment for your agency to look at and see how prepared are you for pediatrics, and then give you that next step of, okay, this is where you're at, this is what you can do next, this is how you can make that flourish. So, it's emspedsready.org. And it does have a lot of components right here just on this page. You can start your assessment, and I'll go through that in a moment. You can also print a copy of the assessment. It's in English and in Spanish if you're more comfortable with Spanish. And there are some links to a FAQ and then pediatricreadiness.org. Also, there's an email to the E.D.C. Center. You can also, of course, email me. So, more information all on this page.

And at the -- down here resources, there's a toolkit and a checklist in case you want to read them, you need some extra information; that's there for that. Also, they built this map. So, I

will say New Jersey, right, New Jersey looks like they're super overachievers that in just a few days. So, New Jersey, North Carolina and one other -- one other program were the -- the guinea pigs. They were the beta testers.

So, New Jersey has a hundred percent because they already did this. So, they started in January and ended, you know, in the beginning of April. So, they were the beta tester just to see how everything went to kind of fine tune the messaging and information that goes out to the E.M.S. agencies, to all the E.M.S. for Children programs.

So, that's why some of these numbers are super high because they were the testing guinea pigs. So, that is ongoing. Also on Vital Signs Academy, there is a tutorial for -- for the survey where I went through it. I went through all the questions. A lot of it is similar, right, where we're asking about pediatric education, but it goes into a little more detail, like, okay, what -- what kind of pediatric education, how are you approaching that, what things are you using, right? Because we don't really have a comprehensive picture of E.M.S. pediatric readiness across the country. And so,

that's what this is meant to be, to kind of see, okay, where are we at? What resources do we need to build? What resources do we need to offer?

So, please complete your survey because it will help the New York State program be able to know what resources our State needs, and how we can better serve you. But also, it helps the larger E.M.S.C. program know what is needed in the states and what is needed by the agencies. So, please do your survey. So, Nickol O'Toole, who is our Family Action Network member, we kind of chatted about this. Did anything come in the FAN meeting specific to this?

MS. O'TOOLE: No. Just other than it was coming out May 1st, and we do have till July 31st to get it done. And they said that the biggest push is from our State reps. So, hopefully we can get it out there. And I was going to say, let's try to beat New Jersey, but that's not going to happen. We'll do our best.

MS. EISENHOWER: Eric Hicken is persistent. Yes. And he has a large office team to help, yes. So, we also have some additions to our teams, speaking of E.M.S. for Children's teams. So,

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

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

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

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

MR. GREENBERG: I can cover it right now.

MS. EISENHOWER: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

DR. COOPER: Thank you, Ryan. Any --

MS. EISENHOWER: I have a few more things too.

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

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

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

DR. COOPER: We noticed. So, continue, please.

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

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

children that might need defibrillation.

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

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

process of mailing them and making sure that the listing contacts are correct. So, if your agency has had a change to the PECC or change to anything, and you're part of the PECC program, please go on our website and update your form, so that Allie can update that. We'll have the most recent contact information for your agency. Sadly, each agency only gets one, because the money was only so much money. But each will have one, and I'm compiling a list that will go out with them, so that you know where these things came from. And you can make as many more as you need if that's what you'd like to do. So, they come in a dry bag, and there's a lot of stuff in here. Oh, and I think something that you guys haven't seen already. All right, we'll get to the rest of that. So, we also have been working on that pediatric agitation document.

So, this is also posted on our website. So, you can get this right now on the E.M.S.C. website. Much thanks to everybody who, you know, contributed to this program and this project and all your hard work. So now we have a New York State one. It's very cute. So go online and grab it. Also, our updated P.A.T. document that you guys

have been working on, and much thanks to Sharon for doing all the editing, because that really helped, because otherwise I would've been like, I -- I don't know, like, just fix it. So, this is up to date. So -- and I mean, release two months ago. So, if you have not gotten a new P.A.T. document in the last two months, it's online. But you can also go onto our website, fill out the order form, and you can order either of these documents or the badge buddies, and Allison and I are -- are working on getting them out. So, you'll get one of each of these in the kit.

You'll also get badge buddies for your agency. In the kit, you'll get twenty-five, so if you need more than that, you have to email us. There's also medical communication cards. So much thanks to all the other E.M.S. for children programs. So, we do a lot of work here, but other states also benefit from that. So, these documents I share with other state programs, these badge buddies I share with other state programs, so that we're not all recreating the wheel, because just like for a long time, there's only been one of me, in many other states there's -- there's only one of them. And so, when we all create something, we share it with each

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

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

MR. BLOCKER: All right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. COOPER: Sure. One question, this will probably come up at CMAG a little bit later this week, but I wondered if you could enlighten our committee about the status of the hiring of a medical director for the Bureau.

MR. GREENBERG: Yeah, so we've gone back and forth. We did go through one round of what was going to be a contracted medical director. It did not yield the subject matter expertise; I believe that the department was looking to hire. And so we are moving forward on a permanent position. And I think you'll see that in this fiscal year.

DR. COOPER: Would that be a full-time position or part-time?

MR. GREENBERG: It looks like it's going to be a full-time position.

DR. COOPER: Wonderful.

MR. GREENBERG: Yeah.

DR. COOPER: Okay.

MR. GREENBERG: Wonder -- wonderful in some ways and challenging in others because sometimes full-time opportunities is not --

DR. COOPER: Yes. Understood.

MR. GREENBERG: Yes.

DR. COOPER: I think I -- I, you know, can express the wishes of the committee that the individual who the department ultimately selects have a, you know, significant background in pediatrics so that, that individual can work with us and -- and ensure that we can continue to provide the best for the kids throughout New York State. Thank you.

MR. GREENBERG: Wholeheartedly agree.

DR. COOPER: Yeah. Okay. I think we're up to some old business at this particular point. And the first item of old business to cover is the Monroe Livingston Regionally E.M.S. regions. A Handtevy implementation project. And we're lucky to have Dr. Maia Dorsett here with us today, who's been leading the charge. Maia, please take it away.

DR. DORSETT: Do it, yeah.

DR. COOPER: There you go.

DR. DORSETT: So red is on, it's good system design. All right. I'm very excited to be here, and I'm going to start off by acknowledging that this is not a project that I have done remotely alone. It's taken a lot of work, and it would not be possible without Amy Eisenhower, who was able to help us with this. So, what we took on was the challenge

of reducing pediatric medication error and improving peds medication safety. And we knew that this was likely a large problem within our region, just like it was in every single E.M.S. system that had ever been examined.

And one of the things that we were looking for were potential solutions because even though that the problem had been described that anywhere in the literature, approximately fifty to seventy percent of the time, pediatric medications, including critical pediatric meds were dosed correctly, which is like flipping a coin and hoping that you get the right dose for a child. There hadn't been a lot of publications showing how to get it right.

There was a lot describing the problem, but not a lot about solutions to the problem.

And in 2020, an M.S.P. published a position statement on best practices for pediatric medication safety and E.M.S. And the most useful part of this document was the resource document, which was a systematic review of the literature about what really are the evidence-based best practices of how

to do this right. And this included a lot of best practices, including getting weights and kilograms and using validated things like length-based tape, which came with its own set of errors, to improve weight estimation. But one of the key things was that there was publications including one by Rapaport L. in Denver Health, saying that one of the key innovations was using a volume-based dosing method. So that essentially the elimination of math in the real time of taking care of sick children who are medication dosing to get it right.

And so at the time, I had been developed a lot of interest. The Rappaport L. had used the Handtevy System, not currently the app, but at the time it was done, it was sort of paper cards within their system to implement volume-based dosing. And so, this was the thing that I had wanted to implement because I wanted a solution that had this particular feature. Not just like we're getting weights on kids, not just opportunities to practice, which are all really important. We'll talk about how we incorporated that into our implementation, but something that took the math out of it.

And I was significantly more motivated

5/6/2024 – E.M.S. for Children – Troy, New York

to do this when we implemented a medication crosscheck regional medication safety initiative in our system. And Sharon actually works at the -- is -- works with the agency where I'm a medical director. And I just happened to pick a scenario of a five-year-old with a seizure as our scenario to practice a medication crosscheck. And the difficulty and the time lag in coming up with the correct dose of midazolam for this simulated seizure patient while I was just standing there, right? Like it was a mannequin. There was no seizing child, no crying parent, none of this in that circumstance, it took forever for a bunch of the paramedics even. And the Broselow Tape was outdated, and it had diazepam in it, and so like I fixed all those things, but I mean, like, I need to have a system to help people take care of children in this circumstance and actually improve safety. So, the Handtevy system was one of the few that does that.

So, this is what it looks like. This is a screenshot of the app and I'm happy to show anybody what it looks like. There's length-based tapes that go along with it, but there's also, you can just use patient age. So like when you get

5/6/2024 – E.M.S. for Children – Troy, New York

dispatched to a six-month-old seizure, you can actually just like click on that and they show that you're actually pretty close to the correct, unless the kid has some other reason that they're going to be smaller than normal or larger than normal. And then it can take you through -- you have the list of medications and the key component of it is that it has, what is the concentration of the medication and the volume to be administered. So, you can click on that, and it'll pull it up. And even more importantly is you can link it directly to your protocol. So, if I'm dispatched to a seizure, I can search a protocol, and it will automatically -- it's integrated into the protocols, pull up the protocol, but pull up all medications, the correct dose for that weight child as part of the application.

So, you can't see this, but it's in the report that was handed is we really felt that it's never just the tool, it's always about how you implement the tool. And so we thought this had to be coupled with education integration into normal practice. We had to get this right, including knowing the concentrations of the medications in our field. So, the first thing we did actually, because

5/6/2024 – E.M.S. for Children – Troy, New York

we were doing a regional implementation. So, to describe our system, we have twelve A.L.S. agencies, a bunch of -- a couple A.L.S.F.R.S. This was initially an A.L.S. implementation. We've brought on 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

5/6/2024 – E.M.S. for Children – Troy, New York

that. So, the only medication with variation in dosing was ketamine, where some carried fifty mgs per 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

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

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

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

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

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

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

So, we have variable usage within the group.

Medication error is a hard thing to

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

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

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

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

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

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

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

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

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

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

at the time.

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

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

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

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

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

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

on how to use this and have people, like when we did that, I realized a bunch of people didn't know how to use a stop for pediatric dosing of pediatric epinephrine in the cause of a cardiac arrest. Like we need to integrate those. So, doing the checklist, one of the things that we're doing regionally because of the -- the readiness checklist is we've -- and I think this created the model for it, was how do we as a region, as a program agency, make it easier for agencies to be pediatric prepared? Because I think thinking of that, every single agency that has a limit of bandwidth, limit of people trying to create these opportunities is going to be successful in completing every element of this gap analysis is not really sort of realistic about what people -- the barriers that people experience every day.

And the Handtevy project showed us that as a region we can actually come together and solve something by creating a system where it's easier to do the right thing, right? Like if they have an issue or suggestion, there's one email they send it to, me or our other administrator take care of it, follow up on those requests. I'm finding errors that agencies didn't know about. Because I'm

looking at regional data and every time I find a clinically significant error, every quarter when I look at the data, I email that agency and let them know so that they can look into it. And so, we've created a pediatric advisory council as a subcommittee of our RMAC. And one of the things that we're going to do is not only continue the work on quality control here because we still have opportunities, but also think about how do we create those continuing education opportunities that are going to like support safe pediatric medication dosing as well as care of critically ill children. Sorry. Thanks. That's it. Lots of people to thank.

DR. COOPER: Thank you so much. That's incredibly thorough report and phenomenal work. And if a program like this could be, you know, exported statewide you know I think we could substantially reduce the rate of, you know, medication errors in children. I see Amy giving me the eye here because of course that -- that would be quite an enormous undertaking. But at the same time, it's a necessary undertaking to make sure that kids are being properly dosed, you know, when medications are utilized. And of course, I -- I also can't help

but comment that, you know, this is, you know, the first time we've heard from -- from Maia Dorsett. And that was just amazing. And we hope that you become part of our family here and going forward. And, you know, your -- your future participation in E.M.S.C. will be, you know, I'm sure a welcomed with open arms by all concerns. So that was just a great presentation and a great job. And thanks for your diligence in carrying this thing, carrying this through. Not easy. Questions for Dr. Dorsett? Dr. Van der Jagt? Of course. It's our microphone.

DR. VAN DER JAGT: First of all, I think this is a great project that you've embarked on in my backyard, incidentally. Okay. And it's -- it's absolutely wonderful. And I think that the -- the examples of seizure management I think is especially noteworthy. You know, over the last ten years, you know, we've really, maybe even five years, the we've recognized the importance of rapid response to seizures. It never used -- I mean, it used to be when I was in training, it was like, okay, give them thirty minutes, then you call it status epilepticus and then you have another half hour.

Now it's recognize it within five

minutes, get it under control within ten to fifteen minutes, and do it that way. And so, the midazolam intranasally, which is I presume you're talking about, is critical. And of course, the dose has to be right. So, if somebody is really, you know, having a problem with figuring out the doses, that is a really important thing. So that example, especially I think in my mind knowing how important it's to treat seizures and how often these occur in children, I think is especially important in terms of rolling something this out statewide.

So, I think you've done the pilot project, which is -- which is absolutely wonderful in a much -- in a controlled, relatively controlled setting. But I've a couple questions, also. One of is of course, and you alluded to this, is the importance of that the concentrations of drugs are the same. Because if the concentrations vary then the volume-based dosing is a problem, right? That's number one. And then the second is a question that has to do more with in rural areas where you may not have the ability of, you know, there's no Wi-Fi, you don't have I internet, you can't do it because of some of the barriers geographically, will that affect

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

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

With regard to timing of medication,

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

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

MR. SENSENBACH: I can answer that one.

DR. DORSETT: Oh, okay.

MR. SENSENBACH: So, the -- the way

the app is designed --

DR. COOPER: Can you identify yourself?

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

DR. COOPER: Jeff sit down too.

MR. SENSENBACH: Which -- which button then?

DR. DORSETT: Right there.

MR. SENSENBACH: Which button?

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

MR. SENSENBACH: Here you go.

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

MR. SENSENBACH: Which button guys?

MS. EISENHOWER: The face.

DR. DORSETT: The face. The theory.

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

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

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

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

DR. VAN DER JAGT: You don't have to be online; you have to —

MR. SENSENBACH: Correct.

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

MR. SENSENBACH: Correct. Correct.

DR. VAN DER JAGT: Thank you.

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

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

DR. COOPER: Thank you.

5/6/2024 – E.M.S. for Children – Troy, New York

MR. SENSENBACH: Yes.

DR. COOPER: Oh, go ahead.

DR. DORSETT: Sorry to roll over the time.

DR. COOPER: Let McEvoy, please.

MR. MCEVOY: There's -- so you're probably aware that there's research going on in peds now looking at age-based dosing versus weight-based dosing. And would this like be able to accommodate that if that pans out?

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

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

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

DR. COOPER: Other questions?

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

MS. EISENHOWER: So that research is

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

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

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

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

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

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

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

best practices. Like that's why I think that paper like outlines like what are the elements, and then you have to think about how do people integrate this tool. The problem with most of what we create for pediatrics is we act like it's special for pediatrics and then nobody pulls it out until they have a sick kid. And the last time they pulled it out was their training two years ago and they don't remember how to use it. Like, just think about like the straps on a pediatric transport device, right? Like, we have to integrate that. And I think that's one of the great things about the pre-hospital pediatric readiness project. It's making you ask like, when was the last time we did pediatric training? Are we doing it regular?

I think the solution has to be something that people use every single day for adults that they then know how to use for a child, right? Like, if it's something absolutely special, they're not going to feel it's going to be foreign and weird and cognitively overloading in the context of the situation of where all those things are possible.

So it can be literally like note cards as long as those note cards are used regularly for

5/6/2024 – E.M.S. for Children – Troy, New York

adult medications, right? And that you're updating them accordingly. It could be another app, but I think it needs to be noted like math free is the solution.

MS. KACICA: Hi.

MS. EISENHOWER: Marilyn?

MS. KACICA: Hi. Thanks for the outstanding presentation. And when I first heard -- when I first heard volumetric dosing, of course my brain went to kind of quality projects in A.E.P. looking at -- oh, going away from volumetric dosing, but you sold me for this group. My question is, have you thought ahead to that doing the right thing pre-hospital, but then you get to the hospital and that handoff; how is that volumetric dosing going to be handed off accurately to the new providers, especially when hospitals may have different concentrations of drugs that are on the truck, et cetera?

DR. DORSETT: Excellent question. So, the app, when you click on the medication, what shows up is the volume, but you also have the correct milligrams. So, you can actually pull up the patient report and when it gives you it does -- if I pull up

5/6/2024 – E.M.S. for Children – Troy, New York

the patient data from my phone, it doesn't give me the M.L., it gives me the milligrams or grams or whatever that I administered. So, it shows me like when I pull it up, the actual dose, not the M.L. administered.

MS. KACICA: So, in that handoff before, you know like the printed stuff that comes down the line afterwards, someone would be able to bring up their dosing on the app and show that to a provider in the handoff?

DR. DORSETT: Yes. And even for like a cardiac arrest, there's a cardiac arrest component of the app that has like a -- a metronome ventilation. So, we have a default set to fifteen to two, right, because kids are, like, different than what we're used to doing. Every time you click on that, it creates a patient record. One of the things we're working on, with some barriers from some of the P.C.Rs who want to charge us more money to do the right thing, is direct integration into the app. So like when the provider is done with their chart, it automatically -- they can import that data with the times of administration as well as the correct dosing directly into their chart.

5/6/2024 – E.M.S. for Children – Troy, New York

There's integrations with ImageTrend, E.M.S. charts. E.S.O. is a bit of a different integration. The hard part for us is that we're a region not an individual agency, which creates its own special circumstances and -- and difficulties. You know, my dream is someday we just have H.L. Seven, right? And the data flows to the hospital and everything is integrated, right? And what appears is I want to know what that kid got, I just like pull it up and it's one seamless thing where I can see exactly what it is that was sort of clicked in the context of the app. That doesn't exist today, but it doesn't mean it's not like the technology exists to make that happen.

But for now, you can definitely pull up the -- like you can review within your chart and show that. And that's actually something that I think we have to be, once you roll something out, you realize all the things that you would've changed. I think how we integrate some of that into our handoff, and how they can use, they can see the milligrams, not the M.Ls;

That was a deficiency in our education that as we roll out some of this other stuff is

something that we need to work on. Simply from the commentary we got where they're like, it only shows the M.L. I'm like, no, it definitely shows you the milligrams, but they weren't sort of clicking on the thing and -- and pulling it up.

MR. SENSENBACH: Yeah, I definitely like that you eliminate math from the equation because a lot of people just really don't -- it's very awkward looking one way and talking the other. Taking math out of the equation because a lot of people yeah, they just don't get it right simply. And when you're in high moments like moments of high stress, you're not necessarily going to be, you know, able to necessarily function that way. So, I really like that. I know that you mentioned as well that there was -- it's all volume or it has the option for volume-based dosing based on common concentrations. I know one thing that is in like the hospital-based system where at least I'm a part of its similar where it pulls up, you can flip a binder to the appropriate weight. It gives all of the appropriate med or all the, you know, A.C.L. or PALS medications that you might be administering, and it gives you the -- the volumes of each of those. And actually, I have a

P.D.F. of all of those.

One of the -- the worries that I have is like too many apps just by, because it would be nice to have a one shop or one stop shop like, and I noticed that I just pulled up like the Muru app, and I was like, okay, I went into the dose calculator and if you put in a particular dose but then you flop to a protocol, it doesn't do the -- the -- the math for you, and it gives you -- it usually kind of defaults to like a -- like adult dosing system. So that could be confusing with our current setup, but to have something where it can be integrated into a preexisting app, and the Muru app is a lot better than, you know, previous protocols that have existed. But it would just be really nice to have a one stop shop to be able to kind of accomplish all those goals. And I think it's great how you've reduced the medication administration errors by, you know, fifteen percent.

DR. DORSETT: Yeah. So, the -- the app -- the protocols are in the app, so in our region it serves as the protocol app.

MR. SENSENBACH: Got you. So, it would basically just go and it's in place of Muru.

DR. DORSETT: In our region, it's used in that way because we've integrated the drug dosing, yep.

MR. SENSENBACH: Nice. And is there a hard stop too to like, so you can't supersede an adult dose? Did you like embed all those? Okay.

DR. DORSETT: Yeah.

MR. SENSENBACH: Yeah. Just signal that could be.

DR. DORSETT: In the setup, we created the entire setup and then we had --we reviewed with a committee, we all like played around with the apps, made sure that we found a bunch of errors. Then we identified a group of clinicians to try and break all the things and find all the errors. And so, we piloted with a small group who found all the things and whenever somebody has brought up anything confusing, they message us immediately, and we fix it. The reason the app is expensive is because there's twenty-four-seven support, and they will fix any error that you identify usually within about twelve hours.

MR. SENSENBACH: No, that's excellent. The -- the other thing that the -- well you -- you've

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

of length-based resuscitative scale and the provider estimation without any of those tools was found to be grossly inaccurate. So, that's just maybe something, and -- and I could share those findings with you at some point too, like because it's interesting like, because especially when you're dealing with like --

DR. DORSETT: When I said they're taking the weight the kids are weighed when they come to the E.D., and the E.M.S. providers are writing it into their chart.

MR. SENSENBACH: Oh, okay. Understood.

DR. DORSETT: Because I can -- because we can pull from the, right, epic rights whether or not it was an actual or stated. The act it's always an actual because our E.Ds have regulations that every patient eighteen and under must be weighed as part of their initial vital signs, like on a scale. So, it's not ideal body weight, but it's total body weight. I think the thing is, it led to clinically significant error. So, we have one that's technically an error on versa dosing where it was point seven five of the actual dose and it's because it was a one-year-old that weighed thirteen kilograms

and, they used an estimate of a one-year-old weighing ten kilograms, and it's point seven five. And I would say I'm not -- that does not keep me up at night, right? Like, you're close to the ballpark fivefold overdoses or children getting twenty five percent of the correct versa dose for their seizure and only getting redosed five minutes later. That keeps me up at night.

MR. SENSENBACH: Definitely understood. Well, it's -- yeah. And -- and taking math out of the equation, you know, that pesky little decimal point, you know, you don't want to give ten times or one tenth of a medication, because that's not going to be therapeutic. Right. So no, I think that's great work. Thank you for sharing.

MS. EISENHOWER: Yes. So, I did just want to address the medication calculation that Ben just brought up in the Muru app, because I have been able to calculate medications in the Muru app. And we -- actually, Steve Blocker is here. He came early for meetings. So, if nobody minds, he can talk to the specifics of that because I used it, but he knows how it works. So, if you want to just come up real quick and explain how that works for, you know,

maybe, you know, you're not the only one that has experienced that.

MR. SENSENBACH: I -- I feel pretty strongly with my ability to do math, but yeah. Thank you.

MR. BLOCKER: Hi, Steven Blocker, CEO of Muru. So just to answer, first of all, this study is amazing. So, rarely do we get to see anyone admit the -- to document a baseline to then watch the improvement. So like, thank you for all that incredible work.

To answer your question about pediatric dosing, about twenty-five of all the doses done in Muru are for pediatrics. They also use it mainly for adult pain management and other things like that as well. But the way we have them do it is rather than focusing on pediatrics, when they either go into Dose Builder, they select an age, but in reality, just with search, they can say, I have a seven-year-old, and it knows that fifteen years old is the cutoff in New York. And then automatically starts calculating for pediatrics.

So, if they say anything from barking cough for a kid, it'll know, right? We're going to

protocol that covers croup all the way through. So, the pediatric dosing is in there too for that purpose. And as far as the adaptability that was brought up before with regards to kind of weight-based testing, I totally agree, right? If it's not all in one place there, it's -- it's incredibly hard to get people to -- to remember which app to pick up for what thing. It does need to really be incorporated.

MR. SENSENBACH: Thank you.

DR. COOPER: Well, I want to thank everybody for their -- their questions and comments. And I want to thank Dr. Dorsett for, you know, an incredible presentation and for fielding these sometimes difficult questions with aplomb and, you know -- and in detail. So, thank you, Dr. Dorsett, and we hope we continue to see you here all the time.

DR. DORSETT: Thank you.

DR. COOPER: If I might add one last comment to the discussion here before we move on. You know I was part of the initial group that developed the initial set of pediatric protocols back, you know, in the thirteen hundreds. And -- and, you know, the -- the truth of the matter is that

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

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

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

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

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

but also the emergency department and in the I.C.U.

So, while this work is really important, we want to make sure that the medication doses are -- are as close to -- as close to exact as we -- as we possibly can. At the same time, you know, we want to ensure that we're not neglecting the basics. And -- and -- and I -- and I think that it -- it's incumbent upon all of us to ensure in our educational programs and quality improvement programs that the -- that the major focus remains, you know, where it belongs: on supportive ventilation, oxygenation, and profusion while we get the kid to the hospital. So that's my -- that's my little soapbox editorial. Forgive me. But I can't help it. I'm a dinosaur, you know, and there we are. So --

MS. EISENHOWER: Jump to this since we're kind of talking --

DR. COOPER: We can do that. And particularly -- and particularly because Meghan Williams is in the room. So, we are going to jump ahead at Amy's excellent suggestion to hear from Meghan Williams about the length-based resuscitation tape review project that has been led by our colleague Meghan Williams from Borough of Manhattan

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

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

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

that the apps have the exact information; there is no gap. And the other big thing that we saw was that there's a very big difference between resuscitation tapes that are focusing on literally resuscitation and excluding the other medications that you would give during an emergency.

So that seemed to be the largest gap when we were talking about resuscitation tapes. They are focused on resuscitation. And as you look through this document and you look at the different resuscitation tapes as opposed to the apps, there are a large amount of medications that are just not on those tapes.

So, they might be cheaper overall as we're looking to fill the gap of the medication errors and also what is out there for providers to use; they're missing a lot of medications. And it really comes down to their focus on resuscitation. And we've expanded from twenty, thirty, forty years ago on the amount of medications that we give, and certainly in the pediatric realm. So, resuscitation tapes are doing resuscitation and creating a very large gap in the rest of the drugs and forcing a lot of math, which we've talked about and lot no one

likes to do, especially in the stressful situations. So, closing that gap is a big thing.

We talked last time in February about whether or not the providers had more difficulty or were taking longer to implement an app versus the actual paper, or just straight up memorizing. And like Dr. Dorsett also said, our students and our newer providers; technology is everything. So, the biggest gap to implementation was really the instructors and the evaluators learning, when they didn't have an app when they first started. The students on the other hand yeah, they were teaching us a lot of the time because it's just intuitive for them. That's we saw that they had much more time delays and much more of a problem not implementing an app and not relying on that. Obviously, we train them in proper technology etiquette.

So not just sitting there and ignoring the person, not having eye contact, and just getting on their phone, and the person, the patient being able to assume, well, they're just taking a picture, or they're not interested, or they're checking their email or making dinner plans. We obviously address that very quickly into proper etiquette to make sure

that it doesn't cause more stress into the situation.

So, we saw a lot with this gap analysis, really just highlighting the basics that the resuscitation tapes are exactly that; they're resuscitation, and we've expanded exponentially into the amount of medications that we can give. And there's a large gap there. And as Dr. Dorsett said again it's expensive. So, we did look at Handtevy. The cost for each one of these is listed on the three devices that we did look at whether or not it was the paper tapes or physical tapes or the apps. So, all of the prices are listed towards the end and Handtevy tends to be very expensive, as everyone talks about.

Muru is another good option as far as coming along and giving or filling the gap here with medications and significantly cheaper if not free in some of these aspects. So, I think that it -- this gap, or this gap analysis really highlighted what are we doing with medications, and where have we come from and gone to, and what are the expectations? And it dovetails perfectly into Dr. Dorsett's research and implementation as well.

DR. COOPER: Thank you, Megan. Where do you think you're going from here in terms of this

project?

MS. WILLIAMS: I'm certainly looking at implementation over the next couple of months with both Muru and Handtevy into our paramedic students, and then into the fall semester with new paramedic students starting and hitting the ground running. I think the original question that caused this analysis to begin with was whether or not the protocols matched or whether or not the protocols had an adjunct to make sure that the providers were able to give the best care possible.

This really just highlights that we don't have one particular system. And I know in the last meeting, we were talking about maybe having a document that was a quick down and dirty one page document for people to reference; that could be an option as well. But whether it's Dr. Dorsett's or this particular project, it really does highlight that there is a gap here that we need to fill in some way, shape, or form.

DR. COOPER: I guess what I would wish for children of New York State is that you and Maia could get together and sort of, you know, dovetail your efforts so that, you know, we can, you know, if

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

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

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

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

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

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

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

well.

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

MR. GREENBERG: Mr. Chair?

DR. COOPER: Sir.

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

look into something and then come back and provide a report and some information from that. And I just think that that's a pretty incredible new kind of way of approaching it for us, both engaging our paramedic students who are the future of E.M.S., as well as, you know, having a need of something to be looked at. We often look and say, well, there's plenty of things we'd like to look at, but we don't have the time or the -- the bandwidth to do it. So, I would just like to -- to recognize also Meghan, her team and the initiative of taking an alternative pathway to -- to look into some research it because I think that's pretty amazing and -- and really appreciate everything that you've done and your students particularly

MS. WILLIAMS: Greatly appreciated for that too. And to be honest, I did it to serve two purposes. One, it definitely benefited their education. and two, I didn't have a lot of time, so they certainly were able to help with that, to say the least. But I will say, just to add on to what you're saying and emphasize what you're saying, the small amount of additional time in putting together the rubric and the homework assignment paid off

tremendously. I have very passionate, interactive students, and they weren't necessarily like that before on this particular topic. They grumbled a whole heck of a lot on the extra work that they were doing, but now they're really invested, and they're really invested in getting down to the minutiae and asking the questions of, but why and why can't we do this? And that is really exciting going forward, because I haven't seen that level of engagement and involvement in the past fifteen years of running paramedic programs. And they are also participating and informed, not only on their county level, but on the state level.

So, I'm getting a lot of questions, whether it's positive or negative with them saying, well, I heard from going to the state meetings that we're not going to have a practical skills exam anymore. Can you tell me? And I'm like, no, good, but roll it back a second. So, it is very exciting about what they can potentially do towards the future, and they're looking into how to get more involved, which is very exciting because we need more people doing more things.

MR. GREENBERG: How many students

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

about our favorite subject for which Dr. Van der Jagt has almost single handedly and assured us that no drugs will ever be needed, because we're going to be doing everything by de-escalation. Let's hear about the Pediatric Agitation Project. Thank you.

MS. CHIUMENTO: Well, the work group has been very busy in the last couple of -- of months. We've actually started to develop the scenarios that we've been talking about doing. They've finally gotten some work done. Meghan has done a great job on one as well as Vera Foyer. So, the two of them have developed their -- their scenarios. I sent them all out. I believe everybody here should have received it on email last week from me with the -- with the scenarios in them, so that you can take a look and see. We would like any comments if anybody has any comments about the -- the current drafts of the scenarios so that we can go the next step and actually start to -- to get some of the videoing done.

So, my goal would be if anybody can -- has any comments, if they can send them to me by let's say Friday of this week, then I can get everything over to Chief Pataky and he can start to

5/6/2024 – E.M.S. for Children – Troy, New York

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

DR. COOPER: Please, Meghan, go ahead.

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

MS. CHIUMENTO: Okay. So --

DR. COOPER: Thank you. That would be great.

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

DR. COOPER: Yeah.

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

5/6/2024 – E.M.S. for Children – Troy, New York

to get these videos produced.

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

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

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

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

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

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

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

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

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

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

DR. COOPER: Thank you. Sharon?

MS. CHIUMENTO: Dr. Van der Jagt, could you send me that contact information? Thank you.

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

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

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

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

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

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

MS. EISENHOWER: Sure. So, there were

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

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

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

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

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

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

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

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

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

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

MS. EISENHOWER: I have their report.

DR. COOPER: Ah.

MS. EISENHOWER: Yes.

DR. COOPER: Okay, please.

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

So, I will read them to you. So, the New York State Department of Health Sepsis team will be presenting the results of the sepsis protocol and training requirements Heard survey that was completed last fall on June 5th, 2024, via Statewide Webinar to be hosted. And it will be on their announcement's page and their webinar link will be posted there in advance of the meeting.

So, the survey was administered to assess how hospitals across New York State that report sepsis data are currently implementing sepsis protocols and sepsis training requirements in accordance with Title 10 Health of the New York State Codes Rules and Regulations Sections 405.2 and 405.4. The regulations have specific protocol requirements for infants and children, and we will be reviewing aggregate results from hospitals across the state and sharing key takeaways. They also mention that the sepsis team has continued to plan for the release of the 2021 sepsis public report. The report will be released in a dashboard format with previously unavailable features to allow users to interact with the data.

The report is not yet available but

will be hosted on the New York State Department of Health Sepsis Webpage when approved. As stated in previous updates for our committee, the New York State Department of Health Sepsis Team will be happy to provide a more thorough update to the committee once the report is public.

DR. COOPER: Thank you, Amy. And please express our thanks to George Stathidis who is assisting Dr. Osinaga and Efferen and, you know, in this arena. I do think that we should impress upon our colleagues in the quality and safety, you know area, how important it is to this committee that they be here in person to provide a report.

You know, I think we all recognize that that -- that sepsis has become, you know, a leading cause of death in New York State's children, probably second only to trauma. And something that needs to be, you know, made exquisitely aware to this particular -- this particular group recognizing the signs of sepsis in the field remains a challenge for our colleagues in -- in E.M.S. but also in many emergency departments where the volume of -- the volume of patients with, you know, pediatric sepsis can be pretty low.

And therefore, the experience in identifying sepsis in its early stages, you know, not always as good as we might like. So, the help of our colleagues in the division of quality and patient safety will be very, very important as we, you know, think about how to really assist our E.M.S. providers in -- in getting the -- the -- in -- in getting the recognition done as -- as quickly and accurately as possible. So, thank you. Elise, please.

DR. VAN DER JAGT: Yeah, I -- as you know, I've been very involved in sepsis. I'm on this committee actually, but I just wanted you to know is that the World Health Organization has put out some statements about this. There's been a recent, as you know world Health Organization International Day of Sepsis in these past few weeks, and I just crossed my -- some data across on their website is that almost half of all estimated sepsis cases worldwide occurred in children under five years of age. So, this is truly a pediatric problem. As you say, Dr. Cooper. This is something that we need to be very involved with, and I think this is important.

DR. COOPER: Thank you, Dr. Van der Jagt. And of course, I -- I would be remiss if I

didn't acknowledge Dr. Conway's contributions to the international efforts in, you know -- in recognition and management of pediatric sepsis. So, Ed has been a, you know -- a real stalwart in that area and member of the -- the -- the committee that helped devise our national protocols. And you know Ed, I'd invite you to add anything you might want to add at this point. If you have anything to say, don't feel as though you do if you don't want to, but that's fine.

DR. CONWAY: Thank you for the acknowledgement.

DR. COOPER: Thank you. Okay. Now we move on to our colleagues Susan Stegich and Kate, Alfonso from what is affectionately known as BOHIP, the Bureau of Occupational Health and Injury Prevention from the department to tell us about current injury prevention activities.

MS. STEGICH: Thanks so much. All right. A few updates that we have for pedestrian safety. We're continuing our pedestrian safety campaign media by. The Department of Health ran a visibility and winter campaign, as well as a distractions campaign in April. And so, our goal is

5/6/2024 – E.M.S. for Children – Troy, New York

to raise awareness and reduce pedestrian related risks through education and outreach on pedestrian related vehicle and traffic law. We're continuing to develop new tip cards to raise awareness on the understanding of traffic control devices at crosswalks and how to use those devices for crossing safely. We're also conducting three focus groups, one of which we just finished conducting in Albany, Rochester, and Yonkers to learn more about what community members believe are barriers to vulnerable road user safety. And we define a vulnerable road user as a pedestrian, bicyclist, person using an e-bike or an e-scooter or other rollers. And this also includes pedestrians working in work zones. We did just finish our -- our first focus group that was in Albany, and it was at Albany High School.

So, we spoke to kids that -- that go to Albany High School to see what some of their concerns were as it related to pedestrian safety and what we could do to help them in that area. For child passenger safety, we have a C.P.S. pictorial video that we're producing that's going to illustrate car seat installation instructions for limited English speaking and reading populations. So, it's

5/6/2024 – E.M.S. for Children – Troy, New York

going to be very picture focused.

Additionally, we have a counterfeit car seats publication that we're collaborating on with different subject matter -- experts, and it's going to be focused on the dangers of using counterfeit car seats. We're also going to be holding a safe travels for all children, or stack training June 19th and 20th at the Helen Hayes Hospital in Rockland County. For motorcycle safety, we are collaborating with Columbia University, the Governor's Traffic Safety Committee, and the Motorcycle Safety Foundation to join the Seneca Tribal Nation at their community fairs. And we conducted a motorcycle helmet fitting and shared our -- our safety publications at those fairs.

In terms of micro mobility, we're going to be collaborating with the Bureau of E.M.S. and trauma systems, thank you to Amy, to develop a micro mobility tip card focusing on e-bikes and e-scooters. And we just intend to bring some familiarity to the topic for folks in E.M.S. for young driver safety, the Driver Education Research and Innovation Center, also known as DERIC. The first of three workshops for DERIC was held on April

5/6/2024 – E.M.S. for Children – Troy, New York

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

REMSCOs.

And the second performance standard that they approved was to track staffing and regularly report calls that are received, calls that are answered, calls that are turned over, and calls that are answered in other agencies jurisdictions, which will give us some data on performance of the system. And both of those are sustainability standards. So, the actual language of them needs to be worked out, and they'll end up in regulation basically at some point in the future.

The other thing that did happen which didn't occur at SEMSCO, but SEMSCO was very excited about all the things that were added into the governor's budget for E.M.S. None of those made it through largely because the assembly doesn't believe in passing legislation as part of the budget. And so, they tend to veto everything that's legislative. However, if you look at the New York State Association of Counties website, there's a section on there called Rescuing E.M.S. And they list out ten bills that are currently one house bills, some of them with co-sponsors that take all of the language that got deleted from the -- the governor's budget

5/6/2024 – E.M.S. for Children – Troy, New York

and put it into separate bills. And so, I would anticipate a significant number of those actually flying through before the end of the session in the next few weeks. So, I think most of us feel relatively comfortable about that. And I think the reason why is there's very little opposition. There's a lot of agreement between E.M.S. organizations, their associations, the Association of Counties, the Hospital Association of New York State, and -- and even the nurses in -- in a lot of those areas. So, I think we'll see some movement on a number of those things.

I think that's -- that's primarily the key things that are happening. There's a -- a lot of work going on with the state council subcommittees in between meetings, and most of them meet at least monthly, if not more often. And we'll -- we'll probably have a whole bunch more news to give you at the next meeting after we meet in the next couple days. Unless there's any questions.

DR. COOPER: Questions for Dr. McEvoy. Okay. Were, hearing none. I apologize to you all for inadvertently skipping over our report from the Healthcare Emergency Preparedness Central Office

5/6/2024 – E.M.S. for Children – Troy, New York

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

5/6/2024 – E.M.S. for Children – Troy, New York

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

Ready for Children Program, please do so. It's really a -- a very, very important program. And of course, Amy can help you, at least I hope she can now -- now that she's, you know, doing both jobs until she -- until she finds, you know, someone to assist with E.M.S.C. But until that time, which we hope won't take forever, please reach out to Amy for assistance in getting involved with that program. It's -- it's really so important. Thank you. Any other questions for Deanna? Okay. Thank you, Deanna. And give our regards to Kate. Thank you.

Last but not least the Estate Trauma Advisory Committee and Pediatric Trauma Subcommittee did meet earlier this year. Really, the major issue that was on the -- on the agenda was in fact, the Always Ready for Children Program. There was some discussion about the -- about the the pediatric TQIP report as well, but most of the meeting focused on the Always Ready for Children Program because and it was, as most of you are aware, or many of you are aware, at least those -- those of us who are part of the trauma world realize that the New American College of Surgeons grade book standards do do include a requirement that pediatric facilities

participate in the, you know -- in the National Pediatric Readiness Project. And of course, Always Ready for Children is a great way to do that. So, bear in mind that that is a requirement now if you are a trauma center.

So please make sure that the folks who work with you are, you know, in the process of signing up for this program if they have not already done so. It -- it's relatively painless as many of these surveys go, you know. It's less painless than some others, or a lot more painless than some others, I should say. And it is really important that that New York State have an opportunity to really review this data in terms of where we are, you know, not just as individual facilities, but on a statewide basis. So please, please, please get your -- get your PGD folks to really participate in this. Of course, those of you who are working with E.M.S. agencies, please be sure that you're, that you're getting your E.M.S. agencies to participate in the -- in the pre-hospital part of this project as well.

The Stack will be meeting at the end of this month. Work, of course, remains ongoing in terms of getting everybody, you know, verified by the

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

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

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

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

5/6/2024 – E.M.S. for Children – Troy, New York

additional projects to focus on as a committee that will improve the -- the lives of children across New York State. So, with that, any final comments from any member of the committee? Well, thank you all for your attendance hearing. Then, Amy, we are meeting again in September --

MS. EISENHOWER: September 16th.

DR. COOPER: September 16th, I presume we are here, correct?

MS. EISENHOWER: We are going to --

DR. COOPER: You're not here.

MS. EISENHOWER: -- be in Saratoga,

DR. COOPER: Oh.

MS. EISENHOWER: September 16th in Saratoga. And there is a time change, but --

DR. COOPER: Microphone.

MS. EISENHOWER: I was -- I -- sorry, I was telling Dr. Cooper so he could relay it, but so it will be in Saratoga. I know that there was some difficulty finding a place large enough for all of us to meet. So, we did find a place in Saratoga. I will relay that information as soon as all of that is confirmed because I work with Theresa so much thanks to Theresa who handles SEMAC and SEMSCO for also

5/6/2024 – E.M.S. for Children – Troy, New York

helping with all the hotel stuff for E.M.S. for children because we work together on it to make both of our lives easier.

So, once I have that I will send out all of that information. Also, the time is changing for the meeting because they had one room that fit all of us. So, we have to share Monday with the program agency meeting.

So, we will, which is currently going on now, which is why some of the people here have left. So there -- here we can have an overlap because there's more rooms, but there, there's one room. So, we have to share, and I will let you know the time difference as soon as all of that is confirmed.

DR. COOPER: Do you have -- do you have a guesstimate as to what the time might be at this point?

MS. EISENHOWER: From off the top of my head, I think we said ten to one, because their meeting is two to five. And I -- I recognize that some people like to drive in in the morning, and I was not trying to make you wake up at two a.m. because I do that for the -- for the airlines, but I

5/6/2024 – E.M.S. for Children – Troy, New York

can sleep on the plane. You can't do that while you're driving on Route Ninety. So, I recognize that some people do need to travel to get here. For those of you who do need to travel to get here, we will work on your travel information and, you know, obviously all the same stuff that applies to coming here, we'll apply for there.

DR. COOPER: And Ryan, I presume that we can expect that SEMAC and SEMSCO will be meeting immediately thereafter, correct?

MR. GREENBERG: They are.

DR. COOPER: Thank you.

MR. GREENBERG: And actually, it will come up, it is not definitive yet, but it looks like that Thursday after will be the E.M.S. memorial. Which had to be moved from May.

DR. COOPER: Thank you very much. That's very important information. And then finally one other special thought for Amy and Ryan. It was stated earlier in this meeting that during E.M.S. week E.M.S.C. Day is May 22nd. I realize time is short, but I -- I wonder if there's anything special we could do to honor our, you know -- our program and its effect on, you know, sanitary effect on the

5/6/2024 – E.M.S. for Children – Troy, New York

children of New York State. Ryan, any thoughts?

MR. GREENBERG: So, I do know that information has passed -- been passed along to the governor's office related to that, and we would have to wait to see what their next steps are related to. So, we will advise everybody if it is.

DR. COOPER: Okay. And, you know, if indeed there is a -- an opportunity for a, you know, some kind of press event or something along those lines, you know, I will certainly do my best to make myself available on that day. And perhaps Dr. Van der Jagt might be able to -- to -- to join you know, to represent the children of New York State and -- and perhaps Nicole as -- as, you know, our family advisor committee network uh representative. So, we, you know -- we have the families represented as well. I think that would be a lovely moment. And you know, it would provide an opportunity for the governor to, you know, get this message out there in a very special way. So, Ryan, I get -- well, I -- I guess the -- the ball is in the governor's court. Perhaps you can -- you can lob the tennis ball again in her direction, letting her know that she'll have, you know, some support in doing that event should she

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

MR. GREENBERG: I appreciate it.

DR. COOPER: Thank you.

MR. GREENBERG: I'll relay the message.

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

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

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

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

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

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

DR. VAN DER JAGT: Yes.

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

THE COMMITTEE: Aye.

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

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

STATE OF NEW YORK

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

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

DANIELLE CHRISTIAN, Reporter

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