

1/31/23 - EMS for Children Meeting - WebEx  
NEW YORK STATE  
DEPARTMENT OF HEALTH  
  
EMERGENCY MEDICAL SERVICE FOR CHILDREN MEETING

DATE: January 31, 2023  
VENUE: WebEx (virtual)  
CHAIR: ARTHUR COOPER, M.D.

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(The meeting commenced at 1:13 p.m.)  
**MS. EISENHAUER:** Good afternoon, everyone. Thank you for joining us. We are all here now and we'll get started. So I'm sharing the agenda on the screen.  
Also, Court Reporter, we can go on the record.  
**THE REPORTER:** Okay. I have us on the record.  
**MS. EISENHAUER:** Excellent. I'm sharing the agenda on the screen, but you can also find this in your Boardable account with the other associated documents attached under the subject that they're in.  
And when you speak, as you know, we have the court reporter here, just say your name beforehand. It makes it easier for them to take the minutes. And with that, I will turn it over to Dr. Cooper.  
**DR. COOPER:** Good morning, everyone -- or good afternoon, I should say. Thank you for your patience in getting started this afternoon. Unfortunately, Boardable would not let me in and I needed Amy's immediate assistance to overcome that --

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2 **APPEARANCES:**  
3 AMY EISENHAUER  
4 RYAN GREENBERG  
5 ELISE VANDERJAGT  
6 JOSEPH PATAKY  
7 SHARON CHIUMENTO  
8 MATT HARRIS  
9 JEREMY CUSHMAN  
10 PAMELA FEUER  
11 EDWARD CONWAY  
12 AMY JAGRESKI  
13 DAVID VIOLANTE  
14 MICHAEL REDLENER  
15  
16 DARLENE REDA  
17 JENNIFER SALOMON  
18 BROOKE LEARNER  
19 MARILYN KACICA  
20 KATE BUTLER  
21 DREW FRIED  
22 GEORGE STATHIDIS  
23 JOSE PRINCE  
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that obstacle.  
Amy's already introduced the agenda to you. The first item of business today will be a roll call. Amy, if you want to do that or if that's something you want to do, just off the -- the Webex?  
**MS. EISENHAUER:** I have to do the -- the roll call and folks have to say that they're present for -- for our record.  
**DR. COOPER:** Okay.  
**MS. EISENHAUER:** So -- so I'll start that and I'll start with you, Dr. Cooper.  
**DR. COOPER:** I'm here; thank you.  
**MS. EISENHAUER:** Dr. van der Jagt?  
**DR. VAN DER JAGT:** Yes, I'm here.  
**MS. EISENHAUER:** Thank you.  
Dr. Albert?  
**DR. ALBERT:** Present.  
**MS. EISENHAUER:** Wonderful. Bruce Barry?  
**DR. COOPER:** I know Bruce said he was going to be here.  
**MS. EISENHAUER:** I -- I -- I saw him on the list.  
**DR. COOPER:** Yeah, he's on the list.

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 2 **MS. EISENHAUER:** Okay. Sharon  
 3 Chiumento?  
 4 **MS. CHIUMENTO:** I'm here.  
 5 **MS. EISENHAUER:** Awesome. Dr. Conway?  
 6 **DR. CONWAY:** Here.  
 7 **MS. EISENHAUER:** Hi.  
 8 Dr. Pamela Feuer?  
 9 **DR. FEUER:** I'm here.  
 10 **MS. EISENHAUER:** Thank you.  
 11 Dr. Jose Prince?  
 12 **DR. PRINCE:** Present.  
 13 **MS. EISENHAUER:** Thank you.  
 14 Dr. Jennifer Havens is excused for  
 15 this meeting.  
 16 Dr. Vincent Calleo?  
 17 **DR. CALLEO:** I'm here.  
 18 **MS. EISENHAUER:** Hi.  
 19 Doug Hexel is also excused for this  
 20 meeting.  
 21 Nickol O'Toole?  
 22 **MS. O'TOOLE:** I'm here.  
 23 **MS. EISENHAUER:** Thank you.  
 24 Dr. Bombard?  
 25 **DR. BOMBARD:** Dr. Bombard here.

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 2 **MS. EISENHAUER:** Thank you.  
 3 Dr. Harris?  
 4 **DR. COOPER:** He was on a minute or two  
 5 ago. I just don't see him now.  
 6 **MS. EISENHAUER:** Okay. Chief Pataky?  
 7 **MR. PATAKY:** I'm here. Good  
 8 afternoon.  
 9 **MS. EISENHAUER:** Good afternoon.  
 10 And Jason Haag?  
 11 **MR. HAAG:** I'm here.  
 12 **MS. EISENHAUER:** Excellent.  
 13 And we have two other members that  
 14 their vetting is still in process. Ben Kasper?  
 15 **MR. KASPER:** Here.  
 16 **MS. EISENHAUER:** And Sara Gruver?  
 17 **MS. GRUVER:** I'm here.  
 18 **MS. EISENHAUER:** Excellent.  
 19 And Bruce, I see that you raised your  
 20 hand?  
 21 **DR. COOPER:** Yes, Bruce Barry just  
 22 joined as well, yes. Thank you.  
 23 **MS. EISENHAUER:** Awesome. Okay. All  
 24 right. Well, we have quorum, and I will turn it back  
 25 over to Dr. Cooper.

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 2 **DR. COOPER:** Thank you so much. And I  
 3 will turn it over now to Professor Ryan Greenberg,  
 4 Director of the Division of -- the Bureau of  
 5 Emergency Medical Services and Trauma Services  
 6 Bureau.  
 7 Thank you, Ryan.  
 8 **MS. EISENHAUER:** Actually, before --  
 9 before Ryan gets started, we need to have --.  
 10 **DR. COOPER:** Thank you. Sorry.  
 11 Sorry. Sorry. And yeah, let's -- has everyone had  
 12 an opportunity to review the minutes from September?  
 13 In that case, I'm -- I'm taking the silence as a yes.  
 14 And can I have a motion to approve, please?  
 15 **MR. BARRY:** I move, Bruce Barry.  
 16 **DR. COOPER:** Bruce Barry. Second,  
 17 please?  
 18 **MR. HAAG:** Jason Haag, I'll second  
 19 that.  
 20 **DR. COOPER:** Jason, thank you.  
 21 Any additions, deletions, corrections,  
 22 or discussion? Hearing none, all in favor, please  
 23 signify by saying aye?  
 24 **ALL:** Aye.  
 25 **DR. COOPER:** Any -- any opposed?

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 2 Motion -- the motion is unanimously approved.  
 3 Okay. Ryan, it's all yours. Thank  
 4 you.  
 5 **MR. GREENBERG:** Good morning -- good  
 6 afternoon, everyone. Not good morning, good  
 7 afternoon. Time flies. So I'm going to talk about a  
 8 couple things with the Bureau, and things going on  
 9 with E.M.S. in general right now for situational  
 10 awareness.  
 11 And then, I know Amy's going to step  
 12 in and really talk about the -- the E.M.S. for  
 13 Children's portion of this. So the biggest thing,  
 14 kind of the main things going on right now is next  
 15 week is state council meeting so starting to prepare  
 16 for that one.  
 17 And there's been a technical advisory  
 18 group set up about a year ago now, probably a little  
 19 over a year ago now to look at E.M.S. sustainability.  
 20 And so that group has concluded and -- and they're  
 21 working writing a white paper for the State Council.  
 22 And so they, we believe, you know, so  
 23 getting approval process and everything and that  
 24 white paper will be released next week, and really  
 25 goes into an amazing analysis of, you know, where we

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 2 are today, where the system is today.  
 3 This was, you know, chartered by  
 4 Chairman Philippe from the SEMSCO to look into these  
 5 issues. And that task, under the ... really pulled  
 6 together this group of about fifty subject matter  
 7 experts from all different parts of -- of E.M.S. So  
 8 from volunteers to career to commercial services to  
 9 fire based non-profit, they all really were well  
 10 represented.  
 11 And so the collaboration was just  
 12 incredible. And you know, when -- when they were  
 13 getting towards the end, the nice part was that you  
 14 look at it and it really is about the system and  
 15 about the design and it's about, you know, kind of  
 16 what -- what will the future look like.  
 17 And so we're -- we're excited to see  
 18 that, you know, come to fruition and move forward.  
 19 E.M.S. has been a hot button topic lately. It was  
 20 mentioned in the budget, so we're still waiting to  
 21 see, you know, what that will yield as well.  
 22 And you know, just the importance of  
 23 where it is, what it can do and -- and also access to  
 24 care. So we, you know, we are working on more  
 25 getting out the emergency triage treatment and

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 2 transfer emergency triage treatment for transport  
 3 program, which uses telemedicine, and which uses a  
 4 number of different people. We've never used any  
 5 kind of support.  
 6 And so you know, through a pilot  
 7 program that the federal government -- that program  
 8 is really starting in New York, just starting to --  
 9 to move forward now.  
 10 And I bring it up -- this up to this  
 11 committee because if that program is moving forward,  
 12 there's going to be another focus on pediatrics. I -  
 13 - I can tell you, as a parent myself, I had two sick  
 14 kids at home, we needed to go and, you know, and see  
 15 -- go to urgent care. We walked in and the urgent  
 16 care said, no problem, we can see you today, come  
 17 back in six hours. And they wrote my name down and  
 18 six hours later I came back, and we were seen.  
 19 But the point is that, you know, we  
 20 need to look at different ways of delivering health  
 21 care that we do. And that's not just to adults, but  
 22 that is equally as important for children, both for  
 23 the care of the children as well as for the parents  
 24 who are, you know, wanting to care for their  
 25 children.

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 2 So we're really excited to kind of see  
 3 what the next chapter will bring. And I think this  
 4 committee, you know, E.M.S. for Children will really  
 5 be a critical component of that, both in the pre-  
 6 hospital setting, and then, obviously, what I think  
 7 Amy's going to be talking about on the actual moving  
 8 into the hospital, and how prepared are our emergency  
 9 rooms.  
 10 Yesterday, Dan Clayton, myself, and  
 11 Patty had the opportunity to go to a hospital which  
 12 is looking to become a level three trauma center.  
 13 And you know, they were showing us -- talking about  
 14 pediatric care, talking about the program, they were  
 15 very well aware of it.  
 16 Why? Because it's part of the  
 17 standards coming out in the future to these E.R.s  
 18 that are trauma centers as well to be pediatric  
 19 prepared. Know what they're doing, and how they're  
 20 going to treat these patients. And so as we went  
 21 into trauma rooms, they had pediatric equipment, they  
 22 had the ... and everything else, and were quick to  
 23 show hey, you know, we have everything here, should  
 24 we, you know, need to care for -- for -- for anybody  
 25 from infants all the way up.

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 2 So again, these programs are making a  
 3 difference. These programs are -- are getting out  
 4 there. People are engaging in them and then  
 5 hopefully, you know, we'll start seeing the outcomes  
 6 as well.  
 7 Other things going on the year right  
 8 now, we have a lot of contracts that are just finally  
 9 being finalized for our program agencies and for our  
 10 regions. On the education front, we continue to, you  
 11 know, look at new and different ways to -- to get  
 12 education out there.  
 13 And during my drive back up from the  
 14 Broome County for that general area, you know, I was  
 15 talking to our education staff to find out where are  
 16 there E.M.T. and paramedic classes between here and  
 17 Albany.  
 18 And you know, the problem with it is  
 19 pretty sparse and so, you know, we want to build a  
 20 workforce, we want to build people who can go out and  
 21 provide the care. But we might -- you know, part of  
 22 our problem might be, we don't have the education in  
 23 the right places. So we're going to take a look at  
 24 that one to see where our core sponsors are, and not  
 25 just being a core sponsor, but actually offering

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 2 classes and putting them out there.  
 3 For data and informatics team doing  
 4 some really great stuff, both using Tableau for a  
 5 number of reports a number of things that we've been  
 6 looking at lately, as well as using biospatial, which  
 7 is a platform that we'll be rolling out during 2023.  
 8 We're just getting started on the rollout now.  
 9 The agencies can start to look at how  
 10 they're doing, how they -- they're benchmarking their  
 11 care. Again, really important on our pediatric side.  
 12 And the important part of biospatial is that most  
 13 agency see only a small amount of pediatric patients.  
 14 And so if we can start to say, well,  
 15 we can compare the small amount that you're seeing,  
 16 to a bigger picture, so you can understand how your  
 17 care is doing, that's huge in being able to allow  
 18 them to continue to improve.  
 19 I'm very excited to have Jacob here on  
 20 the -- on the E.M.S. for Children side, officially.  
 21 I can't remember if that was the -- the case at the  
 22 last meeting or not. We have Vital Signs coming up  
 23 in October, but the important part right now is our  
 24 Vital Signs call for speakers is open.  
 25 And again, bringing up to this group

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 2 send them out to you. So if you want to be a  
 3 champion and help us out, if you have some space to  
 4 hold that class, it's a wonderful class and a great  
 5 opportunity.  
 6 Two last thing, kind of, on our side,  
 7 from a regulatory point of view, we have two  
 8 regulatory packets that are going up. One which is  
 9 for education, which is, you know, to really  
 10 modernize some of our education's needs. The other  
 11 one's for operations where we're going to update our  
 12 equipment ... of that nature.  
 13 And that's really important on the  
 14 pediatric side, because those -- some of the things  
 15 weren't a requirement prior to that will be a  
 16 requirement now related to pediatric care in New York  
 17 State.  
 18 We continue to have the executive  
 19 order four in place, which is for staffing crisis.  
 20 That helps us a lot related to paramedics being able  
 21 to work in alternative locations and community  
 22 paramedicine and things like that, so that was  
 23 renewed for another thirty days.  
 24 And then, a -- a really important one,  
 25 and hopefully, starting in February -- actually, will

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 2 who are subject matter experts in pediatrics, you  
 3 know, if you are interested in speaking at our  
 4 Syracuse conference, please go to Vital Signs  
 5 conferences webpage and take a look at there and  
 6 please ... We'd love to have some more pediatric  
 7 topics there, you know. Amy will be pushing for more  
 8 pediatric topics.  
 9 And, you know, in addition, we --  
 10 we've seen it. We see it, you know, in both our  
 11 patient population, but also as well as, you know, in  
 12 our providers, but -- is our mental health.  
 13 And so we're really excited to have  
 14 the substance abuse and mental health course that is  
 15 going around the state by one of our ... It's an  
 16 eight-hour course for E.M.S. providers to be better  
 17 prepared on how to deal with patients with substance  
 18 abuse or mental health issues, as well as for their  
 19 own health and what to do there.  
 20 So that class can be offered for free  
 21 anywhere around the state and we're looking for  
 22 locations. So if you are an agency or a hospital or  
 23 something and you think you want to offer that in  
 24 your community, we'll send the instructor, literally  
 25 traveling around the state. I will set dates and

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 2 start in February, I don't know when, is a Rural  
 3 Health Taskforce. The Rural Health Taskforce is put  
 4 together through -- through the legislative action  
 5 and they've had about twelve or fourteen members on  
 6 it.  
 7 And they'll be doing a study just  
 8 looking at E.M.S. in rural settings and the care that  
 9 they're delivered, and what we need to look at in the  
 10 future.  
 11 So again, pediatrics, I'm sure will be  
 12 a portion of that in making sure that even if you  
 13 live in a rural part of New York that you're still  
 14 able to get the care that you need.  
 15 That is everything that I have. I'm  
 16 happy to answer any questions, comments, or concerns.  
 17 I know there'll be a lot happening in the next week  
 18 or so. So look forward to hearing from any of you.  
 19 If you do have any questions that didn't come up,  
 20 please, by all means, feel free to reach out and I'm  
 21 going to pass it to Amy.  
 22 **MS. EISENHAUER:** So --  
 23 **DR. COOPER:** Ryan, thank you so much.  
 24 I -- I -- I do have a question. The mental health  
 25 course that you referenced, do you know, regarding

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2 the mental health course that you -- that you  
3 referenced, as you well know, we're working very hard  
4 on the pediatric education training for New York  
5 State.

6 I wondered to what extent if the  
7 statewide eight-hour course includes any information  
8 relative to pediatrics ... on de-escalation of the  
9 pediatric age range?

10 **MS. EISENHAUER:** So yeah. So it does  
11 include pediatrics. And the crux of the course,  
12 which is funded by OASAS is substance use disorder  
13 and behavioral health and how those intersect. So  
14 there is some information on pediatrics because, as  
15 we know, pediatrics in New York State, you know, for  
16 E.M.S.C., we cover up to the age of eighteen. In our  
17 protocols, we cover up to the age of fifteen as  
18 pediatrics. So there is some information on rates of  
19 substance use disorders among older children and how  
20 those things intersect with behavioral health.

21 There is some information on basic de-  
22 escalation for all patients and there's also  
23 information on trauma informed care and how to  
24 converse with patients that might have had poor  
25 experiences in health care previously, and how we can

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2 better relate to patients, so they trust us to help  
3 them.

4 And Jenny will be on in the end half  
5 of our meeting to talk about the program.

6 **DR. COOPER:** Great. Will -- will it  
7 be possible for those of us who were on this  
8 committee to attend one of the programs, so we can  
9 learn more about it and have a very clear  
10 understanding of what -- what it addresses and what  
11 it doesn't from a pediatric point of view?

12 **MS. EISENHAUER:** Absolutely. That  
13 would be wonderful.

14 **DR. COOPER:** Okay. Amy, let's you and  
15 I converse about after the meeting and we'll figure  
16 out a way to make that happen. Okay?

17 **MS. EISENHAUER:** Yeah.

18 **DR. COOPER:** Any other questions to  
19 Dr. Greenberg?

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

21 **DR. COOPER:** Elise?

22 **DR. VAN DER JAGT:** Yeah. Thank you.  
23 Dr. Van der Jagt here. Just two things. First, I  
24 want to endorse what Dr. Cooper said about that  
25 eight-hour course. I'm glad we're hearing a little

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2 bit more about it later.

3 But I think it would be great to just  
4 look at it and see whether there's some areas that,  
5 you know, could include maybe more -- a little bit  
6 more pediatrics.

7 But what I wanted to ask you, Ryan, is  
8 you mentioned Vital Signs is in October and you're  
9 looking for pediatric speakers. If we know of, you  
10 know, a few people who might be relevant for that,  
11 who do we contact?

12 Is it you or is it someone else who is  
13 running -- who was developing the program for that  
14 Vital Signs?

15 **MR. GREENBERG:** Yeah. So anybody can  
16 apply. So -- so what I would recommend for them to -  
17 - to submit, to present on the Vital Signs academy --  
18 sorry -- Vital Signs conference website. And then,  
19 if you know the person or you've heard the speaker,  
20 you know, have a strong recommendation of them, I  
21 would recommend that you pass it along to Amy. And  
22 Amy can make sure that Val Ozga, who's our conference  
23 coordinator, is aware of that so when we're looking  
24 through and evaluating all the speakers, definitely  
25 give weight to those who we, you know, know have a

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2 great course, great content, is a good speaker.

3 **DR. VAN DER JAGT:** Okay. So what I'm  
4 hearing here is go to the Vital Signs website to look  
5 a little bit over the conference, and then use Amy as  
6 the person to refer folks for who might be good  
7 speakers for that?

8 Because you have to sort them out if  
9 you have ten zillion speakers, which I don't think  
10 you'll have and you might have in pediatrics, and you  
11 would have to obviously decide which ones to do so.  
12 Thank you very much.

13 **DR. COOPER:** Elise, Tiff Bombard just  
14 posted in the chat the link to the -- to the  
15 speaker's site that Ryan referenced. So let me just  
16 also add that Amy and I had a very brief discussion  
17 about -- about presentation at Vital Signs.

18 And I know she's planning on two  
19 presentations at the present time.

20 That's not actually listed in your --  
21 your grant report, Amy, but do you want to share with  
22 the group what -- what your thoughts were about at  
23 least two programs at the Vital Signs conference?

24 **MS. EISENHAUER:** So yes, Dr. Cooper  
25 and I talked about some potential programs and

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 2 topics. And one of them was de-escalation, which  
 3 obviously right is -- is a big topic for all patients  
 4 at this time. So I know Sara Gruver, who is awaiting  
 5 vetting for -- for our committee, she does quite a  
 6 bit of education on de-escalation for pediatric  
 7 patients. And it's kind of her wheelhouse, so I hope  
 8 that Sara will submit that topic.  
 9 And then, also triage, so triage  
 10 update which is one of our subgroups, obviously,  
 11 having some -- some information on that so that  
 12 providers can be up to date on that topic and have  
 13 all the most relevant information.  
 14 **DR. COOPER:** Thank you, Amy. I see  
 15 that Sara put a note on the chat, saying that she is  
 16 working on her submission, and will get it in this  
 17 week. Thank you.  
 18 Thank you so much, Sara.  
 19 Any other questions for Ryan  
 20 Greenberg, or -- or Amy part one? All right.  
 21 **MR. GREENBERG:** One more --.  
 22 **DR. COOPER:** Sure. Ryan, go ahead.  
 23 **MR. GREENBERG:** One more thing, I want  
 24 to thank Chief Pataky who will be joining us on our  
 25 training and education committee over on the SEMSCO.

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 2 And I bring that up to this committee because you  
 3 talk about education, you talk about the importance  
 4 of pediatrics and the different options, you know,  
 5 that are there. This could be another great  
 6 opportunity to bridge those two and make sure that,  
 7 you know, pediatric is, you know, well represented  
 8 within the training and ed committee on the SEMSCO.  
 9 So again, just something else that's  
 10 worth thinking about that and I know there's a lot of  
 11 crossover views, but I don't know if anybody on the  
 12 committee or on this council asked this on training  
 13 and ed committee within SEMSCO so that can be another  
 14 great bridge to talk about, you know, pediatric  
 15 education.  
 16 **DR. COOPER:** Thank you, Ryan. Your --  
 17 your comment just reminded me of another mental  
 18 health issue with respect to children. The National  
 19 Advisory Committee on Children and Disasters met last  
 20 week and in its -- in its -- one of its semi-annual  
 21 public meetings.  
 22 Children's mental health during  
 23 disasters figured very prominently in that -- in that  
 24 discussion. But one of the points that -- that was  
 25 made is that there seems to be a sense that

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 2 psychological first aid is almost, you know, sort of  
 3 something that comes naturally to E.M.S. providers.  
 4 While I won't disagree that that's  
 5 true, at least in principle, there are -- there are  
 6 certain, you know, tenets that really need to be  
 7 addressed during, you know, psychological first aid  
 8 discussions. And -- and I do hope that this will be  
 9 part of any future discussions that we have going  
 10 forward regarding pediatric mental health for  
 11 individual cases that E.M.S. encounters every day in  
 12 a disaster situation.  
 13 So just something to make note of for  
 14 all of us. And, Amy, I'll now turn this over to --  
 15 to you for the grant update. Thank you.  
 16 **MS. EISENHAUER:** Dr. Van der Jagt, you  
 17 have your -- your hand up.  
 18 **DR. VAN DER JAGT:** Yeah. I just want  
 19 to -- thank you very much. I just want to endorse  
 20 what you said, Dr. Cooper, about the importance of --  
 21 of approach to children who have challenges, anxiety,  
 22 or other mental health disorders.  
 23 And what I -- I think the -- the  
 24 effort should be is the statement of that every  
 25 phrase or every word is to be considered in

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 2 medication, you know. And so if we take think about  
 3 it in those terms, then, it becomes very clear that  
 4 what you say does matter, how you say it does matter.  
 5 And that some guidance, very specific guidance about  
 6 those words that might be said might be very helpful  
 7 to the E.M.S. provider.  
 8 **DR. COOPER:** Thanks, Elise. I'm --  
 9 I'm -- I've not heard that -- that phrase before that  
 10 for pediatric mental health issues that every word is  
 11 like a medication. I think that's a beautiful way to  
 12 think of it.  
 13 I -- I will share those thoughts with  
 14 David Schonfeld who is, as you know, a major  
 15 pediatric mental health expert and is currently  
 16 chairing the National Advisory Committee on Children  
 17 and Disasters.  
 18 And I know that point was made during  
 19 the recent meeting, not in those words, but I -- I  
 20 think that -- that it deserves reinforcement. And I  
 21 really appreciate your -- your bringing that up  
 22 again. Thank you.  
 23 So now, unless there are other  
 24 comments, I think Amy, it is your turn, at long last.  
 25 Thank you.

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 2 **MS. EISENHAUER:** Thank you all. And I  
 3 would -- I would like to add that we have a lot of --  
 4 we were very lucky on E.M.S.C. that we have a lot of  
 5 the training and ed folks. You know, in addition to  
 6 Chief Pataky being drafted, we have Jason Haag and,  
 7 of course, Mike McEvoy is here, so lots of folks to  
 8 help us with -- with any trainings that we might  
 9 need.  
 10 So E.M.S. for Children grant update, I  
 11 know that and let's -- let's see if I can get my  
 12 computer to work.  
 13 So welcome, Jacob DeMay. So excited,  
 14 if only you knew. So Jacob is here in the background  
 15 right over here. You can't see him, but he is the  
 16 one making all the tech things happen and all our  
 17 data things happen. And so I'm very excited that  
 18 Jacob is here to help. So welcome again, Jacob.  
 19 So E.M.S. for Children grant  
 20 submission update. Our last meeting, I believe, was  
 21 in September. And in that time, in November, we  
 22 submitted our next four-year grant submission. And  
 23 it covers April 1st of this year to March 31st, of  
 24 2027. It was submitted by H.R.I. in November and I'm  
 25 hoping that they tell us before April that we are re-

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 2 funded because the next grant year starts April 1st.  
 3 So hoping that they notify a little  
 4 sooner, but by April we will know if we are funded  
 5 again.  
 6 So specific performance measures, as  
 7 we had this last five to six years, there was a  
 8 booklet with all the performance measures and  
 9 information and where you can find the resources.  
 10 That document has not been released yet.  
 11 But the notice of funding opportunity  
 12 highlighted some focus areas that we needed to  
 13 respond to. And obviously, that's the pre-hospital  
 14 and emergency department, pediatric emergency care  
 15 coordinator programs. Those will be -- those will be  
 16 a major focus and also recognition programs to  
 17 coincide with the pediatric emergency care  
 18 coordinator programs for both pre-hospital and  
 19 emergency department.  
 20 Also, pediatric disaster response has  
 21 an increased focus with both hospitals and E.M.S.  
 22 involved. So prior to now, hospitals have been  
 23 involved in disaster preparedness for pediatric  
 24 patients and also patients with special needs has  
 25 been a focus of the E.I.C., but E.M.S. is now

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 2 included in that -- in that focus for E.M.S.C.  
 3 All right. Hang on. I feel like --  
 4 here we go. Okay. So E.M.S.C. advisory committee  
 5 participation is going to be a highlight, which  
 6 thankfully is great for us because we already have a  
 7 really robust participation with all of you.  
 8 They are highlighting the specific  
 9 work of the family advisory network, or the FAN,  
 10 members in E.M.S.C. programmatic work, which we  
 11 already have, which is wonderful. Sara Gruver and  
 12 Nickol O'Toole are both practicing paramedics and  
 13 work in E.M.S. education, so they've already been  
 14 doing that work so I feel very confident with that --  
 15 with that highlight.  
 16 Also continued focus on including  
 17 pediatric skills in education for both E.M.S. and  
 18 hospital providers. Ryan mentioned that E.M.S. at  
 19 large sees a small portion of pediatric patients,  
 20 which really highlights the need for -- for continued  
 21 education in peds, especially using the tools,  
 22 practicing skills, practicing scenarios.  
 23 And then, also weight measured in  
 24 kilograms, not converted from pounds, actually  
 25 weighing in kilograms for hospital-based providers.

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 2 So those are the highlights that were  
 3 in the notice of funding opportunity that we  
 4 responded. And hopefully, the performance measures  
 5 will come out soon so we can get the specifics of  
 6 what things they're looking for under each of those.  
 7 Other E.M.S.C. initiatives, many of  
 8 you may have received my email about the E.M.S. for  
 9 Children's survey for pre-hospital agencies. As of  
 10 maybe thirty minutes ago, I checked it out. We're at  
 11 twenty-seven point eight percent. So that's really  
 12 great for just a month in. It started on January  
 13 4th, and it assesses E.M.S. agencies' use of pre-  
 14 hospital pediatric emergency care coordinators and  
 15 skills training during pediatric-centered education.  
 16 So that's currently a performance  
 17 measure two and performance measure three. Ryan, do  
 18 you have a question?  
 19 **MR. GREENBERG:** Can you just explain  
 20 to everybody who that survey went to, so that they  
 21 know maybe who they can help in getting those numbers  
 22 up?  
 23 **MS. EISENHAUER:** Absolutely.  
 24 **MR. GREENBERG:** Hospitals, all ...  
 25 just certified ones?

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 2 **MS. EISENHAUER:** I can do that. So  
 3 this survey surveys pre-hospital agencies. And for -  
 4 - that would be nine-one-one responding agencies and  
 5 B.L.S. ambulance and above. So B.L.S. C.F.R. was not  
 6 included. B.L.S. ambulance, A.E.M.T., paramedics,  
 7 A.L.S. fly cars. So that's included in the survey.  
 8 And you can find that at E.M.S.C. surveys dot org.  
 9 And who has not submitted their survey  
 10 is still listed and it's listed by state, and then by  
 11 county. So if you have a -- a specific county or  
 12 regional area and you want to reach out to those  
 13 agencies that have not responded yet, you can find  
 14 them all there or you can contact me, and I can let  
 15 you know who has responded and who hasn't.  
 16 Dr. Van der Jagt had a question.  
 17 **DR. VAN DER JAGT:** Yes, I just  
 18 wondered whether it might be good to send information  
 19 about that to all the REMAC chairs because that's --  
 20 for dissemination in their region, that you may get  
 21 it back, you know, maybe there'll be some additional  
 22 emphasis to get that filled out.  
 23 **MS. EISENHAUER:** That would be great.  
 24 So I have sent it out to the program  
 25 agencies for -- for their assistance, and they've

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 2 been very responsive. I also sent it out to the  
 3 E.M.S. coordinators and many of them have also been  
 4 very responsive.  
 5 Tomorrow, I am planning to send out  
 6 more reminders to both agencies and all of those  
 7 groups. So I will include the REMAC also. That's a  
 8 great idea.  
 9 So it concludes March 31st, so we  
 10 still have a little bit of time for everybody to get  
 11 their survey in. And if you have any questions about  
 12 the survey, about any event, you can email me, or  
 13 Jacob, and we'll be happy to help you.  
 14 So E.M.S.C. E.I.I.C. has some quality  
 15 improvement collaboratives. The E.D. Stop Suicide  
 16 Q.I. collaborative starts tomorrow or Thursday. So  
 17 registration for that was open until, I believe,  
 18 January 27th, and a bunch of emails were sent out.  
 19 Last I saw, we have one hospital  
 20 participating. So that will be great. But also all  
 21 that information can be found on the E.I.I.C.  
 22 website.  
 23 There's also a collaborative that is  
 24 open for emails, right, so for interests is the  
 25 Pediatric Readiness Quality Collaborative, and that's

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 2 for any emergency department.  
 3 And the -- the link's on the screen  
 4 that'll -- that will take you right to the  
 5 collaborative so that you can view all of that. You  
 6 can also Google E.M.S.C. E.I.I.C. and the whole  
 7 website will come up and you should be able to find  
 8 it that way as well.  
 9 Does anybody have any questions?  
 10 **MR. PATAKY:** Amy, I have one question.  
 11 Just regarding the survey, is -- is there a person to  
 12 email, just email you on that to see who has and who  
 13 hasn't completed it?  
 14 **MS. EISENHAUER:** Yeah. You can email  
 15 me and -- and I can get you that information, Chief.  
 16 **MR. PATAKY:** Thank you.  
 17 **MS. EISENHAUER:** You're welcome.  
 18 **DR. COOPER:** Any other questions for  
 19 Amy?  
 20 **MS. EISENHAUER:** We have one other  
 21 topic that was not included in my slides. So many of  
 22 you may have heard we're doing a medication project  
 23 with Handtevy. So just a short update on that, I got  
 24 one this morning that is in the process of loading  
 25 all the protocols and information into the Handtevy

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 2 app and that continues -- that work continues.  
 3 And so once the app and everything is  
 4 set up, there'll be some education going out to those  
 5 agencies, and then the process will begin. So more -  
 6 - more on that in May as we move forward.  
 7 Go ahead, Ryan.  
 8 **MR. GREENBERG:** Has there been any  
 9 movement related to that topic ...? I know the REMAC  
 10 chair on there was talking about that at our last  
 11 meeting.  
 12 **MS. EISENHAUER:** I have not heard  
 13 anything, but I can follow up on it.  
 14 **MR. GREENBERG:** That will be great.  
 15 **MS. EISENHAUER:** Okay. All right. If  
 16 there's no other questions for me, I give it back to  
 17 Dr. Cooper.  
 18 **DR. COOPER:** Thank you, Amy, very  
 19 much.  
 20 So we now move on to old business and  
 21 we're going to speak about the pediatric education  
 22 protocol. I will begin this discussion just by  
 23 saying that we had an excellent meeting before the  
 24 holidays, I recall, with our -- many of our  
 25 colleagues, particularly from the collaborative



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 2 group.  
 3 And I think in summary, it's fair to  
 4 say that all were in agreement that -- that  
 5 reasonably intensive education needed to be, you  
 6 know, utilized, prepared in order to, you know,  
 7 ensure that our field providers are familiar with the  
 8 approach to dealing with, you know, education and  
 9 pediatric patients.  
 10 Work in that -- in that realm is  
 11 ongoing and, as Amy mentioned, there is some hope  
 12 that we might have presentations be made at the Vital  
 13 Signs conference. And Amy and I had actually talked  
 14 about potentially putting together a, you know, a  
 15 program for the E.M.S. academy, which is, as you all  
 16 know, part of the -- the Bureau's educational  
 17 programs on the website.  
 18 And, of course, we have the fact that  
 19 Sara Gruver has been working very hard on getting  
 20 something together for Vital Signs, which presumably  
 21 could also be potentially utilized for there's  
 22 something on the learning ...  
 23 So that's what I have at the moment.  
 24 Amy, do you want to add anything about this? You  
 25 probably have more up-to-date information than I do

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 2 at the moment.  
 3 **MS. EISENHAUER:** No, I think that --  
 4 that covers it. We had one meeting, kind of getting  
 5 everybody together. And those folks at that meeting  
 6 are just getting the content together that we  
 7 discussed. So that work is -- is ongoing and in the  
 8 process.  
 9 **DR. COOPER:** Ryan, I see you have your  
 10 hand up. Please, Ryan, did you have a comment?  
 11 **MR. GREENBERG:** Yeah. Just forgot to  
 12 take it down. I apologize.  
 13 **DR. COOPER:** That's all right. No  
 14 problem. Okay. So next is the emergency department  
 15 pediatric emergency care coordinator program. Amy  
 16 did briefly comment on this during her report.  
 17 Is there more than needs to be said at  
 18 this time, Amy?  
 19 **MS. EISENHAUER:** So this is also in  
 20 progress. We had our first meeting, kind of  
 21 reviewing what is -- what has been expected in the  
 22 past by E.M.S.C. for this program. And we reviewed  
 23 the program that many of the E.M.S. for Children  
 24 programs in the northeast are using.  
 25 So edits to those documents is

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 2 underway and our next meeting should be shortly, I  
 3 hope in the next few weeks. I'll set that up for  
 4 them. So my hope is that we will review the  
 5 document, make any updates, and then, get that into  
 6 the process for E.D.C.C.  
 7 **DR. COOPER:** Thank you.  
 8 Any questions on the education issue  
 9 or the PECC program at the moment?  
 10 Okay. Pediatric triage  
 11 recommendation, that was another group that we formed  
 12 after the last set of SEMAC and E.M.S.C. meetings.  
 13 That group also met. If you -- if you  
 14 all recall, the focus was on the fact that -- or the  
 15 initial focus was on the fact that the -- the way the  
 16 -- the new national triage protocol is structured, it  
 17 provides a great deal of explicit guidance as to  
 18 areas that an E.M.S. provider should consider in sort  
 19 of gray areas when it's unclear as to whether a  
 20 patient ought to be taken to a trauma center or not.  
 21 And the focus of our review was to see  
 22 if there were any areas that might have been excluded  
 23 from that -- from that -- that grouping. And, you  
 24 know, and to make the point, of course, that the  
 25 advice that was included in the -- in the -- in the

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 2 second box, yellow box on the right was meant not to  
 3 be exclusive, but inclusive, sort of, if you will,  
 4 these are examples of conditions that might need to  
 5 be considered, there could well be others.  
 6 Now, of course, the issue here is  
 7 that, you know, STAC had previously approved the --  
 8 the national triage criteria that had been  
 9 promulgated in 2013. And the question was whether  
 10 STAC had actually, at the time, endorsed that  
 11 protocol or -- or -- or that -- or that field triage  
 12 protocol and all subsequent versions of same, or  
 13 whether it was just limited to that particular  
 14 protocol.  
 15 I don't know that we know that for  
 16 sure as of this moment, but certainly when the STAC  
 17 meets next week -- sorry -- not next week, the  
 18 beginning of March, I think it's March 1st now when  
 19 STAC meets. At that time, it's likely that they  
 20 will, if they had -- did not officially endorse the  
 21 national triage criteria, that it will do so at that  
 22 time.  
 23 And I think all on our call understood  
 24 that that was likely to be the case, but it felt that  
 25 what was really needed more than -- than any change

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2 to the protocol or modification thereto by us, which  
3 would be difficult in and of itself, would be  
4 creation of some educational materials that really  
5 sort of set out our view of, you know, of the -- of  
6 the triage issues.

7 That led us to recognize that, after  
8 2013, a document was created, talking -- or that set  
9 out the guidelines for triage of pediatric patients  
10 to regional and area trauma centers, both adult and  
11 pediatric.

12 I had thought I had a copy of that  
13 document on my computer. It turns out I did not.  
14 And I know Amy has been diligently searching for  
15 that. I don't know if that's turned up yet or not.

16 So Amy perhaps, you have some  
17 additional information on that at this time?

18 **MS. EISENHAUER:** I do have some  
19 unfortunate additional information for that. I went  
20 through all the archived E.M.S.C. documents. I went  
21 through Martha's documents. I went through the  
22 program managers that were here before her. And I do  
23 not find any document related to trauma triage. So I  
24 think, unfortunately, we may need to recreate the  
25 wheel on this one.

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2 **DR. COOPER:** All right. Well, let me  
3 do -- let me do a couple of things here. Let -- let  
4 me reach out to Trish O'Neill. Trish may have a  
5 copy.

6 **MS. EISENHAUER:** Okay.

7 **DR. COOPER:** I don't know. And it's  
8 also possible that, you know -- I will make another -  
9 - another search in the electronic files here and see  
10 if I can send something up. I vaguely remember this  
11 could -- this might or might not be true that in the  
12 white paper document that was put out, around 2014  
13 and 2015, a copy of that document may have been  
14 included. It's very vague in my memory. I don't  
15 know.

16 And I'm just going to ask Sharon  
17 Chiumento, who keeps everything, if she might have a  
18 copy of it somewhere in her electronic files.

19 So -- so more work to come on that and  
20 policies to the group that we have been unable to  
21 locate that -- that document and so more to come at  
22 our -- at our next meeting, no doubt.

23 And speaking of electronic files, the  
24 next item on the old business list is review and  
25 update the E.M.S.C. document. First, I'm going to

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2 ask Sharon to update us on where we are with the  
3 pediatric assessment reference card, and if she  
4 believes that there are any updates that need to be  
5 made.

6 And Sharon, I don't mean to put you on  
7 the spot here, but I think you're -- you have been  
8 instrumental in -- in helping us create these  
9 documents, and wondered if you had any information  
10 for us on this -- on this document at this time?

11 **MS. CHIUMENTO:** Yes. Dr. Van der Jagt  
12 and I have worked very closely on this going back and  
13 forth. I had the old files and so was able to bring  
14 it -- bring it up. And we were reviewing through it  
15 and we were -- we found there wasn't much we needed  
16 to change. On the first page, the logo needs to be  
17 changed and the date at the very bottom of the page.

18 But this is -- this is basically just  
19 vital signs and assessment steps, there really was no  
20 need to do very much on that page.

21 The second page, however, there were a  
22 few items that we needed to -- to update. Dr. Van  
23 der Jagt found several different things, I'll let him  
24 talk about it in just a second. I'll just briefly  
25 point out the areas, and then Dr. Van der Jagt, do

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2 you want to go into a little more detail on that.

3 One of the big things, of course, was  
4 in the ventilatory rate for the infants and child --  
5 and child related that the American Heart Association  
6 had increased that. So we made that change.

7 We also did a lot of updating in the  
8 C.P.R. notes to -- to bring things either into more  
9 compliance or to make it more easily understood. And  
10 then, in the protocols below, the A.L.S. guidelines,  
11 we changed a lot with the intubation, been brought in  
12 the advanced airway since more people are now using  
13 advanced airway mechanisms rather than just a  
14 laryngoscope -- I mean E.T. tubes. So -- so we  
15 modified that.

16 And then, again, did some additional  
17 explanations or enhancements to make sure that the  
18 epinephrine doses were a little clearer, that type of  
19 thing, especially with the change in the dosing on  
20 the bottle, since it's no longer the one to ten  
21 thousand, one to one thousand, but instead, the zero  
22 point one or the point one, or the one milligram per  
23 milliliter.

24 So Dr. Van der Jagt, I'll turn it over  
25 to you at this point, if you want to update?

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 2 **DR. VAN DER JAGT:** Sure. Thanks a  
 3 lot, Sharon. As Dr. Cooper said, you -- you keep  
 4 everything so you -- it was nice that you still had  
 5 the electronic version of this originally.  
 6 As Sharon said, we really basically  
 7 updated the card using the -- the most current A.H.A.  
 8 guidelines. And as you know, that was largely in the  
 9 respiratory area for infants and children that we --  
 10 that ventilatory rate is higher than it -- than it  
 11 was initially.  
 12 We also cleaned up just sort of the  
 13 redundancy of words and just, you know, made it --  
 14 made that so it read a little bit easier. We also --  
 15 if you can go down just a little bit further, you  
 16 know, that the epinephrine issue, as you can see in  
 17 that first box under asystole, there's an asterisk  
 18 and there's a plus sign so that it's really clear  
 19 what concentration of epinephrine needs to be used  
 20 for I.V., I.O. versus endotracheal tube.  
 21 And then, we did add this capnography.  
 22 And I don't remember that that was there as clear,  
 23 but we know that there are E.M.S. providers that have  
 24 capnography capabilities, and we would like them to  
 25 use that, particularly in -- in C.P.R. because the --

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 2 the recommendation is that the end-tidal CO2 be  
 3 attained up to twenty, if at all possible during  
 4 C.P.R.  
 5 And if they have capnography, then  
 6 that would be an important thing for them to use in  
 7 assessing the adequacy of C.P.R. And this relates a  
 8 little bit to the concern, I think, is nationally we  
 9 still worry about cardiac arrest in pediatric  
 10 patients and the -- the -- the very low survival from  
 11 that. So we want to make sure that we can optimize  
 12 that and give direction where we possibly can.  
 13 And I think everything else you  
 14 covered, Sharon. Thank you so very much.  
 15 **DR. COOPER:** Any questions or comments  
 16 for Sharon and or Elise?  
 17 **MS. EISENHAUER:** There is -- there is  
 18 one --.  
 19 **DR. HARRIS:** It's -- it's Matt. I --  
 20 I have one question if that's okay.  
 21 **DR. COOPER:** Sure.  
 22 **DR. HARRIS:** Hey, guys, I apologize  
 23 for my tardiness, and I'm on my phone so this could  
 24 just be a Zoom issue.  
 25 Are we specific in stating or

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 2 discussing on the card where end-tidal CO2 is  
 3 concerned, using it on a bag valve mask prior to  
 4 intubation or is this only post-intubation evaluation  
 5 of end-tidal adequacy of C.P.R., because now most of  
 6 the inline end-tidals can be hooked up to V.D.M.?  
 7 **DR. VAN DER JAGT:** Yeah, so this is --  
 8 this is actually a very interesting question, Matt.  
 9 You know, we had put this on this card because  
 10 clearly if there's an advanced airway, whether it's  
 11 an L.M.A., whether it's an E.T. tube, that's really  
 12 reasonable.  
 13 To my knowledge, there is not an  
 14 update available, you know, if it's bag valve -- bag  
 15 mask ventilation. I know that actually in some  
 16 hospitals, Johns Hopkins, notably, in their I.C.U.  
 17 and in their E.D., they do measure capnography during  
 18 bag mask -- bag mask ventilation.  
 19 I just am not aware that there are  
 20 very good studies on that, unless some of the --  
 21 maybe Dr. Calleo or some of the other E.D. docs are -  
 22 - are aware of that, I'm not aware of it. And so I  
 23 was a little hesitant to put that in there because I  
 24 wasn't sure it was supported by data.  
 25 But -- but that doesn't mean it can't

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 2 be done. It's just that I -- it's a document here  
 3 that we're making recommendations, obviously.  
 4 **DR. HARRIS:** Yeah. I also wonder,  
 5 Elise. You and I have had this conversation before.  
 6 Is this an opportunity for E.M.S.C. to advocate for,  
 7 you know, the -- this -- this is an F.D.A. approved  
 8 device. Maybe this is something we advocate for a  
 9 trial for in our state.  
 10 **DR. VAN DER JAGT:** I -- I would  
 11 totally agree that Matt. I didn't know -- this was a  
 12 course, it's -- it's -- we didn't want to put E.M.S.  
 13 providers in a bind, you know, either, that if they  
 14 didn't have it and they couldn't afford it, for one  
 15 reason.  
 16 But I do think that in the E.M.S.  
 17 world, I think where capnography can be extremely  
 18 useful, this would be a wonderful thing to advocate  
 19 for. And this is maybe -- maybe we've only taken the  
 20 first step towards that. I don't know if we can do  
 21 it stronger than that.  
 22 But I didn't want to put E.M.S.  
 23 providers in a bind that they -- if they didn't have  
 24 it now or maybe it's -- it's out of order, they  
 25 haven't gotten it yet, you know, and now they've got

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 2 a kid and now they say, well, we -- we gave some  
 3 optimal care.  
 4 I -- I didn't -- I was worried about  
 5 that. So that's why I put it this way. But I think  
 6 your point is extremely well taken and I wish  
 7 everybody had a capnograph out there.  
 8 **DR. COOPER:** If I can just add the one  
 9 -- one -- one point here. Probably the one person  
 10 that I know of who might have any kind of data on  
 11 this, how good it is I don't know, might be Dan Spade  
 12 from -- from Arizona. He's done a lot of work with -  
 13 - you know, with ventilation and pre-hospital care,  
 14 so might be worthwhile.  
 15 Matt, I believe you know him pretty  
 16 well, as well.  
 17 **DR. HARRIS:** I can reach out. Yeah.  
 18 I can reach out.  
 19 **DR. COOPER:** Yeah. Might be  
 20 worthwhile reaching out to him. He's collected a lot  
 21 of -- a lot of good data on -- you know, on  
 22 ventilation of head trauma patients. You know, it's  
 23 authentic. So he might have some data that can help  
 24 us here.  
 25 **DR. HARRIS:** I know that -- I know

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 2 that our colleague, Kathy ... out in Colorado has  
 3 published a small paper from -- I -- I believe it was  
 4 from an E.D. study that looked at children, the  
 5 accuracy of end-tidal CO2 by ...  
 6 But again, I think to Elise's point,  
 7 it's limited but happy to pursue this. I think it's  
 8 probably something that's in the future. Thanks for  
 9 considering it.  
 10 **DR. VAN DER JAGT:** And I think it's --  
 11 .  
 12 **DR. HARRIS:** Sure.  
 13 **DR. VAN DER JAGT:** And I totally agree  
 14 that I think exploring this to the best of our  
 15 abilities across the country, what's published, what  
 16 the experiences are would inform, you know, any  
 17 further, you know, information on this.  
 18 But the accuracy of it certainly is --  
 19 Matt, if I could ask you, do -- do you currently do  
 20 end-tidals on bag mask ventilation in the E.D.?  
 21 **DR. HARRIS:** This is a very timely  
 22 question. We just started, and actually Northwell  
 23 C.E.M.S. will be doing this, as well.  
 24 **DR. VAN DER JAGT:** Okay. Because we  
 25 had discussed it and I -- I -- if --

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 2 **DR. HARRIS:** Yeah.  
 3 **DR. VAN DER JAGT:** ...  
 4 **DR. HARRIS:** That would be great.  
 5 Thanks Elise.  
 6 **DR. COOPER:** Wonderful.  
 7 **MS. EISENHAUER:** We also have -- also  
 8 Dr. Cushman has his hand raised and has a comment.  
 9 **DR. COOPER:** I'm sorry. Jeremy,  
 10 please.  
 11 **DR. CUSHMAN:** No problem. If I could  
 12 perhaps speak to that? A couple -- a couple of  
 13 things for consideration. Amen to capnography, so I  
 14 appreciate the discussion and E.M.S.C. support of  
 15 that. There's a few considerations, though.  
 16 Number one is that it is not currently  
 17 within the scope of the E.M.T. to be able to evaluate  
 18 a capnographic waveform for effective ventilations.  
 19 That is exactly why there is a demonstration pilot in  
 20 project -- in progress as we speak, supported by  
 21 Hudson Valley REMSCO that addresses not only the  
 22 placement of the i-gel by B.L.S. providers, but more  
 23 importantly, the ability of E.M.T.s to be able to  
 24 monitor a capnographic waveform to determine whether  
 25 or not ventilations are effective.

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 2 Although, it is not in the national  
 3 standard curricula yet, there are a number of states  
 4 that have added that to the scope. So the first  
 5 step, again, completely support this, is that it has  
 6 to be within the scope of an E.M.T. to be able to  
 7 expect an E.M.T. to do it.  
 8 You know, number two to the-- to the  
 9 data perspective, I -- I -- I would be hard pressed  
 10 to find at least an E.M.S. physician that is not  
 11 making the expectation that when a bag valve mask is  
 12 used, if capnography is available, it is expected  
 13 that it is on even if it's not being ventilated  
 14 through an E.T. or an i-gel.  
 15 Dan Spade's date on the epic T.B.I.  
 16 trial very -- very conclusively demonstrated that  
 17 ventilation makes a huge difference. And -- and I  
 18 think that -- I mean, honestly, I don't think we need  
 19 a study to extrapolate it to kids who are notoriously  
 20 more difficult to ventilate.  
 21 What -- what capnography is doing is  
 22 simply telling you that you're actually getting air  
 23 in and out, which we know sometimes we have no idea  
 24 whether that's really effectively happening. So  
 25 again, completely support that.

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 2 I -- I had the -- the comments in  
 3 there, I would encourage Sharon that advanced airway  
 4 with capnography period, end of story. It's not an  
 5 if-available. It is a requirement within the State  
 6 of New York that if there is an advanced airway, it  
 7 has capnography attached, whether it's an E.T. or an  
 8 i-gel, particularly as part of this project. I don't  
 9 want anyone to get the idea that it's okay to have an  
 10 i-gel without capnography -- or sorry -- an advanced  
 11 airway without capnography.  
 12 But overall good stuff. Sorry, but  
 13 context for everybody.  
 14 **DR. VAN DER JAGT:** Dr. Van der Jagt  
 15 here again. Dr. Cushman, that's great, actually.  
 16 You know, I -- I mean, I think we just toyed around.  
 17 We weren't sure it was always going to be available.  
 18 But I am completely fine with saying advanced airway  
 19 with capnography, you know, and we will be if  
 20 available.  
 21 If that is the standard that E.M.S. is  
 22 being held to, then, that's what the card should say  
 23 for absolutely for sure. So it's just that I did not  
 24 know that at this point. So you're saying that is  
 25 extremely helpful and I think --

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 2 **DR. COOPER:** I totally agree.  
 3 **DR. VAN DER JAGT:** -- if we could  
 4 remove that, if available from the card, then I think  
 5 we're all in agreement that that's the way to go. So  
 6 thank you very much for that insight.  
 7 **DR. COOPER:** Is there any objection  
 8 from any member to removing if available from the --  
 9 from the advance airways with capnography phrase?  
 10 Well, hearing none, let's remove it.  
 11 **MS. EISENHAUER:** I will make that -- I  
 12 will make that note.  
 13 **DR. COOPER:** Any other changes or  
 14 discussion points regarding the reference card?  
 15 Okay. Then, I guess, did everyone have an  
 16 opportunity to -- to -- to receive this prior to the  
 17 meeting and review it prior to the meeting, or is it  
 18 just being presented here today for the first time?  
 19 **DR. FEUER:** I saw it.  
 20 **DR. COOPER:** Okay. So in that case,  
 21 we are in a position to -- as a committee to approve  
 22 the -- the updates. And I'm going to take it as --  
 23 as, if you will, a seconded motion from the -- our --  
 24 our task force consisting of Sharon and Elise to, you  
 25 know, the -- the committee accept these changes and -

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 2 -. **MS. EISENHAUER:** Dr. Cooper?  
 3 **DR. COOPER:** Yes.  
 4 **MS. EISENHAUER:** Sorry. We need to  
 5 have like -- have somebody make a motion, and then  
 6 someone else second it just because we are -- we are  
 7 -- in the record, it needs to be recorded.  
 8 **DR. COOPER:** I -- I'm aware that many  
 9 other committees are doing it the way I just  
 10 suggested, but I'm happy to do.  
 11 **MS. EISENHAUER:** Okay.  
 12 **DR. COOPER:** I'm happy to have you --  
 13 I'm happy to have you make us a -- make -- make the  
 14 recommendation that we have a motion and a second.  
 15 **DR. VAN DER JAGT:** This is Dr. Van der  
 16 Jagt. I'd like to make a motion that the changes in  
 17 this card be accepted with the proviso that if  
 18 available under -- with the advance airways that  
 19 capnography be removed.  
 20 **DR. HARRIS:** I would second that.  
 21 It's Matt.  
 22 **DR. COOPER:** Discussion? I see Pam  
 23 Feuer had her hand up.  
 24 **DR. FEUER:** I was just going to second

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 2 it. Third.  
 3 **DR. COOPER:** Thank you, Pam.  
 4 Okay. Any discussion? All in favor,  
 5 please signify by saying aye.  
 6 **ALL:** Aye.  
 7 **DR. COOPER:** Opposed?  
 8 **UNIDENTIFIED SPEAKER:** Aye.  
 9 **DR. COOPER:** Any -- okay. I hear --  
 10 heard an aye after opposed. Was that meant to oppose  
 11 or -- or still on the approved?  
 12 Let me put it another way. Are there  
 13 any objections to approving the -- the changes in the  
 14 reference card? All right. Hearing none, then we  
 15 don't need a roll call vote because we're not a  
 16 rulemaking body. So -- but we will note in the -- in  
 17 the record that the vote was unanimous in favor of  
 18 approving the changes, absent the -- the words if  
 19 available after the word capnography at the bottom  
 20 left in the second page.  
 21 Okay. So we now move on to the -- the  
 22 minimum pediatric care standards for New York State  
 23 hospitals emergency department, the intensive care  
 24 unit.  
 25 And now, this is a set of standards

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 2 that is actually in code. And so I -- I imagine this  
 3 is going to take a bit of time and effort for us to -  
 4 - to look over and make appropriate recommendations.  
 5 These standards were approved, you  
 6 know, around 2013 or '14 in the aftermath of  
 7 extensive discussions regarding pediatric sepsis with  
 8 the quality and patient safety group. And so  
 9 anything that we do in this regard, we might want to,  
 10 you know, share our thoughts with the quality and  
 11 patient safety group if the group so decides.  
 12 But I think at this point, Amy, unless  
 13 you had different thoughts, I think we should  
 14 probably form a small group to look at these  
 15 standards and see if there are any changes that need  
 16 to be made.  
 17 I will note that in a prior time when  
 18 we were participating in the E.I.I.C. collaborative  
 19 regarding patient quality and -- and safety, New York  
 20 State had put together a -- you know, a quality  
 21 improvement initiative looking at our data, and, you  
 22 know, with the help that that data would lead us to  
 23 make some, you know, recommended changes to this  
 24 document.  
 25 The -- it was decided at senior levels

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 2 in the Health Department that because the data that  
 3 we were collecting was based on survey data, that it  
 4 needed to be validated. Then Covid came along, and  
 5 the attention of the Health Department was certainly  
 6 distracted away from that project, not -- not for  
 7 anything less than a very good reason.  
 8 But that put us in a position where  
 9 the data was really very old data, pretty stale,  
 10 almost ten years old now. And, you know, so the  
 11 question became should we be pursuing, you know, this  
 12 initiative based on more recent data from the  
 13 pediatric readiness projects.  
 14 The difficulty there arise is in that  
 15 Amy's predecessor, Martha Gohlke, had been able to  
 16 obtain about eighty percent participation in terms of  
 17 the pediatric -- pediatric ready --readiness project,  
 18 but in the aftermath of Covid -- or during -- during  
 19 and after Covid, which we're not really after --  
 20 after the ... shall we say, you know, the -- the  
 21 number of agencies that have actually responded,  
 22 emergency departments and E.M.S. agencies that have  
 23 actually responded to the rate of this project has  
 24 been at a much lower level, you know, making the, you  
 25 know, the survey data perhaps even less compelling.

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 2 So that's sort of the bind that we're  
 3 in. But at the same time, you know, the minimum care  
 4 standards are about ten years old, and do need to be  
 5 looked at. So I see no, you know, alternative, but  
 6 to put together a small group and, you know, take our  
 7 -- you know, take our best crack at it and see what  
 8 we come up with in terms of making improvements to  
 9 the -- you know, to the -- to the -- to the  
 10 standards.  
 11 So unless, Amy or Ryan, you have  
 12 anything else to add on this issue, I will ask Amy  
 13 to, you know, collect names of people who wish to  
 14 participate in this project. I will certainly be  
 15 participating, personally, and I invite any others  
 16 who have a strong interest in that area, please let  
 17 Amy know of their interest so we can get a working  
 18 group together.  
 19 Amy or Ryan, any additional comments  
 20 on that -- on that subject?  
 21 **MS. EISENHAUER:** No. I do have a few  
 22 people that had reached out to me that were -- were  
 23 interested in working on this. So I do have their  
 24 names and I will send out a survey for a first  
 25 meeting soon.

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 2 **DR. COOPER:** Okay. Just as a -- you  
 3 know, one issue that did arise sort of nearing the --  
 4 the end of our discussions last time, really had to  
 5 do with whether, you know, that standards ought to be  
 6 different for more and -- more comprehensive and less  
 7 comprehensive emergency departments.  
 8 You know, as you all know, on -- on  
 9 the more general side, the -- the -- the state code  
 10 designates an emergency department as -- as a group  
 11 that's seeing or -- or a department that's seeing  
 12 more than fifteen thousand unscheduled visits a year,  
 13 and an emergency service seeing less than fifteen  
 14 thousand unscheduled visits per year.  
 15 We were looking at a similar kind of  
 16 approach for pediatric patients. I don't think  
 17 anyone disagreed with -- with that approach. The  
 18 question was whether there -- if we did adopt that  
 19 approach, there should be separate sections for  
 20 emergency departments and emergency services with  
 21 respect to children.  
 22 So just as food for thought for that  
 23 group as we move forward. And unless there are  
 24 additional comments at this time, I think we can move  
 25 on to new business here.

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 2 **DR. HARRIS:** Hey Art?  
 3 **DR. COOPER:** Yes.  
 4 **DR. HARRIS:** If I may, it's not --  
 5 just two things. One, Amy, I'd love to join this  
 6 group. I just put into chat.  
 7 You know, just a -- just a point  
 8 which, you know, I brought up, I think, in New York  
 9 City REMAC. You know, for -- for those who are  
 10 unaware, pediatric emergency departments and critical  
 11 care, quote unquote, critical care receiving  
 12 hospitals in New York City for pediatrics is a self-  
 13 designation.  
 14 So just to get a better understanding  
 15 are -- are these standards, they're described as  
 16 statewide right, they're described as built into  
 17 regulation. But it seems like our colleagues down  
 18 here don't abide by this.  
 19 And I wanted to understand like what  
 20 our regulatory responsibility is and how we can  
 21 influence and -- and, you know, use the peds  
 22 readiness tools and other things to help facilitate  
 23 those E.R.s that want to be pediatric critical or  
 24 pediatric receiving hospitals, because I think of the  
 25 seventy-two hospitals in New York City, I think

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 2 sixty-eight of them call themselves pediatric  
 3 receiving.  
 4 So I just wanted to -- if someone can  
 5 clarify for me how -- how bound are hospitals by  
 6 these regulations, or are they more of a guideline?  
 7 **DR. COOPER:** Well Matt, that was an  
 8 issue that was discussed at length last time, as  
 9 well. And I think that, without taking any more of  
 10 the committee's time at this point, and without --  
 11 without the work group having had an opportunity to  
 12 do a deeper dive into the document, I'm going to ask  
 13 that we hold that discussion until next time.  
 14 Clearly, you know, it's an issue that  
 15 needs to be addressed. And it's not something that  
 16 we reached consensus on, last time. But I think --  
 17 as you pointed out, it's high time that we -- you  
 18 know, that we focused on that issue.  
 19 You know, that we've learned through  
 20 the -- the New York City Pediatric Disaster Coalition  
 21 project that's sponsored by the New York City  
 22 Department of Health and Mental Hygiene that -- you  
 23 know, that in the event of a disaster when all hands  
 24 must be on deck, that, you know, we have to have a  
 25 reasonable system in place that -- that identifies

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 2 which hospitals are more or -- or less able to care  
 3 for pediatric patients, recognizing that in the event  
 4 of a large-scale disaster that involves large numbers  
 5 of pediatric patients, we simply may not have enough  
 6 pediatric space in New York City to handle the entire  
 7 issue.  
 8 But it is a very complex issue, as you  
 9 well know. And I would just suggest we put off  
 10 further discussion on this until the group has a  
 11 chance to meet. And maybe, Matt, you and I can have  
 12 a discussion offline about this in greater detail.  
 13 Is that okay?  
 14 **DR. HARRIS:** That would be great.  
 15 Thank you so much.  
 16 **DR. COOPER:** Okay. Sure.  
 17 Any other comments or questions on  
 18 that issue?  
 19 Okay. Well, that -- that brings us to  
 20 -- to a point where we're -- wow, we're right back on  
 21 time, under new business. And the first issue under  
 22 new business is the length base measuring tapes and  
 23 New York collaborative pediatric protocols issue.  
 24 We discovered during the last, I  
 25 believe, SEMAC meeting it was that there was some

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 2 discrepancy between what we have in the collaborative  
 3 protocols and what's on the current version of the  
 4 length-based color-coded resuscitation tape, which is  
 5 -- it was initially devised by Jim Broselow and  
 6 colleagues and is therefore commonly called the  
 7 Broselow tape, even though there are other tapes out  
 8 there. And the Broselow tape is just, you know, if  
 9 you will, one commercially available device.  
 10 We need a way to clean this up. And,  
 11 you know, with, hopefully, your -- your support, I  
 12 volunteered us as a committee to take this on. So  
 13 that means I think we need to put together another  
 14 working group to really look at this in -- in some  
 15 detail. I imagine that the --.  
 16 **MS. EISENHAUER:** Dr. Cooper?  
 17 **DR. COOPER:** Yes.  
 18 **MS. EISENHAUER:** Hi. I'm sorry to  
 19 interrupt. I just wanted to let you know that Megan  
 20 Williams is a paramedic program director and she came  
 21 up to me during that SEMAC meeting and offered her  
 22 paramedic students as our researchers to compare all  
 23 the associated protocols and put together some  
 24 information for us, essentially doing the legwork  
 25 with the educators overseeing this, so that we can

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 2 then adjust what is necessary. And she is here at  
 3 the meeting if you'd like to hear from her.  
 4 **DR. COOPER:** Well, I just saw a chat  
 5 from her and she, I think, may have lost her voice.  
 6 **MS. EISENHAUER:** Okay.  
 7 **DR. COOPER:** If I'm not mistaken,  
 8 Megan?  
 9 But I think we'd be delighted to  
 10 accept any help we can receive along -- along this --  
 11 this pathway. And perhaps if you're unable to speak,  
 12 you can put something in the chat as to when you  
 13 think you might have, you know, some information for  
 14 us, hopefully, by the time of our next meeting.  
 15 Sorry, Megan, I don't mean to put you  
 16 on the spot. Just -- just trying to keep the wheels  
 17 of progress moving here.  
 18 **MS. EISENHAUER:** For reference, our  
 19 next meeting is in May. It will be virtual, and I  
 20 believe it's the 2nd.  
 21 Jacob, can you find out what that --?  
 22 Jacob is going to look it up.  
 23 **DR. COOPER:** Megan is saying in the  
 24 chat, they can have it done by then.  
 25 Megan, I think -- I think that we

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 2 would need to have it done quite some time before  
 3 that.  
 4 **MS. EISENHAUER:** Yes.  
 5 **DR. COOPER:** Because there's a process  
 6 that Amy has to go through in order to get documents  
 7 that are going to be officially on the agenda  
 8 potentially for approval, you know -- you know,  
 9 approved by the -- you know, the smarter people up,  
 10 and us -- than us.  
 11 So I know you and Amy can work on that  
 12 one and -- and where we are.  
 13 Jeremy Cushman has raised an issue.  
 14 Jeremy, do you want to state that  
 15 verbally for the record?  
 16 **DR. CUSHMAN:** Yeah. Happy to, thank  
 17 you -- thank you, Dr. Cooper.  
 18 To my knowledge, the only big  
 19 difference is related to the dosing of midazolam. So  
 20 our -- our statewide A.L.S. protocols has midazolam  
 21 dosing at zero point migs per kig for that.  
 22 All the -- the length-based tapes that  
 23 at least I have looked and I -- again, to -- to Megan  
 24 and the team, please prove me wrong with your  
 25 thorough review, reference the zero point two migs

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 2 per kig, which I -- I think we all know is -- is  
 3 actually recommended by more of the neurologists than  
 4 the -- than the lower dose.  
 5 And so -- so irrespective of any  
 6 differences between the collaborative or A.L.S.  
 7 statewide protocols and the length-based tapes that -  
 8 - that Megan's team is going to do, it is going to be  
 9 important for E.M.S.C. to weigh in on the potential  
 10 protocol change of midazolam being increased to point  
 11 two migs per kig.  
 12 **DR. COOPER:** Thank you, Jeremy.  
 13 Ed Conway, I know you had two comments  
 14 you made in the chat. Do you want to make them  
 15 verbally for the group?  
 16 **DR. CONWAY:** Yeah, sure. I mean, this  
 17 is not my area of expertise, but there are  
 18 institutions that don't believe that Broselow  
 19 accurately represents their patient population. And  
 20 there is some literature out there on it.  
 21 So I think when we're looking at items  
 22 like this, I mean, we'll have to consider diversity  
 23 as well as sort of before we come out with a blanket  
 24 recommendation.  
 25 **DR. HARRIS:** I believe at ... but I

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 2 actually think the pediatric committee, in their drug  
 3 dosing resource document that came out of S and P  
 4 took a similar stance.  
 5 **DR. COOPER:** Thank you, Matt.  
 6 So Matt and Ed, if you have any  
 7 specific literature on that, if you could forward it  
 8 to Amy to share with the group, that would be very  
 9 helpful.  
 10 **DR. HARRIS:** Sure thing.  
 11 **DR. COOPER:** Okay. So we'll look  
 12 forward to -- I think, given the comments that Jeremy  
 13 and -- and Ed Conway have made, I think it's probably  
 14 going to be best, Amy, if we try to schedule, you  
 15 know, a meeting of folks who were interested in this  
 16 subject well enough before the deadline to submit to  
 17 the -- I think you call it the E.D.C.C. process, is  
 18 that right?  
 19 You know, before you submit to -- to  
 20 them, so we -- we've got our ducks in a row in terms  
 21 of making sure that the document that comes forward  
 22 in the May meeting is -- is appropriate.  
 23 By the way, I'm -- I'm going to go out  
 24 of order here for a moment. I see a note from Amy  
 25 Jagareski in the chat regarding the update from

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 2 BOHIP.  
 3 Amy, if you'd be willing to make that  
 4 comment now, just because I see you have to leave the  
 5 meeting due to a conflict? Forgive me for putting  
 6 you on the spot.  
 7 **MS. JAGARESKI:** Hi, everyone. No,  
 8 that's okay. I just wanted to put in the chat  
 9 because, as Dr. Cooper mentioned, I have to run. But  
 10 a couple of quick updates from the Bureau of  
 11 Occupational Health and Injury Prevention.  
 12 First, we are working with an intern  
 13 currently on a project to evaluate providing training  
 14 to domestic violence shelters around home visiting  
 15 for their clients.  
 16 We put out a survey in early 2020,  
 17 which revealed there was really a lack of connection  
 18 and understanding between the programs. So we're  
 19 looking to kind of fit that niche there.  
 20 We're also evaluating a Vehicle and  
 21 Traffic Law video module that we produced this past  
 22 grant year for law enforcement agents on spotting  
 23 misuses in car seat safety. We will be sending a  
 24 questionnaire to family service providers, WIC,  
 25 D.S.S., Head Start, Early Head Start, and again, to

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 2 evaluate their capacity and their needs for car seat  
 3 safety information.  
 4 And then, two, kind of, Bureau-wide  
 5 updates, we have an upcoming injury community  
 6 implementation group meeting on the 21st. If anyone  
 7 would like to join or hasn't received that  
 8 registration link, please send me an email.  
 9 And then, we have also revived our  
 10 quarterly newsletter. BOHIP had previously done this  
 11 before Covid -19, but kind of fell by the wayside  
 12 then, so we're reviving it. And it obviously covers  
 13 three months' worth of injury-specific topics and  
 14 events and information. So again, if you'd like to  
 15 receive those newsletters, please send me an email.  
 16 That's all. Thank you.  
 17 **DR. COOPER:** Thank you, Amy, so much  
 18 and thanks for letting us know you -- you had a -- we  
 19 had a conflict, so we could get your report in, in a  
 20 timely manner. Thank you.  
 21 **MS. JAGARESKI:** Thank you. Have a  
 22 great day everyone.  
 23 **DR. COOPER:** Any questions for -- any  
 24 questions for Amy before she has to leave the call?  
 25 Well, hearing none, thank you, Amy. Have a great

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 2 evening.  
 3 Back to new business, so I think we're  
 4 just about done with the length-based color-coded  
 5 recitation tape issue. So unless there any other  
 6 comments on that, we'll plan on bringing this back to  
 7 the committee in May with a document to be prepared,  
 8 based on the search done by -- by Megan, and  
 9 potential thoughts on the part of -- of the working  
 10 group, particularly addressing the comments raised by  
 11 Jeremy Cushman and Matt Harris.  
 12 Okay. Is there any -- any further  
 13 comments on that?  
 14 Okay. Well, hearing none, let's move  
 15 on to the pediatric respiratory, New York State  
 16 Collaborative protocols review. Amy, I -- and maybe  
 17 Jeremy, I think you guys were kind of taking the lead  
 18 on this one.  
 19 And I see there's a note in the chat  
 20 from Elise regarding -- regarding benzodiazepine  
 21 doses. So Elise, perhaps you could, just before we  
 22 move into the respiratory, maybe if you just verbally  
 23 make that comment so everyone here hears it?  
 24 **DR. VAN DER JAGT:** Yeah. Sure. I  
 25 just -- I was -- I was involved with developing the

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 2 status of ... guidelines here at our institution  
 3 along with neurology. And for -- we are using  
 4 intranasal ... patients who do not have an I.D., but  
 5 that dose is zero point three milligram per kilogram.  
 6 And we use it intramuscularly for zero  
 7 point two milligrams per kilogram for patients who do  
 8 not have an I.D. And if they have an I.D., the  
 9 preference ... instead so.  
 10 **DR. COOPER:** Thank you, Elise. I do  
 11 hope you're going to be part of the group that -- you  
 12 know, that looks at this issue so we can, you know,  
 13 get -- get this resolved. I'm sure that you have  
 14 more than enough conference calls to keep the busy.  
 15 But -- but, you know, this one's  
 16 important for the providers of the state. I know  
 17 you'll step up as you always do. Thank you.  
 18 **DR. VAN DER JAGT:** Glad to help.  
 19 **DR. COOPER:** Okay. So let's move on  
 20 to the respiratory issues. So Amy and Jeremy, let's  
 21 take it away.  
 22 **MS. EISENHauer:** I will turn it over  
 23 to Dr. Cushman because he's -- so for reference,  
 24 during the R.S.V. surge, we had some -- some folks  
 25 approach -- approached me and E.M.S.C. and I had

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 2 talked with Dr. Cooper because our meeting had  
 3 already -- our meeting time had already passed by the  
 4 time that this topic came up.  
 5 So we did bring it to Med Standards  
 6 and SEMAC and SEMSCO for discussion. And during that  
 7 discussion with Med Standards, the review, Dr.  
 8 Cushman had found that perhaps the pediatric  
 9 respiratory protocols could use a review by our  
 10 group. And so I'll turn it over to him to discuss  
 11 any specifics that he'd like to reference.  
 12 **DR. CUSHMAN:** Forgive me, because I --  
 13 honestly, I don't know where the email is. But I  
 14 think the -- the context of -- of what was brought  
 15 forward, if I recall from our colleagues upstate,  
 16 were excellent. It is absolutely something that I  
 17 would certainly appreciate the input from -- from  
 18 E.M.S.C. on.  
 19 And there -- there were, I think, two  
 20 primary components to this. One was the use of high  
 21 flow nasal cannula in pediatric patients. Both --  
 22 and I think that the primary circumstance was -- was  
 23 in the process of inter-facility transport rather  
 24 than primary ground nine-one-one response.  
 25 And there are -- I will just offer

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 2 there are all sorts of practical limitations that --  
 3 that may preclude that from happening with, honestly,  
 4 any -- any reasonable effect for the pediatric  
 5 population. But more importantly, from E.M.S.C.  
 6 perspective of -- you all know the data better than I  
 7 do, whether it's something that we should, as a  
 8 state, be exploring the use of high flow nasal  
 9 cannula for pediatric patients.  
 10 And related to that, because it is  
 11 generally less oxygen consuming, is the use of  
 12 pediatric CPAP or potentially pediatric BiPAP. And  
 13 therefore, what would the indications,  
 14 contraindications, lower age limits, et cetera -- et  
 15 cetera be for that being added to the scope, again,  
 16 in two different use cases?  
 17 I think primarily in the inner  
 18 facility transport range, which is questionable  
 19 whether -- whether under Article 30, we really have  
 20 that -- that role, but I think you -- you definitely  
 21 do as you are also an advisory board to the -- to the  
 22 E.D.s, but also in the nine-one-one transport  
 23 environment.  
 24 So I'll throw that bomb in your laps  
 25 and you can figure out where you -- where you want to

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 2 take things, if -- if anything, from there.  
 3 **DR. COOPER:** Certainly a topic that is  
 4 ripe for discussion. Any other -- any -- any --  
 5 anybody want to add anything to what Jeremy has said?  
 6 **DR. HARRIS:** Yeah, I'd like to jump  
 7 in. So I can say that in Northwell, we do use high  
 8 flow pretty ubiquitously for inter-facility  
 9 transport. We have Hamilton ventilators, which are  
 10 very capable of ... which is actually quite  
 11 dangerous.  
 12 So we have a cool mist that we put in,  
 13 which again is fine for our ... less okay for ... but  
 14 to Jeremy's point because of the humidification need  
 15 in the high risk ... without it, it does become a  
 16 little rate limiting.  
 17 And I do have some concerns because we  
 18 currently use this in the hands of very, very skilled  
 19 critical care transport nurses who spend all their  
 20 time with sick kids. And given the limited exposure  
 21 that most E.M.S. clinicians have to high ... has to  
 22 be very prescriptive about it.  
 23 You know, and then, the CPAP, BiPAP  
 24 issue, it becomes one of weight, right, so we can't  
 25 do BiPAP on most ventilators under the age of --

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 2 excuse me -- under the weight to ten kilo. So I  
 3 think that it's just a little limited.  
 4 I do want to just sort of add to  
 5 Jeremy's point, though, that if there's an ability,  
 6 especially in line with our conversation of reviewing  
 7 the regulations on a pediatric facility, I think one  
 8 of the things that this last R.S.V. surge showed us,  
 9 and again, this may be out of the purview of E.M.S.C.  
 10 so please correct me if this is not, is that we found  
 11 very quickly that the ability of a pediatric  
 12 hospital, whatever that means at a future version, to  
 13 have things like high flow on the floor where many of  
 14 our patients, many -- many of our patients needed to  
 15 go help reduce the burden on precious pediatric  
 16 I.C.U. beds.  
 17 So again, I don't know whether that's  
 18 something we can blend to future discussions on this  
 19 topic and on the topic of redefining pediatric  
 20 hospitals and emergency departments.  
 21 **DR. COOPER:** That's a great -- that's  
 22 a great comment, Matt.  
 23 I see Elise has his hand up, as well.  
 24 **DR. VAN DER JAGT:** Yeah, thanks very  
 25 much, Art. This is -- I don't know if it's a bomb --

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2 I don't think it's a bomb. I think it's just that I  
3 think I totally get it because we were struggling  
4 also with patients at outlying hospitals with severe  
5 respiratory distress, and some of them were able to  
6 start high flow and some of that were not.

7 I think it depends an awful lot on the  
8 -- as -- as Matt said, the expertise of the folks who  
9 are doing this. We find that even in outside  
10 hospitals and E.D.s where they don't see many kids  
11 with those kinds of difficulties, they're very shaky.  
12 They're not sure that they can assess patients very  
13 well. They have to have a really good respiratory  
14 therapist to make sure that the equipment they used,  
15 you know, isn't too big and obstructs entire nose  
16 kind of thing and resulting with a potential  
17 complication of a pneumothorax.

18 So there are -- there are really a lot  
19 of nuances here that would have to be looked at  
20 extremely carefully. Right now, at least in our area  
21 high flow nasal cannula patients were all transported  
22 between hospitals by our pediatric transport team,  
23 because they end up in our PICU, by and large, if  
24 they're that sick, although we certainly have high  
25 flow nasal cannula on the floor.

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2 The other thing is -- is that any  
3 discussion needs to clearly be done, I think, with  
4 pediatric emergency medicine providers, because what  
5 we are also finding is that people -- kids get put in  
6 high flow, this is a sort of a panacea. Well, now,  
7 you've got all these kids in high flow, and now,  
8 they're on all on oximetry and there's prolong length  
9 of stay. And now, decisions have to be made in the  
10 E.D. potentially do they go in high flow, not on high  
11 flow, PICU, no PICU depends on that.

12 So it is a very thorny issue, I think,  
13 that would have to be approached very carefully. And  
14 I guess personally, I -- I think that to say start  
15 high -- this would be inter-facility, I do understand  
16 that, but because there are nuances of this mode of  
17 doing it, they -- it has to be humidified, it has to  
18 be warmed, it has to be the right size in terms of  
19 the nasal cannulas that are used. This may be more  
20 than can be handled by most E.M.S. agencies  
21 independently.

22 Certainly would need to be under very  
23 careful medical control during the transport. If  
24 there was no pediatric specific team, there would  
25 have to be some sort of a -- you know, a connection

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2 with a critical care center -- children's hospital  
3 kind of thing, so that the core E.M.S. folks, you  
4 know, they develop a problem, you know, that they  
5 immediately have access to someone who is quite  
6 expert in dealing with this.

7 And BiPAP and CPAP is another whole  
8 venture of a little different kind of scenario. I  
9 was thinking -- I relayed the sort of question is --  
10 is BiPAP for pediatric asthma, which we also do, it  
11 sort of falls in that same category, can you maintain  
12 competencies in your E.M.S. providers to really do  
13 this when it's already very challenging for emergency  
14 medicine physicians. So -- anyway, enough said.

15 **DR. COOPER:** Elise, I think you have  
16 just, you know, described the situation in your usual  
17 eloquent and intensive manner. I mean, that's it, in  
18 a nutshell. You know -- you know, it's -- it's  
19 difficult enough for a pediatric emergency medicine  
20 physician, even in some cases pediatric I.C.U.  
21 physician, you know, to deal with this issue, you  
22 know, in a consistent manner.

23 And certainly to ask our emergency  
24 medical technicians who have, you know, very limited  
25 training in terms of the numbers of hours, paramedics

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2 have more, of course, you know, to take this on, may  
3 be -- may be, you know, a bit more than we can -- we  
4 can take on as a committee here.

5 But let me raise the larger issue, at  
6 least what I see as the larger issue. The issue of  
7 inter-facility transport has been a broad issue in  
8 the E.M.S. world and in the critical care world for  
9 years.

10 Deb Funk was a prominent emergency  
11 medicine physician at the Albany Medical Center, many  
12 -- many years ago, led a task force. Jeremy's  
13 smiling, I can see that, hiding behind his hand  
14 there. Led a taskforce for the -- for -- for SEMAC  
15 and state council, many -- many years ago on this  
16 issue, you know, which laid out some of the issues of  
17 inter-facility transport that needed to be addressed.

18 But you know, we never really have  
19 adopted a set of, if you will, inter-facility  
20 transport protocols, you know, for anybody. Whether  
21 we should or not is another matter. But you know,  
22 let me summarize the issue by saying that inter-  
23 facility transport turns out to be, you know -- you  
24 know, Article 28 care on an Article 30 platform.

25 You know, if there are nurses and

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 2 physicians transporting the patient, as with -- as  
 3 with a critical care transport -- transport team,  
 4 that's one issue. But if we're involving A.L.S.  
 5 providers, paramedics in the mix of doing the  
 6 transport, you know, what are their responsibilities  
 7 and the limitations of those responsibilities? And,  
 8 of course, what's permissible? And what is in their  
 9 scope of practice under those circumstances? That's  
 10 never been defined at any level, really, you know.  
 11 There are certainly many critical care  
 12 transport agencies out there, many curricula out  
 13 there, many of them homegrown, you know, nothing that  
 14 I'm aware of that has really received national --  
 15 sort of a national stamp of approval.  
 16 Guys, correct me, I'm not -- if I'm  
 17 wrong. I haven't thought about this issue, you know,  
 18 in depth in -- in a few years. But -- but I think if  
 19 we're going to start getting into issues of the -- of  
 20 what E.M.S. providers, let alone E.M.S. providers  
 21 dealing with children should be doing in the inter-  
 22 facility transport arena, I think we really need to  
 23 have a little bit better understanding of -- you  
 24 know, of what's going on in that arena and you know,  
 25 where, if any -- where, if any -- anywhere in that

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 2 facilitate. You know, this -- this is more than just  
 3 kids. The -- the -- the issues transcend all ages.  
 4 So I think it -- it is absolutely  
 5 critical that we have a diverse -- a diverse group  
 6 because we have some things that might work in the  
 7 adult population that absolutely will not work in the  
 8 pediatric population and -- and potentially vice  
 9 versa.  
 10 So I completely agree with -- with the  
 11 need for that and to expand that. You know, also  
 12 just -- just to be clear, I'm actually, for a change,  
 13 not advocating to add this stuff to the E.M.S. scope  
 14 of practice. The question came up. Amy was kind  
 15 enough to throw the update on my lap. I bit because  
 16 I don't stay quiet sometimes.  
 17 I -- Elise, I completely agree with  
 18 you. I -- I -- I don't think this has, quite  
 19 frankly, any -- any role in the nine-one-one world  
 20 and in the inter-facility transport world. But it's  
 21 -- it's folks like Matt that are extraordinarily well  
 22 trained.  
 23 It's folks like yours that are  
 24 extraordinarily well trained, where you know what  
 25 you're getting into before you even get there and can

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 2 arena, we can -- we can make a difference.  
 3 So sorry, Amy, time for another  
 4 taskforce. We got to put together a group that's  
 5 really interested in this. I know Jeremy and Elise  
 6 will be delighted to participate. I will, too.  
 7 Pam Feuer, you have a boatload of  
 8 experience dealing with issues like this. I'd like  
 9 to ask you to be part of that.  
 10 Matt, of course, and anybody else who  
 11 wants to participate because this is something that's  
 12 going to happen -- that's going to require a good  
 13 deal of thought on all our parts. And I think, as  
 14 Elise and Jeremy have both indicated, is an area  
 15 where -- in which we really need to tread very  
 16 carefully. But at the same time, we all know that  
 17 there is value, you know, in -- in things such as  
 18 high flow nasal cannula under select circumstances,  
 19 with appropriately trained providers, you know, under  
 20 appropriate -- with appropriate medical support.  
 21 So any other comments before we move  
 22 on to pediatric quality measures?  
 23 **DR. CUSHMAN:** Yeah, Art, just -- just  
 24 two real quick things. One is I -- I hope that, you  
 25 know, perhaps Dr. Doynow or Director Greenberg can

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 2 match the -- the patient with -- with those things.  
 3 But we also do have to recognize that  
 4 we have, particularly in some of our more rural  
 5 areas, some tremendous challenges in moving these  
 6 kids with teams that are capable of moving them.  
 7 And -- and ultimately, Art, to your  
 8 point, that that's a system issue, not necessarily a  
 9 peds issue, but we still have to address it either  
 10 way.  
 11 **DR. COOPER:** Hear hear. Thank you,  
 12 Jeremy.  
 13 Matt, did you raise your hand or is  
 14 that from before, Matt?  
 15 **DR. HARRIS:** Forgive -- forgive me.  
 16 That was from before. I'll lower it.  
 17 **DR. COOPER:** Okay. Elise, please.  
 18 **DR. VAN DER JAGT:** Yeah, I just -- I  
 19 just put something in the chat here because it makes  
 20 me think of, you know, first of all the E.M.S.C is  
 21 more than E.M.S. You know, it's E.D.s, it's  
 22 hospitals, it's I.C.U.s --  
 23 **DR. COOPER:** Yeah.  
 24 **DR. VAN DER JAGT:** -- inpatient. And  
 25 I think that it, really with the push, as Amy had

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 2 suggested looking -- giving us a little bit of  
 3 information about nationally the emphasis on disaster  
 4 response, this really falls open, in many ways,  
 5 across -- into disaster response with a particular  
 6 area. And in pediatrics respiratory issues, we were  
 7 hit with basically a disaster. And how do we triage,  
 8 how do we do this, can E.M.S. do more than they  
 9 usually do?

10 Many of you know that we're in a rural  
 11 -- I'm in a rural area, that we had -- we asked  
 12 hospitals to do a lot more than they were comfortable  
 13 doing in terms of even physicians' scope of practice,  
 14 because there was just simply no beds.

15 And so it really becomes a way of  
 16 looking at this. And maybe Jeremy, what you were  
 17 saying about is respiratory, it's -- it's a big  
 18 issue, but it could be used as a model, perhaps, of  
 19 how we might orchestrate this.

20 And so -- so that may be the  
 21 overarching umbrella disaster response in a  
 22 situation, whether it's Covid for adults, whether  
 23 it's respiratory issues for kids, I -- I think this  
 24 might be a context that we might want to consider.

25 **DR. COOPER:** Absolutely.

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 2 So Amy, I will make it my business to  
 3 reach out to Dan Doynow. Okay? And, you know, see  
 4 how he wants to proceed with this issue. And, as  
 5 Jeremy has pointed out, it's a much bigger issue than  
 6 simply peds. But I do want to make sure that the  
 7 appropriate pediatric voices are included in -- in  
 8 the discussion.

9 And we've identified several pediatric  
 10 voices during this call, all of whom have either  
 11 volunteered or have been voluntold to participate.  
 12 And you know, I -- I -- I think we can probably get  
 13 together a reasonable group to -- to discuss this.

14 I don't know if any of us -- if it  
 15 would be possible for us maybe to -- to put together,  
 16 at least at a very, very, very preliminary stage  
 17 setting discussion at the -- at the SEMAC meeting  
 18 next week, you know, informally, totally.

19 But let's see what we can do to come  
 20 up with -- with an appropriate response to this. I  
 21 just noted Elise's comment that there are people with  
 22 expertise in this area who are not part of either  
 23 group.

24 And Elise, if you have any special  
 25 names that you want to forward to the group,

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 2 especially Amy, please let us know. Okay? And I'll  
 3 reach out to Doynow and -- Dr. Doynow and we'll --  
 4 we'll see how he wants to proceed in this -- in this  
 5 area.

6 Well, that was exhausting. Any other  
 7 comment on the peds respiratory issue which expanded  
 8 well into critical care and inter-facility transport  
 9 and E.M.S. as a whole? We're going to -- we're going  
 10 to try to -- maybe we won't boil the ocean, but maybe  
 11 -- maybe a small lake. I don't know. We'll see.

12 Okay. Pediatric quality measures,  
 13 Amy, where are we on this one?

14 **MS. EISENHAUER:** All right. So we  
 15 have some guests with us, David Violante and Dr.  
 16 Michael Redlener are here. I had a meeting with them  
 17 to discuss pediatric quality measures and the quality  
 18 measures program at the state. So I invited them  
 19 here because, obviously, some things are -- we  
 20 already have one pediatric quality measure and the  
 21 set that are out currently that deals with pediatric  
 22 respiratory, we discussed that. But they are looking  
 23 for other things that we might be interested in.

24 So if David or Dr. Redlener would like  
 25 to kind of give some background information on the

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 2 project and where it's going and how we can help in  
 3 the future, that would be great.

4 **DR. COOPER:** I see Michael on the  
 5 call. I don't see -- David -- oh, yes.

6 **MR. VIOLANTE:** Thank you so -- so  
 7 much. Dr. Redlener, do you -- is there -- do you  
 8 want to take this away?

9 **DR. REDLENER:** I'm happy -- you want  
 10 to give a broad overview, and then I'll -- I'll pick  
 11 up after you?

12 **MR. VIOLANTE:** Okay. Sounds good.  
 13 The quality metrics committee is -- is currently  
 14 working on the number of measures at the state level  
 15 and want to expand it out to some other measures.  
 16 And so we're looking at a -- a number of different  
 17 quality sources, nationally, to vet some of these  
 18 measures from the American Heart Association, et  
 19 cetera.

20 And wanted to broaden it out from  
 21 where we currently stand now to a short group of  
 22 measures. And it'd be inclusive by the different  
 23 kinds of agencies that would be involved in it, so  
 24 trauma, pediatrics, et cetera, on from there.

25 And so to that end, we had a great

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 2 meeting with Amy and talked about a number of  
 3 measures that we want to look at. And I'll ask Dr.  
 4 Redlener to take a -- take a run through those with  
 5 the group if that's okay.  
 6 **DR. REDLENER:** Thanks, David. And  
 7 just to add a little bit of -- of context, you know,  
 8 so that the availability of E.M.S. quality measures  
 9 has grown and --.  
 10 **DR. COOPER:** Michael -- Michael, would  
 11 you be kind enough to try to get a little closer to  
 12 your microphone, please? I think --  
 13 **DR. REDLENER:** Is that better now?  
 14 **DR. COOPER:** -- we're having trouble  
 15 hearing you.  
 16 **DR. REDLENER:** Can you hear me?  
 17 **DR. COOPER:** Yes, we can hear you, but  
 18 can you come a little closer to your microphone?  
 19 Thank you.  
 20 **DR. REDLENER:** I can't get much closer  
 21 than this.  
 22 **DR. COOPER:** That's better; thanks.  
 23 **DR. REDLENER:** All right. I'll do my  
 24 best. I hope I'm not yelling for everyone else, so I  
 25 don't mean to yell.

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 2 So my -- what I was saying is that  
 3 there are -- there's an increasing opportunity for us  
 4 for standardized measures in E.M.S. related to using  
 5 them. And that is being developed as we speak.  
 6 I'm -- I'm a part of the national  
 7 E.M.S. Quality Alliance, which is -- which is an  
 8 organization that is doing that work to create  
 9 measures within the NEMESIS dataset. And the  
 10 opportunity presents itself now for states like New  
 11 York to really embrace that and look for  
 12 opportunities where we can overlap with our  
 13 colleagues around specific specialties and -- and  
 14 systems of care and priorities to different groups.  
 15 And so the conversation with Amy and  
 16 team was really around how do we take that work and  
 17 translate it for New York State into the pediatric  
 18 environment.  
 19 So there are things that -- there are  
 20 specific measures that we have -- that we have at our  
 21 fingertips that we could implement, should we choose,  
 22 in terms of the pediatric environment and area. So  
 23 things like using weight-based -- weight-based  
 24 augmentation in kilograms, looking at the assessment  
 25 of pediatric patients and -- and the respiratory --

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 2 you know, the respiratory assessment for pediatrics.  
 3 You know, some of these things align  
 4 exactly with what E.M.S.C. is interested. Others,  
 5 there's probably a discussion to be had around the  
 6 specifics of what we're trying to measure to make  
 7 sure that it's aligned with the projects that  
 8 E.M.S.C. is supporting and the priorities of the  
 9 E.M.S.C.  
 10 So I think that we've initiated those  
 11 conversations. And over the next six months, we're  
 12 really going to be looking to -- to kind of really  
 13 put pen to paper when it comes to this -- what the  
 14 state is interested in looking at and thinking about.  
 15 So I -- I don't know. Maybe it's best  
 16 to respond to any questions, or Amy, if there's  
 17 anything that you wanted to make sure to cover during  
 18 this conversation?  
 19 **MS. EISENHauer:** I don't have anything  
 20 specific. I think we kind of discussed the -- just  
 21 reviewing the respiratory assessment, and that I  
 22 would bring this to the group to see, because I know  
 23 that people had varied interests and that some of  
 24 those do depend on our ability to collect the data  
 25 based on the platform that we have.

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 2 So that's why I wanted to include both  
 3 of you in those discussions because you know more  
 4 about what's possible and what isn't so we're not  
 5 chasing our tails but actually getting good data that  
 6 we can use to inform our care.  
 7 **DR. REDLENER:** Yeah. So one -- one  
 8 example that we discussed during our conversation  
 9 that I think is -- kind of illustrates that point is  
 10 the -- the pediatric respiratory assessment. Right?  
 11 And it's hard looking at big data in E.M.S. to say  
 12 did somebody follow the pediatric assessment triangle  
 13 -- the pediatric assessment, kind of the -- the  
 14 qualitative nature of that.  
 15 But, you know, the way that the net  
 16 score measure is written for respiratory assessment  
 17 for -- for kids is really around did they document  
 18 the respiratory rate? Did they document the O2 sat?  
 19 And so, you know, things might not be  
 20 exactly perfect. And -- and what I always encourage  
 21 people to think about is, maybe we should start with  
 22 what's practical and possible within the existing  
 23 dataset and think about how we can improve and  
 24 broaden it as we get to -- you know, again, closer to  
 25 exactly what we want to measure. Right?

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 2 And I -- I try not to let the -- the  
 3 common saying of the perfect being the enemy of the  
 4 good get in the way of -- of some -- doing something,  
 5 something that's valuable to us as -- you know, as  
 6 practitioners -- as E.M.S. providers, practitioners,  
 7 and leaders. I think that -- I think it's really  
 8 important to do something. And getting the input of  
 9 this group on that is -- is very valuable.  
 10 What I would say is that there's a lot  
 11 of existing measures that can be stratified by  
 12 pediatric, by -- by age, so that it's pediatric-  
 13 focused. So for example, if we wanted to do the  
 14 pediatric trauma to trauma centers, that's a  
 15 possibility.  
 16 NEMSCO worked with the American  
 17 College of Surgeons to create quality measures for  
 18 the new trauma triage guidelines. So that's also an  
 19 opportunity to think about how it fits in with the --  
 20 that work. I think that there's really practical  
 21 ways to implement those things, as well.  
 22 There's -- you know, if you're looking  
 23 at airway and capnography utilization, that's also,  
 24 you know, potentially a good opportunity. So there's  
 25 lots of directions to go. And if there's a

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 2 particular priority of this group, I think that it's  
 3 important to hear it and to -- you know, to integrate  
 4 it into what we're going to do.  
 5 Right, David?  
 6 **MR. VIOLANTE:** Absolutely. Yeah,  
 7 there's a -- there's a lot of data that -- that --  
 8 that we could get. And we're working with the state,  
 9 that informatics team, to look at some of the -- the  
 10 data dictionaries that are out there, especially from  
 11 NEMSIS, so that we can get that data, analyze it  
 12 appropriately, stratify it by age, also, to use for  
 13 pediatrics. And there's a new dataset that's going  
 14 to be coming up fairly soon from NEMSIS that's going  
 15 to be very helpful in looking at improved data and  
 16 better data overall in documentation. So we're  
 17 looking forward to those -- those components, as  
 18 well.  
 19 **MS. EISENHAUER:** I think you're muted,  
 20 Dr. Cooper.  
 21 **DR. COOPER:** Thank you, Amy.  
 22 Before I recognize Dr. Van der Jagt, I  
 23 just want to ask David and Michael if, you know, for  
 24 our next meeting, you know, I think while it's --  
 25 it's absolutely true that we can, as a group, provide

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 2 you with good input, I think that what would be most  
 3 helpful, as you had indicated, Michael, is to find  
 4 some issues that, you know, are relatively  
 5 straightforward and relatively low-hanging fruit, if  
 6 you will, that we can focus on early.  
 7 And, you know, I think a -- you know,  
 8 a specific proposal from your group, you know, that  
 9 we could, you know, discuss at the next meeting might  
 10 be helpful. If that's something that --  
 11 I see Jeremy has to go. Thank you,  
 12 Jeremy.  
 13 I -- I do think that if you could get  
 14 that to Amy in time for us to be able to run it up  
 15 the flagpole through the E.D.C.C. process, so it can  
 16 be officially discussed at our -- at our next meeting  
 17 on the agenda, it would be very helpful.  
 18 But, you know, I think there's no one  
 19 on this call that disagrees with anything either of  
 20 you has said. We're -- we're totally into ensuring  
 21 that we're measuring quality as best we can, given  
 22 the resources we have available to us.  
 23 And the expertise you both bring to  
 24 this process is immeasurable and we're extremely  
 25 grateful for it.

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 2 Elise, please, didn't mean to be so  
 3 long winded but so please -- please chime in.  
 4 **DR. VAN DER JAGT:** I think -- no --  
 5 thanks very much, Dr. Cooper. No, this is extremely  
 6 exciting, I think. I think -- I just had a couple of  
 7 questions about the little bit of logistics and  
 8 things.  
 9 So when you are looking at that data,  
 10 you basically look at data of New York State  
 11 residents from the national database. Is that  
 12 correct? That's number one.  
 13 Secondly, is there a way to assess how  
 14 complete each of those data elements are because if  
 15 you have a data element you want, but, you know, most  
 16 of the values are missing, that is not going to be  
 17 very helpful. So that -- that's one thing that would  
 18 be helpful, I think.  
 19 And then, the third thing in the data  
 20 dictionary, itself, is -- I mean, for me, I'm not  
 21 exactly sure what the dataset contains and so it  
 22 makes it a little bit harder to say, oh, you know,  
 23 we'll just get this, but then it turns out that the  
 24 data dictionary doesn't have that data.  
 25 So I don't know if there's a way to,

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 2 you know, have access, or to have -- to look at a  
 3 little bit of what's happening, a little bit like,  
 4 you know, we -- I'm in the sepsis group, as well, for  
 5 New York State. And you know, we have the sepsis  
 6 data dictionary, so you can look at that and you can  
 7 get a pretty good sense of what's being collected.  
 8 But I don't have any good idea of what might be in  
 9 this -- in this database.  
 10 **MR. VIOLANTE:** Yeah.  
 11 **DR. VAN DER JAGT:** And then, finally,  
 12 you know, once we have a little bit better sense for  
 13 that, I think, as a committee, we should probably  
 14 identify at least some areas that we think that we  
 15 should be looking at across the board. And I would  
 16 say, not only E.M.S. but certainly, this is the  
 17 E.M.S. database, but areas that cross over into E.D.  
 18 and inpatient because, you know, E.M.S. kind of  
 19 illnesses and injuries, inevitably crossover there  
 20 hopefully. And then the outcomes depend on all those  
 21 areas. So it could be looked at as a place to start,  
 22 at least, and go from there.  
 23 Anyway, that's my --.  
 24 **DR. REDLENER:** If I -- if I could,  
 25 I'll -- then I'll make a few comments about NEMSIS in

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 2 elements.  
 3 And that -- those are the elements  
 4 that have been used to kind of think about what's  
 5 available currently. So I guess, David, I'll -- I'll  
 6 -- maybe stick to our -- our thoughts about process.  
 7 Right? So I think what will happen is that we will  
 8 pull from the existing measures that have been, you  
 9 know, kind of created out of the -- the NEMSIS data.  
 10 And we will have a core group of -- of  
 11 things that we think are important from -- from a  
 12 pediatric perspective that will come -- that will be  
 13 included in kind of our -- our middle range, you  
 14 know, databases or we'll make a few recommendations  
 15 and then we would ask for your advice about the  
 16 specific core ones.  
 17 And then, as you kind of learn about  
 18 that and we have an opportunity to speak about it  
 19 more, then we would, you know, again, kind of think  
 20 about how to create the measures that cross from the  
 21 E.M.S. to the hospital, that cross from, you know,  
 22 like these outcome measures that are important, how  
 23 they're related to E.M.S. data.  
 24 All of those things are a much larger  
 25 and probably longer discussion and would have to be -

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 2 general. So -- so NEMSIS is the national E.M.S.  
 3 dataset. It actually lives at the state level. And  
 4 when E.M.S. -- when an E.M.S. provider or agency goes  
 5 on an E.M.S. call, they fill out an electronic P.C.R.  
 6 medical record and that data goes directly to the  
 7 state dataset.  
 8 And then there's a national dataset  
 9 that has common elements from every state, and then  
 10 it goes up to the -- so it's not a -- it's really a  
 11 state-based dataset that goes up to the national  
 12 level and gets combined.  
 13 And so there's a lot of work done  
 14 related to what's called pseudocode, which is -- you  
 15 know, the good thing about E.M.S. data is that it's  
 16 pretty common. Like there's -- I mean, there's --  
 17 it's pretty organized and set out to what exactly  
 18 needs to be in it, as electronic medical records for  
 19 E.M.S.  
 20 And using that dataset, I think that  
 21 Dan -- Dan put in there that the trauma data  
 22 dictionary, but also there's the NEMSIS data  
 23 dictionary that is used and populates, you know,  
 24 every -- every electronic medical record that gets  
 25 uploaded into New York State database has some common

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 2 - you know, take some work to get to -- to those  
 3 points.  
 4 So -- so I guess, I think we're in  
 5 line with the -- your -- your thinking. I think  
 6 let's do the easy things first, that make sense, that  
 7 are evidence-based, that fit into the E.M.S. existing  
 8 dataset. And then we'll move from there into the  
 9 realm of, hey, what are the higher-level things that  
 10 we need to -- to do. How can we include those in  
 11 what we think about. But love that -- love those  
 12 discussions and -- and how to think about, and value  
 13 everyone's input.  
 14 **DR. COOPER:** But more -- more to come  
 15 on this, no doubt.  
 16 Oh, David, you had a point?  
 17 **MR. VIOLANTE:** Yeah. I'm sorry. Dr.  
 18 Cooper, I just wanted to say we did get a  
 19 presentation out to the state so that we could  
 20 present at SEMAC/SEMSCO in February of exactly what  
 21 we're doing, where we're going, what we'd like to get  
 22 from -- from each representative group of folks in  
 23 terms of data, in terms of what they would like to  
 24 see, their needs, their wants, et cetera.  
 25 And also, to answer a question about



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 2 areas that cross over, there are some areas that  
 3 might cross over into the hospital. In summary,  
 4 we're happy to take a look at those as long as those  
 5 are things that are reported. And we have two  
 6 programs that we're looking at, ... biospatial, and  
 7 make it a lot nicer for folks to look at and -- and  
 8 easier in terms of functionality.  
 9 And that -- in pieces of this, as  
 10 well, the outcomes coming out from the hospitals back  
 11 to the agencies can help the datasets that we look at  
 12 to find that crossover that you're looking for, as  
 13 well. And so we're looking forward to that.  
 14 Some of these things are coming down  
 15 the line. It's a lot of work by the D.I. team of the  
 16 state. They're doing a tremendous job at it. And  
 17 the -- the committee here is doing a ton of work. So  
 18 much appreciation to them.  
 19 And thank you very much for being a  
 20 part of what we're looking at doing. It's super  
 21 helpful for us to get this feedback so that we can  
 22 provide you the things that you're -- that you want  
 23 and are looking for and need.  
 24 **DR. COOPER:** Elise, you had a comment?  
 25 **DR. VAN DER JAGT:** I put it in the

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 2 chat, actually, just some, I think, areas that would  
 3 be really great. So one is cardiac arrest because of  
 4 the high mortality of that across the state, I think  
 5 we've talked about this a little bit in the last  
 6 meeting, and then also the status epilepticus issue,  
 7 the context of course, today was the midazolam issue,  
 8 but the increasingly important role of speed to  
 9 treatment, I think, and the very high incidence of  
 10 pediatric epilepsy lend itself as two areas we may  
 11 want to consider.  
 12 **DR. COOPER:** Thank you, Elise.  
 13 David and Michael, we'll look forward  
 14 to additional information in our May meeting. And if  
 15 there is a slideshow that you're going to be  
 16 presenting next week at SEMAC, once that has been  
 17 approved, Amy, perhaps you could share that with us  
 18 so we can see what David and Michael have been saying  
 19 verbally for the last twenty minutes or so, a little  
 20 bit more in a -- you know, on -- on paper, so to  
 21 speak.  
 22 **MR. VIOLANTE:** Okay.  
 23 **DR. COOPER:** Thank you so much.  
 24 All right. It is almost three ten.  
 25 We now have an opportunity to move in to updates from

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 2 our -- our D.O.H. partners and -- and others. And  
 3 we'll begin with Darlene Reda. I hope I'm saying  
 4 that correctly, Ms. Reda. From the Westchester  
 5 County Domestic Violence High Risk Team.  
 6 **MS. REDA:** Thank you so much. I  
 7 appreciate it. Thank you for having me.  
 8 Thank you, Amy, for arranging to have  
 9 this presentation today. If you just give me a  
 10 second, I'll share what I have. Can everyone see  
 11 that? We're good?  
 12 I just want to give you a brief  
 13 background on myself before I get started. I -- I  
 14 know most of you are in the medical field or at least  
 15 affiliated in some way with the medical field. I  
 16 actually took a different path. I'm an attorney. So  
 17 I have a somewhat different perspective, but we have  
 18 worked extensively with those in the medical field.  
 19 What I'll be talking about today, in a  
 20 very brief presentation, is a high-risk team that we  
 21 put together about five years ago based upon  
 22 situations that we saw occurring and here in  
 23 Westchester County where we had a very high number of  
 24 domestic violence homicides. And I'll -- I'll talk  
 25 about -- a little bit about domestic violence and how

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 2 we came about creating our team, assuming my computer  
 3 cooperates with me today.  
 4 So just initially, I will be using the  
 5 term, she, when I refer to victims, he when referring  
 6 to abusers. And even though our Westchester  
 7 statistics show that women are victims approximately  
 8 ninety to ninety-five percent of the time and  
 9 nationally that appears to be about the same, we know  
 10 that men can be victims as well.  
 11 Members of the L.G.B.T.Q.I.A.  
 12 community are also victims and abusers. And our team  
 13 is fully committed to serving everybody.  
 14 So in addition to being an attorney, I  
 15 was also an accountant, an accounting major. So I  
 16 kind of like numbers. I know a lot of people are not  
 17 as fascinated as I am. So I'll just keep it very  
 18 brief just to give some perspective to this  
 19 presentation.  
 20 Women murdered by intimate partners,  
 21 we know that of all women killed in the U.S. each  
 22 year, forty to fifty-four percent of them were killed  
 23 by an intimate partner. And women are killed by  
 24 intimate partner nine times more often than by a  
 25 stranger.

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 2 So when we have children and we're  
 3 teaching them about stranger danger and to be aware  
 4 of, you know, that person on the street, you know,  
 5 everyone is very careful, especially when walking in  
 6 big cities, they're afraid they'll be assaulted by a  
 7 stranger and -- and for sure that is ...  
 8 But women are more likely to be  
 9 injured by an intimate partner, by someone they're  
 10 close with, than by a stranger. Two-thirds of women  
 11 killed by an intimate partner have been physically  
 12 abused by that partner prior to the murder. That  
 13 statistic is likely higher because the incidence of  
 14 physical abuse and domestic violence are very  
 15 underreported, probably the most underreported crime,  
 16 actually. And so that's -- that's an estimate, a  
 17 rough estimate but again, probably a little on the  
 18 low side.  
 19 We do know, and this is probably most  
 20 relevant to all of you here, that forty to forty-  
 21 seven percent of the women who were murdered by an  
 22 intimate partner were seen by a healthcare provider  
 23 prior to the murder occurring. The reason for that  
 24 is many women who are victims are reluctant to reach  
 25 out to the police, reluctant to confide in family,

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 2 friends, colleagues, but they will go for medical  
 3 attention.  
 4 And this gives you, as E.M.T.s and as  
 5 doctors and nurses and -- and medical professionals,  
 6 a very unique opportunity to be open and responsive  
 7 to people that come forward and want to confide in  
 8 you about a situation that they're experiencing at  
 9 home.  
 10 For every one woman killed by an  
 11 intimate partner, there are eight to nine attempted  
 12 murders. And someone strangled just once by an  
 13 intimate partner is eight hundred percent times more  
 14 likely to be killed in a future attack by that  
 15 partner. A probation officer who was part of our  
 16 domestic violence high risk team once referred to  
 17 strangulation victims as homicide victims who  
 18 survived. That's how dangerous strangulation is for  
 19 victims of domestic violence.  
 20 To be fair, we'll look at men who are  
 21 murdered by an intimate partner. Of all the men  
 22 killed in the U.S. each year, the statistics are much  
 23 lower, as you can see. Five to eight percent of men  
 24 are killed by an intimate partner. And in those  
 25 cases, about three-quarters of them included prior

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 2 domestic violence that the male partner had  
 3 perpetrated against the female.  
 4 One-third of male perpetrators who  
 5 killed their intimate partners then commit suicide.  
 6 In Westchester County, we have a very -- I would say,  
 7 it's probably higher than one third. We have a very  
 8 high correlation between suicidality and  
 9 homicidality. I'll talk about that in a little bit.  
 10 Just to, again, bring it down and give  
 11 perspective, New York State and Westchester County  
 12 stats, the prevalence, again, is difficult to  
 13 quantify because domestic violence is one of the  
 14 most, if not, the most underreported crime.  
 15 Domestic incident reports which are a  
 16 measure of domestic violence, they are required to be  
 17 filled out by police officers every single time they  
 18 respond to the scene of a domestic. In Westchester  
 19 County, in 2020, there were just ten thousand, nine  
 20 hundred and seventy-seven reports filed. And that's  
 21 for a population that's roughly a million. So you  
 22 can see how low those statistics are.  
 23 In 2018, our family courts here issued  
 24 just under twenty-six hundred orders of protection.  
 25 That sounds like a lot, but again, when you look at

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 2 the population, it's a really low number of people  
 3 who are reaching out to get orders of protection and  
 4 really coming forward with the domestic violence that  
 5 they're experiencing.  
 6 The most horrible and egregious  
 7 statistic that we've -- that we came across during  
 8 our research was that, outside of New York City,  
 9 Westchester County had the horrible distinction of  
 10 ranking number two in the number of children killed  
 11 in domestic violence homicides between 2008 and 2017.  
 12 We are trying to get updated  
 13 statistics on that. We're hoping, obviously, that  
 14 our numbers have gone down, but that was a horrific  
 15 number that we came across and it was one of the  
 16 pieces of information that we found out that really  
 17 spurred us to create this high-risk team.  
 18 So briefly, what is domestic violence?  
 19 The New York State Office for the Prevention of  
 20 Domestic Violence defines it as a pattern of coercive  
 21 tactics that can include a variety of forms of abuse  
 22 such as physical, psychological, sexual, financial,  
 23 emotional, that's perpetrated by one person against  
 24 an adult intimate partner. And the goal of that is  
 25 to establish and maintain power and control over the

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 2 victim.  
 3 So when we're looking at domestic  
 4 violence, we're really looking at something that  
 5 happens over a period of time. It's not a one-and-  
 6 done. It's not something that happens within a week.  
 7 It's a pattern of tactics that an abuser will employ  
 8 over that period of time. And at the heart of it is  
 9 power and control. He wants to gain and maintain  
 10 power and control over the victim.  
 11 So many people think of physical abuse  
 12 when thinking of domestic violence. That's probably  
 13 the first thing that comes to mind. There are many  
 14 of other -- many other types of abuse, as I just laid  
 15 out. And in addition to the ones I just mentioned, I  
 16 wanted to add technological and litigation abuse.  
 17 Very briefly, I'll give a very brief  
 18 overview on these types of abuse. Sexual abuse is  
 19 forced sex that you may think of, and it also  
 20 includes cybersex such as sextortion and other sorts  
 21 of cybercrimes that people are induced into doing,  
 22 such as other forms of sexual abuse can include  
 23 sharing images, like very explicit images of someone.  
 24 I had one client come in, who left her  
 25 husband. She moved to a different country, wanted to

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 2 have a fresh start. And when she got to the new  
 3 country, she was a teacher. When she got there, she  
 4 found out that her ex-husband had sent across some  
 5 very explicit videos that she consented to having  
 6 taken during their marriage, but obviously, she never  
 7 consented to him distributing them. So you can  
 8 imagine like the psychological, you know, damage that  
 9 was done when she got there, thinking she was going  
 10 to be starting over and these images followed her  
 11 across the seas even.  
 12 We can have physical harm without  
 13 violence. We see this a lot with our disabled  
 14 clients, our elderly clients, where the caretaker  
 15 will leave the medication, food, and water just far  
 16 enough away from the patient so that they can't get  
 17 to it during the day. So that patient is sitting  
 18 there. They're not -- the abuser is not physically  
 19 harming them with violence, but yet he is causing  
 20 harm because he is not enabling the victim to reach  
 21 the water that she may need or the food that she may  
 22 need or the medication that she may have to take  
 23 throughout the day.  
 24 Financial abuse is one of the main  
 25 reasons that victims tell us they stayed in a

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 2 domestic violence situation because they couldn't  
 3 afford to leave. They -- they were just, you know,  
 4 trapped financially.  
 5 Emotional psychological abuse.  
 6 Psychological can be extremely controlling, I would  
 7 say. We had one client whose husband was not  
 8 necessarily physically abusive, but extremely  
 9 psychologically abusive. So he would take her --  
 10 they had an argument one time. She was about five  
 11 feet tall, and ninety pounds soaking wet. He grabbed  
 12 her by the ankles, hung her out the window of their  
 13 second-floor bedroom, and said accidents happen. So  
 14 it kind of put her on notice, so to speak, that if  
 15 she didn't comply with all his demands and, you know,  
 16 appease him at all times, she knew what he was  
 17 threatening to do. And she knew that he was capable  
 18 of doing it.  
 19 Litigation abuse. We see that abusers  
 20 are using the court system to perpetuate abuse long  
 21 after the -- the relationship ends. And this is  
 22 really a problem in cases where there are children  
 23 involved, so the children are used as pawns. And the  
 24 courts -- the abusers will engage the courts  
 25 repeatedly, costing the victim a lot of time. She

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 2 may, you know, be in jeopardy of losing her job and a  
 3 lot of money.  
 4 Technological abuse, again, cyber  
 5 abuse is really prevalent now. It just gave abusers  
 6 one more platform that they can work from. And  
 7 stalking, sexual abuse, all these other type --  
 8 different types of tactics and abuse can fall within  
 9 the technological spectrum. Victims often tell us  
 10 that these other forms of abuse can be much more  
 11 damaging than physical violence.  
 12 So you might think with all this going  
 13 on, why are these two still together, why doesn't she  
 14 just get out of the situation. And in the interest  
 15 of time, I'll just go over a few of these. And this  
 16 is, by no means, an exhaustive list.  
 17 But children is one of the top reasons  
 18 that victims will tell us they stayed. They did not  
 19 want their children to be alone with their abusive  
 20 partners during visitation, whether it was court  
 21 ordered, or you know, or -- you know, even with  
 22 supervised visitation, they didn't want the husband  
 23 alone with the kids. So they stayed way longer than  
 24 they would have under normal circumstances.  
 25 People are often heavily influenced by

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 2 culture, their families and religious beliefs. If --  
 3 we had one client come in one time whose arm was  
 4 black and blue from the shoulder down to the wrist.  
 5 And we talked to her about, you know, what her plans  
 6 were. And she said -- she was engaged at the time.  
 7 She and her husband were both -- her future husband -  
 8 - were both doctors and their families had talked it  
 9 out and her parents were very influential and they  
 10 said they wanted them to have a discussion. Everyone  
 11 would have a discussion to work this problem out and  
 12 the marriage would still go forward.  
 13 So this woman was, you know, even as a  
 14 professional and as someone who was very capable of,  
 15 you know, making very independent decisions, heavily  
 16 influenced by her family and their cultural beliefs.  
 17 Immigration is a -- a tremendous  
 18 influence on why women will stay. Love, sometimes  
 19 they just want the abuser to go back to what they  
 20 were when the relationship started.  
 21 So the Westchester County Domestic  
 22 Violence High Risk Team really was spurred by an  
 23 event that occurred in 2017 when Loretta Dym was  
 24 killed by her husband. He also killed their  
 25 daughter, Caroline.

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 2 Loretta had just gotten back from  
 3 dropping their son, William, off at college in  
 4 California, the day before Steven Dym, again, Loretta  
 5 Caroline, before turning the gun on himself.  
 6 And the reason this case was so  
 7 influential to us is that the police chief of the  
 8 town in which it occurred, which was Pound Ridge, New  
 9 York, was very proactive in the D.V. community. He  
 10 was on our domestic violence counsel. He headed the  
 11 domestic violence chapter for the P.B.A. and he was  
 12 very responsive to victims. He knew the family. He  
 13 never really anticipated this and never knew that  
 14 anything was going on behind closed doors.  
 15 So we knew that if this horrific crime  
 16 could happen in a family like that, in a town like  
 17 that, where the police chief was so responsive and  
 18 where so many resources were available, that it could  
 19 happen anywhere.  
 20 And so as a county, we created a  
 21 multidisciplinary team. We -- literally this  
 22 happened on a Friday. We sat down on Monday morning  
 23 together after, of course, being on the phone all  
 24 weekend. We pulled a bunch of us together from the  
 25 D.A.'s office, Probation, our office, the Office for

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 2 Women, civil legal attorneys, and we said, we need to  
 3 do something here to prevent this from happening  
 4 again.  
 5 So we put together an evidence -- we  
 6 looked into these various options and we now utilize  
 7 an evidence-based model called the lethality  
 8 assessment program. And the purpose of that is to  
 9 reduce the risk of death and serious physical harm  
 10 for victims of intimate partner violence and their  
 11 families.  
 12 So this was initially created as a  
 13 pilot program. We -- around the same time this  
 14 happened, we were able to get some funding for --  
 15 from New York State to implement a two-year pilot  
 16 program and we put that in five of the counties in  
 17 Upper Westchester.  
 18 But we knew we had to do better.  
 19 Right? We can't have victims' safety depend upon  
 20 their ZIP code, and we wanted to roll this out  
 21 countywide. So right around 2020, January of 2020,  
 22 before the world fell apart, we trained our first  
 23 police department. We have forty-two police  
 24 jurisdictions in Westchester County. So this was  
 25 quite a huge undertaking.

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 2 We trained our first police  
 3 department. And then COVID hit. And so we obviously  
 4 had to, you know, pedal back for a little bit. We  
 5 then moved forward. We started training virtually at  
 6 first and then we put our masks on. We went out  
 7 there and we continued training the police  
 8 departments.  
 9 Around that time, I just want to note,  
 10 we were awarded, in 2021, a one-million-dollar grant  
 11 from the United States Department of Justice to  
 12 expand this team. But this money was not needed for  
 13 these police departments to train. We -- we were  
 14 fortunate to get this money. We were able to hire a  
 15 program director, additional advocates, more  
 16 training, but the police departments were entirely on  
 17 board.  
 18 Everybody that's participating in this  
 19 team was entirely on board and was not looking for  
 20 more money, which is really, really important when  
 21 you're rolling out a team like this.  
 22 As of today, we've trained all forty-  
 23 two police jurisdictions, including New York State  
 24 Police, county police, and local police. Actually,  
 25 tonight I'm going to do a refresher training for one

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 2 of the first towns that was implemented, Somers, in  
 3 this program and we are actually underway,  
 4 undertaking efforts right now to expand this program,  
 5 statewide. So we're really excited about that. We  
 6 think everyone should have access to this program.  
 7 As I said, the team includes County  
 8 New York State Police Departments, along with our  
 9 local police departments, service providers --  
 10 providers, D.A.'s office, civil legal, different  
 11 county agencies, and the Westchester Medical Center  
 12 which houses our twenty-four-seven hotline, where the  
 13 police when they respond to a domestic incident,  
 14 after asking the victim a series of questions, which  
 15 I'll show you in a minute, if the victim screens in  
 16 as a yes, as a high risk client, they will call the  
 17 medical center.  
 18 The advocate who answers the phone  
 19 there will then talk to the victim if she'd like to  
 20 get on the phone, get some information from her,  
 21 educate her on -- on what her availability of  
 22 services is within the county, do some safety  
 23 planning, and then that's the end of the call.  
 24 And then that case will be referred to  
 25 the domestic violence service providers throughout

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 2 the county, who then provide ongoing services for the  
 3 victim and her family.  
 4 So as of 2022, we had over twelve  
 5 hundred high-risk cases. In 2021, when the team was  
 6 not fully rolled out, when the police departments had  
 7 not been fully trained, we had just three hundred and  
 8 twelve. So we've already quadrupled the number of  
 9 victims that we've reached since, you know, 2021.  
 10 And at the core of this program is the  
 11 Jackie Campbell Danger Assessment. You may have  
 12 heard of Dr. Jacqueline Campbell. She was a nurse in  
 13 Maryland who, way back in 1985, developed this  
 14 program. It's an evidence-based tool, provides  
 15 validated information to predict the risk of serious  
 16 harm or lethality.  
 17 And the benefit of this to those of us  
 18 who are an attorney or is that this document can be  
 19 used in court. And essentially, it's a questionnaire  
 20 that's designed to assess a woman's risk of being  
 21 killed by her abusive partner. And when you're going  
 22 through the questionnaire with the victim, it also  
 23 gives her an idea of a better sense of the type of  
 24 danger that she is facing for her and her kids.  
 25 We know that the risk to mom is equal

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 2 to the risk to children. If the children are in that  
 3 situation, they're equally at risk of being injured  
 4 or killed.  
 5 So the main objectives of our team are  
 6 understanding and identifying the risk factors for  
 7 victims of intimate partner violence, launching an  
 8 action-oriented collaboration of a multidisciplinary  
 9 team that supports the survivor and her family from  
 10 every discipline.  
 11 So again, we have police. We've got  
 12 law enforcement, District Attorney's office, civil  
 13 legal, counseling services, mental health. We -- we  
 14 help them from every possible angle.  
 15 Develop and strengthen good  
 16 communication among the partners. And we look at  
 17 offender behavior as well. It's a very, very  
 18 important piece to us, offender accountability,  
 19 because if we're not addressing that piece, then the  
 20 victimization is going to continue.  
 21 We know often that the non-offending  
 22 parent may make decisions that seem counterintuitive,  
 23 such as staying with them, you know, when -- for a  
 24 longer period than you might think is necessary, but  
 25 they're actually based on the children's safety, as I

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 2 described earlier.  
 3 So I'll give you a look at the  
 4 lethality screen. It's a twelve-question  
 5 questionnaire. In this case, it's used by law  
 6 enforcement. There is a longer model that's used by  
 7 advocates. You can see the top three questions. Has  
 8 he ever used a weapon against you? Has he ever  
 9 threatened to kill you or the children and you think  
 10 he might try to kill you?  
 11 And if the victim answers yes to any  
 12 one of those questions, it immediately triggers a  
 13 phone call to the LAP line, which is at the medical  
 14 center. If she answers yes, or he of course, to four  
 15 of the next four -- of questions four through twelve,  
 16 that would also trigger a phone call.  
 17 Does he have a gun or can he get one  
 18 easily? We know that the presence of a gun in a  
 19 household or the ability to get a gun increases the  
 20 risk of being killed by that gun by four to five  
 21 times.  
 22 Has he ever tried to choke you or  
 23 obstructed your breathing? Notice the use of the  
 24 word, choke, because that's how many victims will  
 25 describe it. They won't say strangled. They'll say

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 2 choked and so this was put in language that was  
 3 understandable and used by victims.  
 4 Is he or she violently or constantly  
 5 jealous? Has he -- have you left him or separated  
 6 after living together or being legally married? We  
 7 know that separation is the most dangerous time  
 8 because that's when the victim is leaving and the  
 9 abuser is losing his power over her and he becomes  
 10 desperate.  
 11 Is he unemployed? Has he ever tried  
 12 to kill himself? Again, suicidality and the way that  
 13 ties in.  
 14 Do you have a child that he or she  
 15 knows is not hers? And does he follow or spy on you?  
 16 We know that stalking, again, is very high on the  
 17 list of lethality factors.  
 18 So what have we learned from these  
 19 cases? We've seen, as I mentioned earlier, and it  
 20 bears repeating, that common denominator in  
 21 Westchester cases is that in almost every single  
 22 case, the perpetrator had articulated suicidality,  
 23 attempted suicide, or completed suicide when he  
 24 killed the victims.  
 25 We often warn our clients do not

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 2 underestimate the risk. If he comes in and says to  
 3 us -- if she comes in and says he won't hurt me or  
 4 the kids, he will just hurt himself, we're not seeing  
 5 that here. We tell them that that's not borne out by  
 6 the facts of these cases.  
 7 If some is suicidal, they're willing  
 8 to basically take anyone down with them,  
 9 unfortunately. So in addition to -- or I should say  
 10 in conjunction with the LAP screen, we've kind of  
 11 developed our own shorthand that we call the six S's  
 12 to help us kind of spot lethality factors very  
 13 briefly.  
 14 Separation, always the most dangerous  
 15 time. Suicide includes threats or attempts to kill  
 16 himself or children, strangulation, stalking, sexual  
 17 assault, and then a change in socio or economic or  
 18 other status. Even though that's not on the LAP  
 19 screen, we are seeing that here in Westchester  
 20 County.  
 21 So I'm just going to -- Amy, I think  
 22 you said to step it up a little bit up. I'll speed  
 23 through these next couple of slides.  
 24 How can you, as medical professionals,  
 25 help? Many victims are reluctant to reach out, but

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 2 we know they're going to reach out for medical  
 3 assistance and that puts you in a great spot to help  
 4 people who might not otherwise get assistance.  
 5 Keep in mind the mandated reporting  
 6 laws, and they're not applicable to domestic  
 7 violence. So there are no mandatory reporting laws  
 8 for D.V. Make no assumptions; anyone can be an  
 9 abuser, anyone can be a victim. It doesn't matter.  
 10 As I told you earlier, we had a victim  
 11 and an abuser who were both doctors and I wasn't  
 12 using that example because I'm here in the -- it  
 13 would -- with a bunch of medical professionals. It  
 14 was just really to show cultural differences. But  
 15 just because someone is highly educated and appears  
 16 very, you know, put together on the outside doesn't  
 17 mean they're not an abuser, doesn't mean they're not  
 18 a victim.  
 19 Speak to them alone. We had one  
 20 client tell us she was in a hospital and her -- with  
 21 a police officer in full uniform. And the medical  
 22 team at that time came in and spoke to them while the  
 23 cop was in the room with them. What they didn't know  
 24 was that that cop in uniform was her abusive husband  
 25 and he was standing there to make sure she didn't

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 2 divulge any details of what actually happened, what  
 3 put her in the hospital.  
 4 Speak to the patient alone. Rely on  
 5 protocol, if you have to. Ask someone every time,  
 6 are you being abused at home? Do you feel safe? Are  
 7 you afraid? Use good eye contact. Understand  
 8 victims may not self-identify. They may not -- they  
 9 may not know they're in a D.V. situation if it's only  
 10 psychological. And take note of any physiological  
 11 responses to stress and trauma, sadness, P.T.S.D.,  
 12 panic attacks.  
 13 And most importantly, connect them to  
 14 local resources for safety planning.  
 15 So I think that's about it. Here are  
 16 some resources for you. This is my office number  
 17 here at the Westchester County Office for Women, New  
 18 York State Domestic and Sexual Violence Hotline, the  
 19 National D.V. hotline, sexual assault hotline, and  
 20 National Suicide Prevention Lifeline which really  
 21 ties in with, unfortunately, the homicides that we've  
 22 worked with.  
 23 So thank you again for having me  
 24 today. Hopefully, I didn't go too over time. And I  
 25 don't know if we have time for questions. Amy,

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 2 that's entirely up to you.  
 3 **DR. COOPER:** Thank you so much, Ms.  
 4 Reda, for your presentation. You know, this is such  
 5 important information for all of us who are concerned  
 6 about the welfare of children, which means that we  
 7 have to be concerned about the welfare of their  
 8 caretakers, no less urgently or importantly.  
 9 Let me just ask. Is there a specific  
 10 ask that you have for us as a committee, other than  
 11 to be aware of this issue at this time, and aware of  
 12 particularly of the program that you have, you know,  
 13 presented to us? I think it's very clearly a model  
 14 for others if they wish -- if they wish to adopt such  
 15 programs in their own locality.  
 16 But is there something we can do as a  
 17 committee to, you know, assist you and others in --  
 18 in -- you know, in addressing this very important  
 19 public health problem?  
 20 **MS. REDA:** Well, we were always happy  
 21 to talk to anybody about working together. I think  
 22 D.O.H. and -- and really the medical professional, as  
 23 a whole, we're happy to train them. We've trained  
 24 med students. We think it's important to get in, you  
 25 know, while they're still in school as -- you know,

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 2 as they're developing their practices and moving  
 3 forward.  
 4 I'm always available to talk in more  
 5 detail with anyone who is, you know, in a different  
 6 county and wants to roll this program out. We're  
 7 actually training right now in -- in Broome County,  
 8 as well, because they're interested in rolling it  
 9 out, scheduled to talk to people in Suffolk County in  
 10 the spring.  
 11 So you know, if anyone -- any training  
 12 that we can do and however we can collaborate with  
 13 any of you, we're happy to do it.  
 14 **DR. COOPER:** Thank you so much.  
 15 **MS. REDA:** Thank you.  
 16 **DR. COOPER:** Elise, you had your hand  
 17 up, earlier. Did you have a comment about this  
 18 presentation?  
 19 **DR. VAN DER JAGT:** I really don't.  
 20 But I thank you very much. It's very informative. I  
 21 appreciate it very much. Good work.  
 22 **MS. REDA:** Thank you very much.  
 23 **DR. COOPER:** Any other questions or  
 24 comments for Ms. Reda?  
 25 Did I say it properly?

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 2 **MS. REDA:** Yes, perfect.  
 3 **DR. COOPER:** Thank you. Okay. Well,  
 4 thank you again so very much.  
 5 Maybe, Amy, you could make the slides  
 6 available for us, so that, you know, we can all  
 7 review the information on our own? That would be,  
 8 you know, I think good education for all of us.  
 9 I was particularly unaware of some of  
 10 the finer points that you -- that you brought to us,  
 11 brought to our attention. So thank you again for  
 12 your --  
 13 **MS. REDA:** Thank you.  
 14 **DR. COOPER:** -- your time and -- and  
 15 your work in this area.  
 16 Okay. Jennifer Salomon, if you can  
 17 tell us about behavioral health and, you know,  
 18 substance abuse disorder considerations for the  
 19 E.M.S. course?  
 20 **MS. SALOMON:** Good afternoon, folks.  
 21 Thank you so much for being here. I know you've been  
 22 here for a while. I'll try not to keep you too long.  
 23 I'm also aware that Ryan already spoke a bit about  
 24 what I'm doing.  
 25 We have trained, so far, over two

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 2 hundred providers in New York State. We've had over  
 3 a dozen classes. We are continuing on with this, all  
 4 things behavioral health, substance use disorder,  
 5 mental health, the intersection, and the fact that  
 6 everything is connected.  
 7 So if someone were to be sitting here  
 8 today and wonder why that would be relevant to  
 9 children, it would be easily understood when we talk  
 10 about adverse childhood experiences and those  
 11 contributions to substance use disorder and all  
 12 things behavioral health.  
 13 We are also continuing on with some  
 14 other outcroppings of this program. I don't know a  
 15 better word for that. I don't know if I just made  
 16 that one up, but it's great because we're going --  
 17 we're leveraging some subject matter experts to come  
 18 speak on some of these topics in deeper dive.  
 19 So we will have upcoming -- actually,  
 20 you'll be happy to hear --.  
 21 Oh, sorry, I'm being prompted and I'm  
 22 grateful for the prompts, and now I just got thrown  
 23 off my track.  
 24 So we're leveraging our Vital Signs  
 25 academy, as well as, for some subject matter experts.

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 2 I have a meeting set up when we're done here with  
 3 someone who is going to speak towards sexual  
 4 violence, responding to victims and institutional  
 5 sexual violence, as well.  
 6 So that will be great to help further  
 7 our causes and especially what Westchester, what  
 8 Darlene just was able to speak to as well. You can  
 9 find more out about this at our website. Amy is  
 10 already making slides available, so I'm going to  
 11 volunteer her for also making available the signup  
 12 form for providers. And she'll also be able to  
 13 provide you with my email address.  
 14 If your hospital has hospital-based  
 15 E.M.S. and you'd like to host one of these classes, I  
 16 would love to do that for you, as well. We don't  
 17 just need to go to firehouses; we can go to hospitals  
 18 that would want to host us for their providers as  
 19 well.  
 20 I'd love to answer any questions  
 21 anyone has. I know everyone's time is very valuable  
 22 and I promised I would try to keep this under five  
 23 minutes. So I'm at three minutes, which leaves us  
 24 two minutes for questions.  
 25 **DR. COOPER:** Well, I will weigh in

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 2 briefly, Ms. Salomon. Would it be -- do you think it  
 3 would be possible for you to provide us with -- as a  
 4 committee, with -- if you're -- you know, sort of a  
 5 brief overview of the course in writing or perhaps,  
 6 you know -- you know, a PowerPoint summary, something  
 7 along those lines that would give those of us who  
 8 have a particular interest in this an opportunity to  
 9 review the -- to review the program in greater  
 10 detail, particularly given our focus of late in  
 11 pediatric education issues?  
 12 Hello?  
 13 **MS. SALOMON:** I don't have a  
 14 PowerPoint that's prepared to put up here for you  
 15 today. I'm happy to give Amy an outline of the  
 16 course that she can also disseminate.  
 17 The course is broken down into four  
 18 sections in which we speak about substance use  
 19 disorder, mental health, the intersection of the two  
 20 best practices, suicide and provider wellness.  
 21 So if you're looking for specifically  
 22 pediatric agitation, I don't have somewhere where  
 23 that is its own topic. But if that is a critical  
 24 feedback, then what I think I'd like to do with that  
 25 is seek out a subject matter expert to be able to

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 2 speak to that on one of these deeper dives,  
 3 leveraging our -- our learning management system.  
 4 So it sounds like you might be the  
 5 perfect person to talk to about that, anyways, after  
 6 today.  
 7 **DR. COOPER:** That'd be great. Amy  
 8 will get us in touch and we can -- then we can chat a  
 9 bit. Thank you.  
 10 Any other comments or questions?  
 11 And Amy, perhaps, you could  
 12 disseminate that outline to us, so we can get a  
 13 better sense of what's in the course. Thank you.  
 14 And of course, the forms that you  
 15 mentioned, Ms. Salomon, so anybody who wants it, to  
 16 the eight-hour program, can do that. Thank you so  
 17 much.  
 18 Oh, there's --.  
 19 **MS. EISENHAUER:** The links -- the link  
 20 for -- to register for any of the classes that are  
 21 currently available should be in the chat. Jacob  
 22 popped it up for us. And also Jenny's email, so you  
 23 can reach her if you wanted to host a course at your  
 24 agency for -- for your hospital-based E.M.S., she  
 25 would be the one to help you set that up.

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 2 **DR. COOPER:** Okay. Sounds great.  
 3 **MS. EISENHAUER:** Thank you.  
 4 **DR. COOPER:** Okay. So we're up to the  
 5 PECARN report. Brooke and Peter, we're so glad you  
 6 were able to stick with us this whole time. So  
 7 welcome and please give us an update.  
 8 **MS. LEARNER:** Thank you.  
 9 Actually, today, I'm here to share a  
 10 new study that we're hoping, like we did before, that  
 11 this committee would formally approve it, but to make  
 12 sure you have no objections to it before we take it  
 13 to the State.  
 14 This one has the best name ever. It's  
 15 called TREC's. It's Treating Respiratory Emergencies  
 16 in Children. And it's very similar to the seizure  
 17 study that I brought to you before. I will say that  
 18 that seizure study continues to enroll -- I think  
 19 we've enrolled ten people in Buffalo. Study-wide,  
 20 they've enrolled three hundred kids with seizures.  
 21 So that is going very well and very promising.  
 22 In terms of asthma or respiratory  
 23 distress, we know this is about twenty-two percent of  
 24 the reason that we transport children.  
 25 Amy, I lost your share.



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 2 MS. EISENHAUER: Yes, it was  
 3 automatically going forward. I don't know if you  
 4 want me to stop that or --?  
 5 MS. LEARNER: Yeah, if you start at  
 6 two, it won't -- it won't go forward, I think. This  
 7 is the hazard of not using your own slides.  
 8 Anyway, as you know, during a  
 9 respiratory distress or with an asthmatic, there's  
 10 really three drugs that we use. Next slide.  
 11 Albuterol, Ipratropium, sorry for the spelling, and  
 12 dexamethasone, each having their own time of onset  
 13 immediate to two hours first and hours of effect.  
 14 Next slide. And traditionally,  
 15 albuterol and oxygen have been the common E.M.S.  
 16 treatments. And then in the hospital oxygen,  
 17 albuterol, Ipratropium, and dexamethasone are given.  
 18 Next slide. But we know, per emergency department  
 19 data, that when triage nurses give steroids, this  
 20 reduces the admission rate, as well as any early beta  
 21 agonist -- agonist reduces the admission rate.  
 22 So from a pre-hospital standpoint,  
 23 there is some data to show that pre-hospital steroids  
 24 can remove -- reduce admission by thirty to twenty  
 25 percent. This was done in Houston.

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 2 Next slide. So the concept of this  
 3 study is to basically take these treatments that  
 4 normally they wait to get in the hospital and bring  
 5 them out to the patient. So in the hopes that taking  
 6 all of them out will reduce symptoms more quickly,  
 7 reduce hospital admissions, reduce I.C.U. admissions,  
 8 reduce invasive treatments, and hopefully, in  
 9 general, improve quality of life by getting these  
 10 kids back to normal and out of the hospital.  
 11 Next slide. So what we're proposing  
 12 is to create a bundle of treatments that would --  
 13 treatment bundle that would be implemented within the  
 14 E.M.S. agencies. The study would focus on severe  
 15 life-threatening wheezing, so not just any old asthma  
 16 attack but a severe one.  
 17 It would require a small protocol  
 18 change. It would be implemented agency-wide, and it  
 19 would use ... for all patients. It would also give  
 20 early dexamethasone, hopefully oral, if possible.  
 21 And so the picture is really the thing  
 22 you want to look at. That's the bundle that would be  
 23 applied, so they would get vitals, administer  
 24 albuterol -- sorry, it got really small in my screen  
 25 -- then give the dexamethasone, repeat the albuterol

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 2 if needed, and then consider epi with key  
 3 considerations about just the general study things.  
 4 So that is -- looks like -- next  
 5 slide. This study, unlike the seizure study that I  
 6 came to with, is going to start out as a pilot, but  
 7 the aim is to finalize this checklist and make sure  
 8 it's, you know, correct and then to ensure protocol  
 9 adherence, so how can we implement this with good  
 10 adherence.  
 11 Next slide. And then the second thing  
 12 that we'll be looking at is how can we evaluate the  
 13 feasibility collecting the outcomes and making sure  
 14 that we collect at least ninety percent of the  
 15 patient outcomes without missing them.  
 16 So this is kind of a new N.I.H. thing,  
 17 which, I think makes good sense for your tax dollars.  
 18 It's basically, instead of investing in a huge trial  
 19 and hoping it works, they start with these pilot  
 20 studies and then show that -- that it can be done and  
 21 then move on to the bigger trial, so that they're  
 22 being good stewards of the research dollar.  
 23 So for us being a part of this pilot,  
 24 next slide, we would include all nine-one-one E.M.S.  
 25 -- E.M.S. activations for anyone ages two to

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 2 seventeen that had a prior history of wheezing or  
 3 asthma and current asthma symptoms, at least for the  
 4 following to make them severe. So visible  
 5 retractions or accessory muscles, inspiratory or  
 6 expiratory wheeze or silent chest, abnormal  
 7 respiratory rate for age, agitation, drowsiness or  
 8 confusion, and low oxygen saturation.  
 9 Next slide. We wouldn't put anybody  
 10 in the study who had a medication allergy, was  
 11 pregnant, a prisoner, had croup, suspected airway  
 12 foreign body, or respiratory distress not due to  
 13 wheezing or a patient who objected to prior  
 14 treatment.  
 15 Next slide. So like I said, this is a  
 16 pilot. There's only three sites that would be  
 17 participating, Buffalo, Charlotte, and Utah. Sorry,  
 18 it's a city in Utah, now I can't think of it. The --  
 19 the primary thing would be to make sure for these  
 20 patients that get enrolled, we can get their hospital  
 21 I.C.U. ventilation status, as well as their asthma  
 22 impact score at seven days to look at their quality  
 23 of life.  
 24 Next slide. So what would happen is  
 25 all three sites start the study at the same time.

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 2 They would give usual care, so they would do what  
 3 we're doing now. We do that for five months. We  
 4 take three months to train the providers, and then  
 5 convert over to the bundle, and look at that data,  
 6 and then see if it had an impact, how long we got the  
 7 outcomes and those things, and hopefully move on to a  
 8 larger randomized trial that randomized the start  
 9 time.  
 10 Next slide. Prior to ...  
 11 Next slide. Much like the seizure  
 12 study we talked about before, obviously a kid in  
 13 severe respiratory distress isn't going to be able to  
 14 ... parent to be able to consent. So this would  
 15 again use the emergency exception for informed  
 16 consent. This has been approved by the F.D.A. to  
 17 move forward with an I.N.D. and that -- using the  
 18 emergency exception. It's using a single I.R.B.  
 19 through Utah. And we'll just follow the same kind of  
 20 formula as the seizure study did.  
 21 Next slide. It would have a data  
 22 safety monitoring board that would take periodic  
 23 looks at the data to make sure, you know, something  
 24 wasn't happening that we weren't seeing. So there  
 25 would be those extra safety measures in place.

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 2 Next slide. I hope that wasn't too  
 3 super fast, but I'm happy to ask -- answer any  
 4 questions.  
 5 **DR. COOPER:** Brooke, this is, no  
 6 question, your usual outstanding presentation of a  
 7 very well-designed study. Thank you so much. I'm  
 8 presuming that, you know, you're seeking, you know,  
 9 an endorsement from the -- from the committee as was  
 10 the case and with the seizure study, I think you  
 11 bought us earlier?  
 12 **MS. LEARNER:** Yes.  
 13 **DR. COOPER:** Yes. Before -- Pam  
 14 Feuer?  
 15 **DR. FEUER:** Hi. Thanks for the  
 16 presentation. I just had a question about your  
 17 dosing of the DuoNeb. The standard DuoNeb's are  
 18 usually two point five milligrams of albuterol and  
 19 point five milligrams of the ipratropium.  
 20 So how does -- and -- and that's still  
 21 what many E.R.s are using. You know, I know it could  
 22 be higher. So how did you choose that and how might  
 23 it impact your results?  
 24 **MS. LEARNER:** I think they'd show that  
 25 based on the evidence they had and the -- the

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 2 guideline recommendations, you know, that would be a  
 3 change for us is to go to the -- to the five  
 4 milligrams. So you'd have to put two -- two vials  
 5 in.  
 6 **DR. FEUER:** Right. Which would make  
 7 the Atrovent higher, as well. So there might be --  
 8 if you're doing safety things, there might be  
 9 increased heart rate, et cetera, even though you  
 10 might need that -- that treatment. I don't know if  
 11 anyone else has comments about it who uses it in the  
 12 emergency room?  
 13 So that's -- that's the only concern I  
 14 have that I don't think that's fully the standard  
 15 across most E.R.s to give the double DuoNeb.  
 16 **DR. COOPER:** Any other comments?  
 17 Brooke, do you want to respond to  
 18 Pamela's thought?  
 19 **MS. LEARNER:** Yeah. So I'm -- I know  
 20 they selected it based on the evidence that was  
 21 available is really all I can say. I could get more  
 22 information on it. But -- and the F.D.A. did approve  
 23 the dosages and the drugs. So people smarter than me  
 24 picked it. It's not a great answer, but it's the  
 25 answer.

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 2 **DR. COOPER:** Well, who's the lead  
 3 investigator on this?  
 4 **MS. LEARNER:** Matt Hanson from the  
 5 University of Oregon.  
 6 **DR. COOPER:** Got it.  
 7 Perhaps, Pamela, you could reach out  
 8 to him? I don't know? That might be something worth  
 9 asking.  
 10 **DR. FEUER:** Okay. Does anyone else  
 11 from the E.R. or the I.C.U. world have any comments  
 12 about that?  
 13 **DR. HARRIS:** It's -- it's Matt. I'm  
 14 sure Peter can comment the same. It's -- I think  
 15 it's pretty ubiquitous. Most of us are not following  
 16 weight. I mean, there is a weight-based approach to  
 17 albuterol that -- that no one uses except, perhaps,  
 18 for continuous. But I think almost ubiquitously if  
 19 you're two years old or twenty years old, you're  
 20 getting probably two point five and -- and point  
 21 five. I'd say that it's pretty ubiquitous. Just my  
 22 two cents.  
 23 **DR. FEUER:** Right. But the study --  
 24 study is five milligrams of albuterol.  
 25 **DR. HARRIS:** Right, so that's why I

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 2 think it's an issue to raise -- to be raised. I  
 3 agree.  
 4 **DR. FEUER:** Yeah, uh-huh. Thanks.  
 5 **DR. COOPER:** Any other comments? All  
 6 right. Hearing none --.  
 7 **MS. CHIUMENTO:** Just one question.  
 8 **DR. COOPER:** Go ahead. Go ahead.  
 9 **MS. CHIUMENTO:** What about those --  
 10 those drugs all approved for paramedics in New York  
 11 State, the problem is I think that the E.M.T.s can  
 12 give the albuterol portion. What are you going to do  
 13 in your study to -- are they not going to be allowed  
 14 to give albuterol to start off with, so the paramedic  
 15 complies? Or is there anything around that?  
 16 **MS. LEARNER:** The basic protocol  
 17 wouldn't change. This would just be for paramedics.  
 18 **MS. CHIUMENTO:** Okay.  
 19 **DR. COOPER:** Thank you, Sharon.  
 20 And thank you, Brooke.  
 21 I'm -- I think at this time it's --  
 22 it's appropriate for us to entertain a motion to  
 23 endorse the study for those who Brooke is able to  
 24 recruit.  
 25 **MS. CHIUMENTO:** I'll make the motion.

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 2 **DR. COOPER:** Thank you, Sharon.  
 3 Second, please?  
 4 **DR. HARRIS:** I'll second.  
 5 **DR. COOPER:** Thank you. That was Matt  
 6 or --?  
 7 **DR. HARRIS:** This is Matt.  
 8 **DR. COOPER:** Thank you. Thank you.  
 9 Discussion? Okay. Hearing none, all  
 10 in favor of -- of endorsing the study, please signify  
 11 by saying aye.  
 12 **ALL:** Aye.  
 13 **DR. COOPER:** Any opposed? Okay.  
 14 Done. Thank you.  
 15 Thank you, Brooke and -- and Peter so  
 16 much for your -- your presentation today and another  
 17 terrific piece of work and to be -- terrific piece of  
 18 work to be -- to become terrific as the study goes  
 19 forward. Thank you so much.  
 20 We already heard from Amy Jagareski  
 21 for injury prevention.  
 22 Dr. Marilyn Kacica, do you have  
 23 anything from family health that you wish to share  
 24 with us today?  
 25 **DR. KACICA:** Yeah, I'll just give you

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 2 one real brief update. I know we're running late.  
 3 We -- the Division of Family Health is working with  
 4 the Office of Primary Care and Health Systems  
 5 Management. We are finalizing draft regulations with  
 6 the chamber on perinatal services and --.  
 7 (The meeting was interrupted.)  
 8 **DR. KACICA:** So we're working on these  
 9 regulations on perinatal services and perinatal  
 10 regionalization and also freestanding and midwifery  
 11 birth centers. And this regulation package is  
 12 scheduled to be presented to the Public Health and  
 13 Health Planning Council on February 9th, and then it  
 14 will be put out for public comment.  
 15 Once these regulations are adopted,  
 16 the Department will begin the process of re-  
 17 designating each birthing hospital center for their  
 18 level of care based on the new regulations.  
 19 And some of the changes most relevant  
 20 to E.M.S. include the addition of regional perinatal  
 21 centers, coordinating neonatal transfers between  
 22 birthing hospital affiliates, and also obstetrical  
 23 transfers. The current regulations only require  
 24 neonatal transfer coordination.  
 25 There's also updated requirements for

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 2 transfer agreements, including such agreements  
 3 between freestanding and midwifery birth centers, and  
 4 their geographically close birthing hospitals and  
 5 regional perinatal center.  
 6 So -- so that -- that's to come.  
 7 **MS. EISENHAUER:** Okay. So does  
 8 anybody have any questions for Dr. Kacica?  
 9 **DR. COOPER:** Thank you. And -- and  
 10 yeah, I didn't realize I was on -- I was muted.  
 11 Okay. Hearing none. Okay. Let's  
 12 move on to Kate Butler, followed by Drew Fried on the  
 13 -- the Health Emergency Preparedness programs, both  
 14 centrally and regionally.  
 15 Kate first.  
 16 **MS. BUTLER-AZZOPARDI:** Thank you, Dr.  
 17 Cooper. I just have a couple of quick updates that  
 18 are germane to this group. We are currently wrapping  
 19 up the -- the state-level. And I did want to extend  
 20 a thank you because I know that there are some folks  
 21 that sit on this committee that have participated in  
 22 our expert input -- input group as it related to the  
 23 -- the crafting and -- and revisions of that -- that  
 24 plan.  
 25 And then that will then ship down to

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 2 the regional level across all of the state to do some  
 3 work.  
 4 We then will -- so our next grant  
 5 year, so to speak, is that we will have to do a  
 6 chemical search functional annex. We'll probably  
 7 will be reaching out to partners, similarly, as we  
 8 did for that radiation annex next year for some  
 9 input.  
 10 We are currently -- even though we're  
 11 only about halfway through our current budget period,  
 12 we are now looking for -- doing a lot of our planning  
 13 as it relates to our grant-related initiatives for  
 14 the next grant year which is our -- our final grant  
 15 year of a five-year cooperative agreement.  
 16 So we are working on some -- on the  
 17 deliverables for all of our sub awardees. Currently,  
 18 we are anticipating our continuation guidance to come  
 19 out imminently as it relates to that so there may be  
 20 some more information if anything changes to that.  
 21 And I did want to thank Amy. We've  
 22 been having some preliminary chats for some potential  
 23 crossover activities as it relates to those budget  
 24 period ... deliverables for our contract hospitals.  
 25 And that is specific to the contract of hospitals

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 2 outside of New York City, but I have been in  
 3 communication with our D.O.H. M.H. partners that also  
 4 contract with some of the city facilities regarding  
 5 some potential crossover deliverables.  
 6 And hopefully, we'll have some good  
 7 news on that as we move forward in our planning. But  
 8 we are -- are trying to kind to -- to kind of do some  
 9 additional crossover activities that I'm -- I'm  
 10 really eager to -- to see in fruition. But nothing's  
 11 approved. Nothing's set yet, but we are having those  
 12 initial conversations.  
 13 Barring anything else, end of report.  
 14 **DR. COOPER:** Thank you so much.  
 15 Any questions for -- for Kate?  
 16 Hearing none, Drew, how about you?  
 17 **MR. FRIED:** Yeah, just a couple of  
 18 quick things to add to -- to Kate. So locally, some  
 19 of the things we're working in the MARO region, which  
 20 of course is Long Island, the lower Hudson Valley  
 21 area, and similarly some of the other regional reps  
 22 are working in the same type of programs.  
 23 I know down here, we're looking to  
 24 augment the radiological annex. We're looking at  
 25 pediatric decon, decontamination both for chemical

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 2 and radiological. So we're working with the  
 3 hospitals on that.  
 4 We continue to work with our Regional  
 5 Training Center on pediatric-related education for  
 6 both hospitals and E.M.S. folks, how E.N.P.C. has and  
 7 other pediatric-related classes that we can sponsor  
 8 with that group.  
 9 And finally, our hazard vulnerability  
 10 analysis, we look to augment our pediatric-related  
 11 risks and risk areas to bring that more to light.  
 12 And that is something we'll be working on for the  
 13 rest of the third and fourth quarter, which ends in  
 14 June. End of report.  
 15 **DR. COOPER:** Thank you, Drew.  
 16 Any questions for Kate or Drew?  
 17 Hearing none, moving on to Quality and  
 18 Patient Safety/Sepsis Initiative, I see that George  
 19 Stathidis is here, representing the group.  
 20 George, do you have any brief comments  
 21 for us today?  
 22 **MR. STATHIDIS:** Yes, I do. Thank you,  
 23 Dr. Cooper. Thank you for having me today.  
 24 I'll give a brief update on the data  
 25 collection and -- and what we're working on

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 2 currently. At this point, the Sepsis Care  
 3 Improvement Initiative is currently analyzing  
 4 pediatric data for -- from hospitals for calendar  
 5 year 2021.  
 6 I know that several -- I see several  
 7 attendees here who are on our pediatric advisory  
 8 group. So this will be somewhat familiar. But right  
 9 now in 2021 data, we are focusing on the following  
 10 cohorts that have been identified and reported to us  
 11 by I.C.D. 10 -- I.C.D. 10 c.m. code.  
 12 We're currently looking at severe  
 13 sepsis and septic shock, severe sepsis and/or septic  
 14 shock with Covid-19, severe sepsis/septic shock with  
 15 M.I.S.C. or Multisystem Inflammatory Syndrome in  
 16 Children, and then we do have some -- one cohort with  
 17 severe sepsis/septic shock with Covid and M.I.S.C.  
 18 which we're investigating further. We're not certain  
 19 that that's an actual cohort that -- that is possible  
 20 being that Covid-19 and M.I.S.C. are concurrent as  
 21 diagnoses.  
 22 But really, we're currently  
 23 investigating this data as we received it from --  
 24 from our partners and from the hospitals in New York  
 25 State. In calendar year 2021, we received more than

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2 eight thousand pediatric cases, encompassing all the  
3 cohorts I just mentioned that were -- that were  
4 submitted to the New York State Department of  
5 Health's Sepsis Care Improvement Initiative.

6 Of those, more than seven thousand  
7 cases were identified as Covid-only diagnosis. So  
8 really, nearly eight hundred cases are carrying a  
9 severe sepsis or septic shock diagnosis without Covid  
10 or M.I.S.C. And that's really the -- the cohort that  
11 we're focusing on. That's our mandate, the eight  
12 hundred cases of severe sepsis and/or septic shock.

13 For reference, in 2019, the Department  
14 collected six hundred and twenty-four cases of severe  
15 sepsis or septic shock for pediatric patients. So  
16 our -- our 2021 numbers are relatively close to what  
17 we collected in 2019.

18 At the time, in 2019, the inclusion  
19 criteria for patients -- for pediatric patients was  
20 up to age eighteen, whereas in 2021 pediatric  
21 patients were included up to age twenty-one. So  
22 there is a slight change in -- in our inclusion  
23 criteria there, which also may account for the  
24 increase in cases that we saw during that timeframe.

25 Lastly, the clinical center where the

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2 sepsis program is located, continuing to work towards  
3 executing a data use agreement or the bureau of  
4 E.M.S. recently was in touch with Amy, and we're  
5 looking for a date to -- to get together to see if we  
6 can continue working to secure access to NEMSIS data  
7 for the purposes of investigating any pre-hospital  
8 care that was received by pediatric patients with  
9 severe sepsis or septic shock when they're  
10 transported to the hospital via -- via E.M.S.

11 So that is something that we're  
12 continuing to work towards. It's something that I  
13 know this committee was interested in us  
14 investigating. And we do think that, over time, we  
15 will secure access to that data and be happy to come  
16 back to the committee and look for recommendations on  
17 how to analyze that data or, you know, additional  
18 comments on analyzing that data once we've had the  
19 chance to -- to put some results together.

20 So that's the end of my report.

21 **DR. COOPER:** Thank you, George, very  
22 much. I know we're all looking forward to, you know,  
23 the latest iteration of a pediatric report. Do you  
24 think that will be available by the time of the May  
25 meeting?

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2 **MR. STATHIDIS:** I'm not certain that  
3 we'll have a public report available by the May  
4 meeting, but I am confident that we'll have a lot  
5 more information on 2021 data, as well as likely 2022  
6 data. So we'd be happy to come back and give an  
7 update on what we're seeing in those two years.

8 Hopefully, we can provide at least  
9 some trends and some -- some information on the  
10 demographics. And again, you know, hopefully we --  
11 we will be a little bit earlier this time with the  
12 E.D.C.C. process and we'll be able to share some  
13 slides at the next meeting.

14 **DR. COOPER:** Great. Thank you so  
15 much.

16 Mike McEvoy, Chair from the State  
17 E.M.S. Council, unfortunately, had to leave the  
18 meeting today. But as he mentioned in the chat, all  
19 of his issues were covered earlier in the report, I'm  
20 presuming, by Ryan Greenberg and others.

21 And that brings us to the final item  
22 on the agenda, which is the STAC and Pediatric Trauma  
23 Subcommittee report from myself and Jose Prince.

24 I would have to say that we have -- I  
25 don't think a whole lot to share with you today

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2 because the meeting, which was supposed to have been  
3 held within the last week or so had to be -- had to  
4 be postponed until March 1st due to inclement weather  
5 across the state, and the inability of many people to  
6 travel during that -- that period of time.

7 So I don't have anything new for you  
8 at this particular time. Jose, do you want to chime  
9 in at this point? If you -- to add anything to what  
10 I've just reported? Jose, I can -- I can see you're  
11 still with us. I -- you may be tied up with  
12 something else back home.

13 **DR. JOSE:** I do. I'm sorry, I was  
14 having a hard time there for a second.

15 **DR. COOPER:** No problem.

16 **DR. JOSE:** I don't have much to add.  
17 It's been a long meeting. And I -- I think we had a  
18 delay, obviously, in our -- our staff meeting. So  
19 the next meeting will be in March and -- and I'm  
20 happy to report after that.

21 **DR. COOPER:** Okay. That sounds great.

22 One additional item I might mention is  
23 that Tim Wallenstein from Syracuse, who has been  
24 working together with Dr. Prince on the STAC  
25 Pediatric Subcommittee, may be playing a greater role

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 2 in -- with us going -- going forward, but we'll see  
 3 how -- how that plays out.  
 4 Okay. So that having been said --  
 5 **DR. JOSE:** I think those -- I think  
 6 him and Derek Wakeman, as well. I would just say the  
 7 two of them are really going to help transition over  
 8 some of the leadership for the pediatric  
 9 subcommittee.  
 10 **DR. COOPER:** Okay. I wasn't aware  
 11 Derek was going to be involved in that, as well.  
 12 **DR. JOSE:** Yeah.  
 13 **DR. COOPER:** That's great. Okay.  
 14 Terrific. Thanks, Jose.  
 15 So that brings us to the end of our  
 16 formal agenda. We started a couple of minutes late  
 17 and we're finishing, you know, finishing a couple of  
 18 minutes late, but we did pick up three or four  
 19 minutes in the process.  
 20 So unless anybody has anything to say,  
 21 at this point, I will, you know, first say I am super  
 22 grateful for everyone being so involved in the  
 23 meeting today. We got an enormous amount of work  
 24 done. This is one of the busiest agendas we've had  
 25 in recent months.

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 2 We've got a lot of work to -- to do  
 3 ahead of it, but I have no doubt that, particularly  
 4 with Amy Eisenhower's incredibly strong support, that  
 5 we'll get it all done. So thank you again.  
 6 Any final comments from Elise van der  
 7 Jagt or -- or Amy?  
 8 And if not, Amy, please remind us of  
 9 the date of the next meeting?  
 10 **MS. EISENHAUER:** Our next meeting will  
 11 be May 2nd and it will be virtual via WebEx. I am  
 12 working on the last two meetings of the year. I'm  
 13 working with Val and Teresa since they have all the  
 14 contacts for the hotels.  
 15 The last two meetings of the year will  
 16 be in person in Albany. I'm working on finalizing  
 17 contracts so that I can get you the official dates.  
 18 And they will be somewhere here in the -- in the  
 19 Albany area once we get all of that concluded.  
 20 So I hope in the next few weeks, I'll  
 21 be able to have all the dates for you, but the very  
 22 next meeting will be May 2nd and it will be virtual.  
 23 **DR. COOPER:** Thank you, Amy. Is -- is  
 24 Ryan still on?  
 25 **MS. EISENHAUER:** No. I think he -- he

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 2 had to jump off for another conference call.  
 3 **DR. COOPER:** Okay. Elise, any final  
 4 thoughts or -- or are we good to go?  
 5 **DR. VAN DER JAGT:** No, I have no  
 6 comments. Have a great day. Thank you very much.  
 7 **DR. COOPER:** Thanks and -- thank you,  
 8 Elise, for all your incredible commentary and  
 9 participation and co-leadership as always.  
 10 So all right, everyone. Have a  
 11 wonderful rest of the later winter and early spring  
 12 and hope that, you know, the weather remains  
 13 reasonable for you and you're able -- we're to travel  
 14 wherever we need to go. And we'll -- we will try to  
 15 see in May when the -- the flowers just starting to  
 16 grow. So take care, everyone, and let's keep up the  
 17 strong work.  
 18 Thank you so much, again, Amy, for all  
 19 you're doing for us. We really appreciate it.  
 20 Take care, everyone. Thank you.  
 21 (The meeting concluded at 4:11 p.m.)  
 22  
 23  
 24  
 25

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 2 STATE OF NEW YORK  
 3 I, HOWARD HUBBARD, do hereby certify that the foregoing  
 4 was reported by me, in the cause, at the time and place,  
 5 as stated in the caption hereto, at Page 1 hereof; that  
 6 the foregoing typewritten transcription consisting of  
 7 pages 1 through 151, is a true record of all proceedings  
 8 had at the hearing.  
 9 IN WITNESS WHEREOF, I have hereunto  
 10 subscribed my name, this the 9th day of February, 2023.  
 11  
 12  
 13 HOWARD HUBBARD, Reporter  
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