

1-11-2022 - EMSCAC Meeting - WebEx

NEW YORK STATE

DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES FOR
CHILDREN ADVISORY COMMITTEE MEETING

DATE: January 11, 2022

TIME: 1:00 p.m. to 3:48 p.m.

CHAIR: DR. ARTHUR COOPER

VENUE: WebEx

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2 APPEARANCES:

3 BILL LIDDLE

PAMELA FEBER

4 KATE BUTLER-AZZOPARDI

LINDA EFFEREN

5 MATHEW HARRIS

DOUGLAS HEXEL

6 EDWAR CONWAY

ELISON VAN DER JAG

7 DR. BROOKE LERNER

JOSEPH PATAKY

8

JASON HAAG

SHARON CHIUMENTO

9

DR. ALDA OSINGA

10 BRUE BERRY

AMY JAGARESKI

11 BRUCE BERRY

JOSE PRINCR

12 DREW FRIED

DONNA KAHM

13 BENJAMIN KASP

JENNIFER HAVENS

14 RYAN GREENBERG

AMY EISENHAUER

15

JACOB DEMAY

JOHN VAN AUKER

16

BRIAN LEVINSKY

JAMES DOWNEY

17

BRIAN WIEDMAN

18 D'AMBROSIA DENL

MARK DEAVERS

19 MICHAEL FORNESS

STORM TREANOR

20 BARBARA CATETTA

LAUREN OREIUOLI

21 KATE ROSE BULOSE

DAVID SIMMONS

22 VERA FEVER

VALERIE OZGA

23

JASON HAAG

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2 (The meeting commenced at 1:12 p.m.)

3 SECRETARY EISENHAUER: All right, it
4 looks like we have a quorum now. And everybody that
5 was having trouble with their login are now in. Are
6 you ready to get started Dr. Cooper? Do you want to
7 do the roll call Dr. Cooper?

8 CHAIRMAN COOPER: Sure.

9 SECRETARY EISENHAUER: Do you want to
10 share the agenda?

11 CHAIRMAN COOPER: I'd like to -- go
12 ahead, Amy.

13 SECRETARY EISENHAUER: Do you want us
14 to share the agenda on the screen?

15 CHAIRMAN COOPER: Yes, go ahead.

16 SECRETARY EISENHAUER: Okay. Can you
17 make me the presenter? So this should also be in
18 Boardable for board members, actually.

19 CHAIRMAN COOPER: While Amy is getting
20 that pulled up, let me just say good afternoon,
21 everyone. We are absolutely delighted to have you
22 all here with us today.

23 We do have a quorum as Amy just
24 pointed out. And we have a fair amount of business
25 to discuss today and I think a lot of exciting news

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2 and opportunities to bring to the group.

3 And Amy, are you -- the -- the -- you
4 stated that there is a quorum. Do you need to
5 officially take attendance?

6 SECRETARY EISENHAUER: I do. I just
7 want to put up this first and then -- there we go.
8 Okay. So this is the -- the Boardable agenda.

9 CHAIRMAN COOPER: I don't -- I don't
10 see it yet, Amy. Yeah, I don't know if it was there
11 or not.

12 SECRETARY EISENHAUER: All right.

13 MR. CONWAY: Yeah, I don't see it
14 either. I have a black screen.

15 SECRETARY EISENHAUER: Nope. All
16 right. Give me one second. Hold on a moment. How's
17 that?

18 CHAIRMAN COOPER: There we go.
19 Wonderful. All right. As you can see from the
20 agenda, we have a -- we have a fair amount to cover
21 today. After taking attendance and reviewing
22 minutes, we will hear from Ryan Greenberg, Director
23 of the Bureau.

24 We'll then hear from Amy Eisenhauer,
25 our -- our incredibly talented E.M.S. program --

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2 E.M.S.C. Program Manager with an update. We're then
3 going to hear it from Peter Dayan and Brooke Lerner
4 regarding a -- an important study that is being
5 conducted by PECARN, and -- and for which Dr. Lerner
6 and Dr. Dayan are seeking our -- our endorsement.

7 We'll then go through the -- the --
8 our old business focusing chiefly on the pediatric
9 agitation subcommittee report and the pediatric
10 sepsis subcommittee report. And in addition, we'll
11 have an overview of the Sepsis Initiative from Dr.
12 Alda Osinaga.

13 Can you -- can you scroll down,
14 please, Amy? And then, we'll get to new business
15 talking about pediatric Covid-19 vaccine, staffing
16 shortages and the discussion of inter-facility
17 transfers within the E.M.S. system and their effect
18 on pediatric outcomes. We'll then hear from our
19 sister committees who are within the Bureau of
20 Emergency Medical Services and Trauma System.

21 So Amy, would you like to take
22 attendance at this point?

23 SECRETARY EISENHAUER: Sure. So I'll
24 call the voting members first. We still have some
25 members awaiting vetting. I will call them second.

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2 Dr. Cooper?

3 CHAIRMAN COOPER: Dr. Cooper is here.

4 SECRETARY EISENHAUER: Oh, yes. Also

5 for the court reporter --

6 THE REPORTER: Yes.

7 SECRETARY EISENHAUER: -- please state

8 your name for the record.

9 THE REPORTER: Anthony McClain.

10 SECRETARY EISENHAUER: Yeah. So Dr.

11 van der Jagt?

12 CHAIRMAN COOPER: Elise is probably

13 muted.

14 SECRETARY EISENHAUER: Can you unmute,

15 Dr. van der Jagt?

16 CHAIRMAN COOPER: Elise van der Jagt.

17 All unmuted.

18 MR. VAN DER JAGT: I know how to do

19 some of this, so okay.

20 SECRETARY EISENHAUER: There you go.

21 MR. VAN DER JAGT: Anyway, thank you.

22 Bye.

23 SECRETARY EISENHAUER: Dr. van der

24 Jagt?

25 CHAIRMAN COOPER: I know I heard is

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2 what he said, proof of life.

3 SECRETARY EISENHAUER: Dr. Albert is
4 going to be absent because he had an emergency in his
5 clinic. Lucretia Bailey? Bruce Berry?

6 MR. BERRY: Here.

7 SECRETARY EISENHAUER: Is that a here,
8 Bruce? I didn't hear you.

9 MR. BERRY: Yes. Bruce here.

10 SECRETARY EISENHAUER: Excellent.
11 Sharon Chiumento, we are still working on getting her
12 into the meeting and she will be here shortly. Dr.
13 Edward Conway?

14 MR. CONWAY: Ed Conway is here.

15 SECRETARY EISENHAUER: Dr. Pamela
16 Feuer?

17 MS. FEUER: Pamela Feuer is here.

18 SECRETARY EISENHAUER: Dr. Jose
19 Prince?

20 MR. PRINCE: Present.

21 SECRETARY EISENHAUER: Excellent. So
22 currently in the room, we have six of our nine voting
23 members who are vetted and able to vote, so we do
24 have a quorum. And I'll mark those people that come
25 in that are trying to get in.

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2 So for those of us or those members
3 that can't vote yet, I'll still take their
4 attendance. Dr. Tiffany Bombard? Dr. Vincent
5 Calleo? Dr. Jennifer Havens?

6 MS. HAVENS: Jennifer Havens is here.

7 SECRETARY EISENHAUER: All right. Dr.
8 Matthew Harris? I know he was working on trying to
9 log in also.

10 CHAIRMAN COOPER: He is here, muted.

11 SECRETARY EISENHAUER: He is here?

12 CHAIRMAN COOPER: Yes, muted.

13 SECRETARY EISENHAUER: Okay. Doug

14 Hexel?

15 MR. HEXEL: I'm here.

16 SECRETARY EISENHAUER: All right.

17 Chief Pataki? I know he was also trying to get in.
18 Nickol O'Toole?

19 MR. O'TOOLE: Here.

20 SECRETARY EISENHAUER: Is that Nickol?
21 Okay.

22 CHAIRMAN COOPER: Yeah, it looks like
23 it.

24 SECRETARY EISENHAUER: Ben Kasper?

25 MR. KASPER: Ben Kasper present.

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2 SECRETARY EISENHAUER: A little note,
3 so Ben Kasper is from Western New York. And he is
4 undergoing vetting as of a few days ago now. Do you
5 want to introduce yourself very, very briefly?

6 MR. KASPER: Sure. My name is Ben
7 Kasper and I'm the Injury Prevention Coordinator here
8 at John R. Oishei Children's Hospital for Pediatric
9 Resident Health Center, and I have about a decade of
10 experience working in E.M.S. and working on some safe
11 transport initiatives currently with E.M.S.

12 SECRETARY EISENHAUER: And he'll be
13 joining as a prehospital provider member. So
14 welcome, Ben. All right. So we have a quorum, and
15 I'll turn it over to you, Dr. Cooper, for approval of
16 minutes.

17 CHAIRMAN COOPER: Okay. I hope
18 everyone's had an opportunity to review the minutes.
19 Are there any additions, deletions, or corrections to
20 the minutes? Hearing none, I'll entertain a motion
21 for approval.

22 MR. CONWAY: Approved.

23 MR. PRINCE: Second.

24 SECRETARY EISENHAUER: Who are those
25 people that approved and -- and seconded?

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2 MR. CONWAY: Ed Conway approved.

3 MR. PRINCE: Jose Prince second.

4 CHAIRMAN COOPER: Thank you, Ed and
5 Jose. Discussion. All in favor, please signify by
6 saying aye.

7 MR. CONWAY: Aye.

8 MR. PRINCE: Aye.

9 MR. O'TOOLE: Aye.

10 MR. HEXEL: Aye.

11 CHAIRMAN COOPER: Any opposed? Any
12 abstentions? Okay. Carries -- approval of the
13 minutes carries without abstention. So we now have
14 the honor of hearing from Ryan Greenberg, Director of
15 the Bureau, with that he will tell us as to what's
16 happened since our last meeting. Ryan, please.

17 MR. GREENBERG: How are you, sir? I
18 will keep it brief. Thank you, everybody, for
19 joining the -- the council meeting today. I know
20 there's a lot going on around the State, including
21 for us.

22 So just a quick update on -- on where
23 things are. Right now the primary mission going on
24 within the Bureau of E.M.S. is related to around
25 COVID and COVID activity and patient movement, load

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2 balancing, and community support.

3 We currently have two federal
4 deployments in New York State; one assigned to
5 Upstate and one to New York City that is fulfilling
6 additional assistance to the 911 system as well as
7 load balancing and patient movement of hospitals who
8 don't have capacity and need assistance moving their
9 patients to another location, another facility.

10 We currently have thirty ambulances,
11 sorry, forty-two ambulances Upstate and fifty
12 ambulances in New York City, so just under a hundred
13 that are working on this mission.

14 If any of your hospitals or facilities
15 are in need of assistance with patient movement
16 because they can't find a local resource to do it, or
17 they need assistance with even finding a bed for a
18 patient at another facility because of load balancing
19 and your facility E.R.s are holding patients in
20 E.R.s, please feel free to reach out to the CERT
21 operation center and we'd be happy to help you with
22 both of those situations, both in bed matching, as
23 well as the movement of the actual patient.

24 So that's taking up a lot of our time
25 right now. We have a lot of, you know, good things,

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2 hopefully coming in 2022 if we can, you know, just
3 get past the pandemic a little bit. But E.M.S. for
4 children, and I know, Amy, will report out on that a
5 little bit later on a number of things. There is a
6 really important survey that's opening up for -- that
7 actually is open now, for E.M.S. agencies.

8 And then you know, we are working a
9 lot with our data and informatics unit in order to
10 get better data -- getting better data, so really
11 excited about in 2022 is also a program that we'll be
12 implementing, which is called Biospatial.

13 It's an analytic program -- program
14 that -- as it continues to roll out, we'll take the
15 data from E.M.S., put it into one centralized place
16 and then allow us to share that back with our
17 counties and the agencies, and the agencies will be
18 able to see how they're doing in their clinical care
19 compared to other similar sized agencies that they
20 work with.

21 So when we start looking at pediatric
22 care and care of children, and did they do a set of
23 vitals and so on and so forth. These are all things
24 that we'll be able to look at and kind of move
25 forward. We're really excited to be getting that one

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2 on board in 2022.

3 Vital Signs was really successful this
4 year, we're quite happy with it being it was the
5 first time we did a hybrid version with having just
6 over five hundred people in person and another nearly
7 three hundred virtually, so we were at about eight
8 hundred participants.

9 Normally, our -- our participance is
10 about twelve hundred. But super happy with COVID and
11 everything else is actually the numbers we want it to
12 land up to. So really excited about that one next
13 year, it will be October 26th through the 30th in
14 Albany, New York, right, right in Albany.

15 So please come and join us. It's an
16 excellent pediatric component, and to this group, and
17 as I know many of you are subject matter experts, and
18 I just heard someone talk about safe transport is,
19 you know, the call for presenters is now open.

20 So if you do have a great topic that
21 you'd like to bring to the E.M.S. community during
22 our annual conference or a C.M.E. conference, please
23 feel free to submit those now. If you don't know
24 where to submit that, please feel free to ask Amy
25 Eisenhauer.

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2 Our E.M.S. Memorial is May 17th.

3 There are nine heroes as of now that are going on to
4 the wall. And we're working on also an expansion
5 with the wall and -- because we've run out of space.

6 So those are the big things happening
7 there. Happy to take any comments, questions, or
8 concerns. Again, really appreciate that Amy as being
9 here. I may need to drop off in a little bit. I
10 apologize for that one but keep you in the very
11 capable hands of Amy Eisenhower. Thanks so much.

12 CHAIRMAN COOPER: Thank you, Ryan.
13 Any questions to Ryan at this point? Well, hearing
14 none, well, thank you, Ryan, again for your -- for
15 your remarks and your update. Amy, let's move on to
16 the E.M.S. For Children grant report.

17 SECRETARY EISENHAUER: Great, thank
18 you so much, Dr. Cooper. So Ryan did mention a
19 survey and I have a little presentation for you in a
20 moment. We did submit our noncompeting continuation
21 grant request.

22 And that was at the beginning or
23 middle of December. And pretty much E.M.S.C. federal
24 decided that because of the pandemic, this would have
25 been the time that we submitted the competing grant

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2 for the next five years.

3 So E.M.S.C. federal because of
4 everything going on, just automatically renewed it
5 for another year for everybody. So we had to submit
6 a budget like every year and then just some documents
7 about the work that we've been doing. And so we
8 submitted all of that to HRSA, and they are currently
9 reviewing it.

10 Also, I knew that Ryan had mentioned
11 the Vital Signs conference. We did have a PECARN and
12 that has some of our panelists here featured. So Dr.
13 Havens and Chief Pataki and Dr. Calleo came up and
14 did a session on pediatric agitation, mostly
15 discussing the reasons why.

16 So you know, ACEs and traumas
17 surrounding most of those things. And then, also,
18 Dr. Haven shared with us about de-escalation. And
19 actually, that part of the session ran over, because
20 everybody had so many questions, and -- and were very
21 engaged, which is awesome and refreshing.

22 And we had fifty-three live attendees,
23 and I believe thirteen virtual attendees for the
24 PECC. The second half of the PECC also included some
25 of our panelists, including Doug Hexel.

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2 I know Jason Haag is here in the house
3 somewhere. He was there as one of our trainers.
4 Alan Bell from Clifton Park-Halfmoon came and really
5 helped us out. He brought a lot of equipment and
6 different devices with him so that we could do a
7 hands-on skill station for patrons for pediatric
8 patients.

9 And that was also really well received
10 and we had to kind of push everybody out of the room,
11 they wanted to stay, but it was lunchtime, we had to
12 transfer the room for the next group coming in.

13 So hopefully next year, we'll do some
14 more of the same. I'm also going to be at several
15 events around the State. ... session, which is on
16 Long Island that's going to be virtual, they just
17 moved this because of Omicron.

18 They are also having a sponsored call
19 in March and I will be at both of those. I'm also
20 scheduled to be at the Finger Lakes conference. So
21 that would be great.

22 Hopefully things will slow down by
23 then and we can all join in person. I'm also working
24 with State fire chiefs. They are having an E.M.S.
25 show on Long Island and that's in February. So

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2 pending those things occurring, I will be there
3 talking about E.M.S.C. and PECC, Safe Transport of
4 Pediatric Patients.

5 Also at Vital Signs, Sharon Chiumento
6 received our lifetime achievement award from E.M.S.C.
7 and that was really great and well received. And I
8 don't know if she is in the meeting yet, but
9 congratulations again, Sharon, thank you so much.

10 I know that we're going to talk about
11 pediatric COVID vaccines, specifically, five to
12 eleven year old but I also just want to make
13 everybody aware that this morning, and you can go
14 right on the governor's website and find this, the
15 governor is encouraging certain age groups to receive
16 boosters.

17 So that -- all of the specifics
18 related to that are on the governor's website. And I
19 will put the link in the chat in a bit once things
20 slow down and I can get it in there.

21 Speaking of vaccines, we are going to
22 have a Vital Signs Academy this coming Tuesday. Dr.
23 Harris, who is on the panel today, he will be doing a
24 Vital Signs Academy course on pediatric vaccines at
25 large with some highlights on COVID vaccines.

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2 So thank you so much, Dr. Harris, for
3 putting that together and coming to give us some
4 education on vaccines in general and then why it's
5 important for kids to have them.

6 All right. So those are the major
7 items and I will share my presentation on the survey.
8 So much like we have the N.T.R.P. survey recently,
9 every year E.M.S.C. does an E.M.S. agency survey.

10 All right. Well, are you guys seeing
11 my notes or are you seeing the slides?

12 CHAIRMAN COOPER: We see your slides
13 and we see the many -- many slides drive on the left.
14 We don't see notes on this first slide, we may see
15 them on subsequent slides.

16 SECRETARY EISENHAUER: How about now?

17 CHAIRMAN COOPER: We see a note.

18 SECRETARY EISENHAUER: Okay.

19 CHAIRMAN COOPER: We see that.

20 SECRETARY EISENHAUER: Yeah. That was
21 weird.

22 CHAIRMAN COOPER: Yeah.

23 SECRETARY EISENHAUER: All right.

24 Thank God. I'd hate to take the next five minutes
25 and find out but. All right. So every year E.M.S.C.

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2 with NEDARC, which is our data arm in E.M.S.C. puts
3 out a survey, it's a short survey, it takes about ten
4 minutes to complete.

5 It's really covering performance
6 measures number two and three. Number two is, does
7 your agency have a pediatric emergency care
8 coordinator? And number three is, does your agency
9 do skill stations?

10 So training with skills included. So
11 they asked those questions. They also ask basic
12 questions about what level agency are you, so
13 certified first responder, B.L.S., or advanced
14 provider, you know, basic things like that.

15 How many pediatric calls did you do?
16 How many overall calls did you do? So just
17 collecting basic data like that. So that started
18 last week. Thank you so much to the ten percent of
19 agencies who already replied. You will be receiving
20 more emails if you didn't reply throughout the next
21 few months and then ends in March.

22 So for some reference, this is from
23 last year's survey. And this is -- so NEDARC will
24 break it out as national so this is the national
25 information. So out of almost sixteen thousand

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2 agencies across the United States and several
3 territories, almost seven thousand took the survey.
4 And the agencies responding are emergent responding.

5 So they say 911 but for example, if
6 you have a college E.M.S squad and they don't use 911
7 for your campus, but you're responding to emergencies
8 at your campus, you can still be included. And I
9 know that many of our college agencies here in New
10 York State, we have forty-five of them also do mutual
11 aid, so they are included.

12 So as you can see type of licensures,
13 type of providers, and then times of calls, et
14 cetera. And then this is New York State specific.
15 So the percentages at the bottom, the large numbers,
16 now, those are of the agencies that replied.

17 So also considering that this was at
18 the top of the major pandemic with a lot of
19 confusion, out of our one thousand five hundred and
20 seventy-eight, we had a twenty-five percent response
21 rate of almost four hundred. And they clean the data
22 so some of that includes, you know, they don't
23 respond to 911, that's one of the questions.

24 So they excluded, I believe one
25 facility here. So thirty-five percent of those that

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2 responded have a pediatric emergency care coordinator
3 and use pediatric specific equipment and do training
4 on it.

5 So some of these I put these in here
6 just so you see that we're not just asking questions
7 arbitrarily and putting it in a file somewhere. So
8 for this survey it started last week on the fifth.
9 You can find the survey at emscsurveys.org.

10 And what somebody would do with that
11 general address is put New York State, find your
12 county, find your agency. And it's important that
13 agencies use their specific agency name because
14 NEDARC compares year to year data occasionally, and
15 the survey ends on March 31st.

16 And if you forget all of this, you're
17 welcome to email me. I'm happy to share this
18 information with you. Or if you're an agency, I'll
19 send you your specific agency information.

20 CHAIRMAN COOPER: All right.

21 SECRETARY EISENHAUER: Do you want me
22 just to roll into the tech update?

23 CHAIRMAN COOPER: Sure, perfect.

24 SECRETARY EISENHAUER: Donna and
25 Alicia are still handling this for us. They're doing

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2 awesome jobs. We currently have as of the beginning
3 of this month two hundred and three Pediatric
4 Emergency Care Coordinator agencies with many more
5 techs, so some agencies have more than one, depending
6 on their size and specialty.

7 Also, Southern Tiers Health Care
8 Services has been having a variety of sessions with
9 Scott Orr (phonetic spelling) from Pediatrics on
10 pediatric emergency care. And that is in place of
11 their conference that unfortunately was also canceled
12 due to COVID.

13 And we are always looking for more
14 pediatric emergency care coordinators. So if your
15 agency is interested or curious, needs information,
16 they can reach out to Alicia or they can reach out to
17 me, and the website is nyspecc.org.

18 And we'll be happy to share any
19 information or answer any questions for you. I think
20 that is everything that I have. Does anybody have
21 any questions?

22 MR. VAN DER JAGT: Yes, Amy, I had a
23 question about the -- the survey from last year. Can
24 you clarify again, is -- did those responses which
25 are three hundred and ninety-four responses out of

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2 like fifteen hundred or so, are those -- are they
3 people responding on behalf of the agency, or are
4 they individuals that are responding?

5 SECRETARY EISENHAUER: Those are the
6 leaders of the agency.

7 MR. VAN DER JAGT: Okay. So it's
8 really -- this is representative of what the agencies
9 have within New York State. Is that --

10 SECRETARY EISENHAUER: Yes.

11 MR. VAN DER JAGT: -- right? Okay.
12 Which is basically only twenty percent of pediatric
13 equipment and only thirty-five percent have a
14 coordinator?

15 SECRETARY EISENHAUER: Of those that
16 replied.

17 MR. VAN DER JAGT: Of those that
18 replied, yes, which is a twenty-five percent response
19 rate. Yeah, okay. Yeah. Okay. Thank you for
20 clarifying that.

21 SECRETARY EISENHAUER: Welcome. Do
22 you have a question, Dr. Harris? I see your -- your
23 hand icon is raised. All right. I guess not. All
24 right. I will turn it over to you, Dr. Cooper.

25 CHAIRMAN COOPER: Thank you. So I --

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2 I -- I -- do not know if Dr. Lerner or Dr. Dayan have
3 joined us yet?

4 MS. LERNER: I'm on.

5 SECRETARY EISENHAUER: Oh, there you
6 are.

7 MS. LERNER: Dr. Lerner is on.

8 CHAIRMAN COOPER: Yeah, Dr. Lerner is
9 here.

10 MS. LERNER: Peter is on vacation so
11 he is not going to be able to attend today.

12 CHAIRMAN COOPER: Okay. So I guess
13 it's just going to be Dr. Lerner. Okay. You can go
14 ahead.

15 MS. LERNER: Do you share my slides or
16 can I share?

17 SECRETARY EISENHAUER: You can share
18 them. I gave you the presenter control. So if you
19 look at the bottom, there's a little square box with
20 the arrow pointing up that says share.

21 MS. LERNER: Yeah. It's -- and it's
22 grayed out. Shoot.

23 SECRETARY EISENHAUER: Can you make
24 sure that Brooke Lerner has --

25 THE REPORTER: Yeah, give me a moment.

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2 SECRETARY EISENHAUER: -- presenter

3 allowance?

4 THE REPORTER: Yeah, she does.

5 SECRETARY EISENHAUER: Okay. Yeah,

6 you should have it.

7 MS. LERNER: I think it might be my

8 settings. It's my system preferences are wrong.

9 Sorry.

10 SECRETARY EISENHAUER: Oh, that's

11 okay, I can share your --

12 CHAIRMAN COOPER: Go ahead.

13 SECRETARY EISENHAUER: -- I can -- I

14 can share the slides. Just give me one second to

15 take back the control. Can you give me back the

16 control, please?

17 CHAIRMAN COOPER: Uh-huh. You got it.

18 SECRETARY EISENHAUER: And pull up

19 your slides. E.M.S.C. protocol, correct? E.M.S.C.

20 slides.

21 MS. LERNER: E.M.S.C. slides, Lerner.

22 SECRETARY EISENHAUER: I found it.

23 MS. LERNER: Give me one moment.

24 SECRETARY EISENHAUER: There we go.

25 How's that?

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2 MS. LERNER: Great. Thank you. And I
3 apologize for having to say change slides because I
4 know that's super annoying to listen to. Anyway, I'm
5 here on behalf of PECARN. Dr. Dayan and I both
6 represent PECARN in New York State.

7 PECARN is composed of -- of seven
8 grants from HRSA E.M.S.C. office the same that
9 supports the State partnership. And so Peter runs
10 Penn News, which is New York City, Colorado, and
11 Houston and then I run Champ, which is the only
12 E.M.S. focused note of PECARN, which works to bring
13 more E.M.S. research to PECARN.

14 But this brings together E.M.S.
15 pediatric researchers from across the country to do
16 both in-hospital emergency department and out-of-
17 hospital emergency research.

18 Next slide. So we are planning to
19 join your call whenever we can, and hopefully help to
20 exchange information from PECARN to your committee as
21 well as to bring information back to PECARN about
22 things that are happening in New York State.

23 But this map just gives you an idea of
24 the coverage that PECARN has across the country.
25 More specifically, for today, we have been funded for

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2 our first major N.I.H. prehospital research grant,
3 which is called PDOSE.

4 Next slide. This is really exciting
5 because it is one of the biggest pediatric E.M.S.
6 awards from N.I.H. that has occurred to date. And
7 this study is looking at pediatric dose optimization
8 for seizures in E.M.S.

9 Next slide. So what we know is that
10 in 2014, some evidence-based seizure guidelines were
11 put out that make the recommendation shown here, key
12 to them were to give I.M. and I.N. or I.N.
13 benzodiazepines as first-line treatment and to skip
14 giving an I.V. early on to try to get those
15 medications in sooner.

16 But what we found in some of our pilot
17 work through PECARN, next slide, is that some of
18 those recommendations don't necessarily get -- happen
19 in the field.

20 So that preferred I.M. or I.N. route
21 isn't used as often as we'd like. As well as some
22 issues that we found with correct dosing, that
23 there's a tendency to underdose the benzodiazepines
24 when treating seizure patients.

25 And so one of the reasons that we

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2 think this happens, next slide, is that we make this
3 a very complicated process in the prehospital system.
4 We expect providers to determine the weight, to
5 calculate a dose, decide on the route, sorry, arrive
6 -- decide on the route, decide on the weight, decide
7 the dose, calculate that out to get to the
8 milliliters to be able to give it.

9 And these things make -- are both
10 cognitively complicated as well as increase time.
11 The use of length-based tapes can help eliminate with
12 the weight with needing to know the weight, but it's
13 still a complicated process that likely lead to
14 delays.

15 So the P.D. Dose study, next slide,
16 thinks that we can simplify this by using age-based
17 instead of weight-based dosing. So that all you need
18 to know is the patient's weight and then the doses
19 are standard -- sorry, from a patient's age, and
20 then, the doses are standardized.

21 Next slide. So the aim of the study
22 is basically to compare the impact of using a
23 standardized age-based dosing compared to
24 conventional weight-based dosing in seizing patients.

25 So can we -- do we more often have the

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2 seizure stop before the child arrives in the E.D.
3 when we use this age-based dosing scheme as opposed
4 to the weight one. This is an effectiveness aim.

5 The second aim, next slide, is to
6 ensure that this age-based dosing doesn't result in
7 any safety effects. So to compare the frequency of
8 respiratory failure when you do age-based versus
9 weight-based dosing, so to ensure that this change to
10 age-based dosing is, in fact, safe.

11 Next slide. So this study was
12 reviewed by PECARN and I showed you in that initial
13 slide, there are eighteen emergency-department-based
14 sites within PECARN, as well as nine funded E.M.S.
15 agency sites, including the Buffalo site.

16 But then there's also additional sites
17 that have joined as ancillary studies, and so this
18 study will use twenty E.M.S. agencies across the
19 country. All of the medical directors at these
20 agencies have agreed to this protocol.

21 The physicians within PECARN have all
22 approved this study to go forward and then I think
23 it's also important to note the N.I.H. then reviewed
24 the study using their review committees. The F.D.A.
25 has also reviewed this study and all have approved

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2 for it to move forward.

3 Next slide. So interestingly, if
4 you're familiar with most studies, the gold standard
5 is to use a randomized clinical trial. Typically,
6 people do randomization at the patient level. But
7 since this study is looking at a change in protocol,
8 it uses what's called a stepped wedge design, where
9 the agencies that join the study are actually what
10 are randomized.

11 So what will happen is right now we're
12 in that year one planning phase of the study getting
13 all the pieces in place, in May of 2022, the study
14 will start and all of the twenty agencies that are
15 involved will start with their normal or correct
16 protocol and then they'll be randomized to a time
17 point where they would train and then switch over to
18 this age-based dosing scheme that's the study
19 intervention.

20 And so it creates a randomized study,
21 but that really uses a before and after design to
22 look at the rate of stopping seizures as well as the
23 safety outcomes.

24 Next slide. And so this is the
25 protocol. This is the study protocol. In the packet

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2 that you received it shows that what we are asking
3 you today is whether you would agree with us changing
4 just in Buffalo, the protocol to incorporate this
5 study.

6 So you can see the New York State
7 shared protocol update that we made that would only
8 be used at A.M.R. in Buffalo. That essentially
9 follows this protocol where when you get to the
10 dosing for the medication, you would dose it
11 essentially based on age as opposed to calculating
12 out their weight.

13 Next slide. As you know, most
14 research requires that you get the informed consent
15 of the participant before you start. Obviously, at
16 the point that a child is seizing, it's not possible
17 to get consent.

18 So this will use the emergency
19 exception from informed consent, which is used to
20 allow for us to do emergency research. We are
21 currently in the process of doing the community
22 consultation that's required, a notification before
23 we were to start the study.

24 Once a patient is enrolled in the
25 study, we will then notify their legally authorized

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2 representative as soon as feasible to let them know
3 that they were in the trial and to allow them to make
4 a choice to continue to provide data to us or not.

5 This has been reviewed by I.R.B.s it's
6 using -- what's called a single I.R.B. at the
7 University of Utah, that the University at Buffalo
8 I.R.B. has reviewed it and agreed to -- to basically
9 rely on Utah to make decisions for it.

10 And again, this was approved by the
11 F.D.A. for the investigational new drug application.
12 There's also a device exception because one of the
13 things we'll be doing will be when patients get to
14 the E.D. is using, what's called a Ceribell to get a
15 rapid response E.E.G. from these patients.

16 And so that's the gist of this study.
17 I'm happy to answer any questions. This was approved
18 -- I forget, I'm sorry, what the committee is called
19 for New York State to approve just Buffalo changing
20 their protocol, but with a contingent on this group
21 not finding any issues with the study.

22 SECRETARY EISENHAUER: Yeah. So just
23 for everybody's awareness last week, and I'm sorry, I
24 did not write it down, Dr. Brian -- what's his name,
25 Dr. Lerner?

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2 MS. LERNER: Clemency. We're called
3 the I.C.R. in Buffalo.

4 SECRETARY EISENHAUER: I wanted to
5 call him another name and I knew that was not
6 accurate. So Dr. Clemency presented to Medical
7 Standards and then SEMAC and SEMSCO last week during
8 that meeting, and they agreed on allowing A.M.R.
9 Buffalo to participate in the study and just change
10 their protocol if we did not have any issue with it.

11 And I know that of the voting members,
12 some of you kind of had a background with Dr.
13 Clemency on this. I think two weeks ago at this
14 point, but this is the official component. So if you
15 have questions for Dr. Lerner, now is the time.

16 MR. CONWAY: Yeah, hi, Conway in New
17 York. So I'm a peds critical care doc and I'm
18 trained in neurocritical care as well. One of the
19 questions I have is with the Ceribell.

20 My understanding it's not approved for
21 use in kids under some say six, some say two. So
22 does this company have their fingerprints on this
23 study at all? Are they supporting it?

24 MS. LERNER: Yes.

25 MR. CONWAY: Okay. Does this play

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2 into the -- the I.R.B. in the approval and things?

3 MS. LERNER: Correct. So basically,
4 they've given us the Ceribells for free and we're
5 buying the headbands through the grant. This has all
6 been revealed to everyone. So it's -- it's not a
7 hidden fact.

8 It's approved -- it was approved
9 previously to age five, and then, they're in the
10 process, I'm not sure if it's happened yet down to
11 two. But so this was one of the requirements that
12 the N.I.H. asked us to do just to ensure that for
13 patients that aren't conscious, we have a reading so
14 that we can make sure that our outcome, which is
15 actively seizing on arrival or not, is captured.

16 So this was actually a request of the
17 N.I.H. that we add something like this. And you're
18 right, there is a company supporting it, but they
19 really don't have any role in the study other than
20 they've allowed us to use the device. And that's why
21 we have the investigational device exemption to be
22 able to use it in the study --

23 MR. CONWAY: Just another --

24 MS. LERNER: -- and F.D.A.

25 MR. CONWAY: Who is going to read it,

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2 because the company will provide E.E.G. like epilepsy
3 --

4 MS. LERNER: Correct.

5 MR. CONWAY: -- versus you want
6 pediatric, I mean that's the big issue with these is
7 costs, I think it's like six hundred dollars a
8 headband or something.

9 MS. LERNER: Correct. And -- and not
10 really a focus of the study other than to help us
11 ensure that the outcome is measured accurately. But
12 basically, what they're doing is the E.E.G. reading
13 gets saved to a cloud and then there's a panel of
14 three neurologists that will read it separate from
15 clinical care.

16 As you may know, the device has a
17 light and makes a noise. It is up to the clinical
18 site if they want to use that in the care decisions.
19 But they will not get the reading or anything from
20 the study. It just goes up into the cloud and then
21 is reviewed by these neurologists to make sure the
22 outcome is accurate.

23 MR. CONWAY: I'm sorry. Just one more
24 question. So --

25 MS. LERNER: That's okay.

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2 MR. CONWAY: -- just looking I mean we
3 all know that the current recommendation first drug
4 is a benzo. So you know, for eons we used Phenytoin
5 as the first drug based on adult data. And then
6 finally, if -- and correct me if I'm incorrect, we
7 PECARN actually went back after all these years and
8 looked at Valium sort of head to head to Lorazepam
9 that most of us chose.

10 And so there's just so many issues
11 with the pharmacokinetics. Somebody in Status
12 Epilepticus that's profusing poorly, how well
13 absorbed is an I.M. drug going to be versus a per
14 rectum versus getting a nasal, I'm sure this was all
15 looked through and discussed but I'm just bringing up
16 sort of pragmatic, bedside or the stuff that will be
17 dealt with in the field, I think.

18 MS. LERNER: Right. So in full
19 disclosure, I'm an epidemiologist, so I won't answer
20 your drug question, but what I can say is this went
21 through all of PECARN's committees and all of their
22 physicians, all the physicians with the F.D.A. and
23 the N.I.H.

24 And this is based on the best
25 guideline recommendations that were published for

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2 E.M.S. So I think those issues are vetted. I think
3 the other thing to remember is this will have a data
4 safety monitoring board so people will continually be
5 looking at safety for -- for this study.

6 MR. CONWAY: Okay. Thank you.

7 MS. LERNER: Thank you.

8 SECRETARY EISENHAUER: So Dr. Lerner,
9 we also have a question in our chat. What is in the
10 proposal for pediatric patients whose weight falls as
11 outliers, and also what protection for the pediatric
12 patients who fall under the O.P.W.D.D. umbrella?

13 MS. LERNER: Can someone help me with
14 O.P.W.D.D.?

15 SECRETARY EISENHAUER: I don't know.

16 MS. FEUER: Office for Persons with
17 Developmental Disabilities.

18 SECRETARY EISENHAUER: Thank you.

19 MS. LERNER: Thank you. I'm sorry. I
20 should know that. So -- so there is a criteria
21 within the protocol that says if people look small --
22 too small or large for their age, that has directions
23 for -- for those situations that it goes back to
24 weight-base. So it is accounted for in the training
25 and in the protocol.

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2 MS. FEUER: Can I ask a question, Amy?

3 SECRETARY EISENHAUER: Any -- sure.

4 Yes, Dr. Feuer.

5 MS. FEUER: Hi, Pamela Feuer. Just a
6 couple of questions. And since it's I.M. versus
7 intranasal, what are -- what makes that decision
8 tree? Are there specific parameters that allow that
9 or is that up to the operator at the time?

10 MS. LERNER: Yeah, that's up to the
11 operator and up to local. So they would choose I.M.
12 or I.N. based on the decision and the situation.

13 MS. FEUER: And is there a plan to get
14 a standardized intranasal atomizer to every one of
15 these agencies so that it's delivered the same way?
16 Most I.M. shots are -- are kind of the same, you
17 know, a needle in -- in a --

18 MS. LERNER: Right.

19 MS. FEUER: -- muscle, but the
20 atomizers are different.

21 MS. LERNER: Uh-huh. Right. So I
22 don't believe they standardize that across the study
23 but it is within -- so again, this only applies in
24 New York State to A.M.R. Buffalo so they would use
25 the atomizers that they have.

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2 MS. FEUER: Okay. Thank you.

3 MS. LERNER: But I will bring that up
4 because it's probably a good thing for him to keep
5 track of for the study.

6 MR. GREENBERG: Dr. Lerner, this is
7 Ryan Greenberg. So two quick questions for you.
8 One, and -- and I apologize if I missed it when
9 you're talking about it, but my son who is five and
10 wears, you know, size eight or nine clothing.

11 He is a significantly larger, both
12 height and every way than -- than, you know, a
13 typical five-year-old. How does this adjust to
14 situations like that whether it be on the provider or
15 not the provider is there exclusions? Are they all
16 still treated as a five-year-old regardless of that
17 and how is it handled?

18 MS. LERNER: Yes, so significant
19 outliers are addressed in the protocol. I can't find
20 it this second, but it gives them guidance for what
21 to do if they seem out of the norm for the age-based
22 -- for their age.

23 MR. GREENBERG: Perfect, thank you.

24 MS. LERNER: Uh-huh.

25 MR. VAN DER JAGT: Brooke, I just like

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2 to speak in support of the study, because -- or the -
3 - because it is the study. One, it's been well-
4 vetted, I think across the country, but I also think
5 that what strikes me is the -- the problems that we
6 currently have of inadequate dosing for Status
7 Epilepticus and the recognition in the last five
8 years that the faster we get Status Epilepticus under
9 control, the better it is and so that the -- I think
10 I saw in there that the underdosing, that's often the
11 case, is -- is a big issue.

12 And so I think a study that's done
13 under these very -- should we say very diligent and
14 very carefully thought through parameters including a
15 data -- data safety monitoring board, that kind of
16 thing, I think has a lot of merit to do this in one
17 area of New York State because it brings new
18 information to the table about the use of nasal and
19 infused used in this particular way.

20 The other thing is -- that I want to
21 say is that -- as I'm thinking through that hearing
22 is about -- the concerns about, you know, obesity
23 patients versus no obese patients.

24 Currently, I think most people would
25 go with the length-based tapes. But now, it's only

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2 very recently that the length-based tapes have
3 adjusted for weight, as well but it's not purely just
4 the length because of our obesity epidemic, which is
5 now at least twenty or twenty-five percent of the
6 population.

7 The length-based tape is also not as
8 accurate as we once thought it was. So having an
9 age-based, maybe this is a better way to do it. I --
10 I don't know the answer to that but we -- because all
11 I'm saying is that we struggle on both sides of that
12 length-based tape, which is indirectly weight-based,
13 but it's actually not because it doesn't account for
14 obesity.

15 And now we have an age-based. We've
16 always fought against age-based for pediatrics,
17 because of all the various lengths and whatnot, and
18 weights. But I'm not sure that one is better than
19 the other and this study at least has the
20 opportunity, I think, to see whether this makes a
21 difference in terms of outcomes of the rapidity of
22 stopping the Status Epilepticus, that's just my
23 thought.

24 MS. LERNER: Thank you. Yeah, I agree
25 with that. I mean, I think our pilot work showed

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2 that you know, we are underdosing children and the
3 children still come seizing and -- and that's the
4 point of the study, right, to see if we can make this
5 change and get children drugs faster and better and
6 have more children stops seizing using this
7 methodology.

8 So I -- I think you're right that is
9 the point of studying it.

10 SECRETARY EISENHAUER: Anybody else?
11 Any questions or comments for Dr. Lerner? Thank you
12 so much, Dr. Lerner.

13 MS. LERNER: Thank you for your time.

14 SECRETARY EISENHAUER: So Dr. --

15 CHAIRMAN COOPER: That being, hearing
16 none, I think Dr. van der Jagt put forward a motion
17 that we endorse this project. Is there a second to
18 that?

19 MS. FEUER: I second.

20 CHAIRMAN COOPER: Pamela Feuer,
21 second. Thank you, Pamela.

22 MS. FEUER: Pamela Feuer. Uh-huh.

23 SECRETARY EISENHAUER: Who was the
24 initial motion by?

25 CHAIRMAN COOPER: Dr. van der Jagt, I

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2 believe.

3 MR. VAN DER JAGT: Yes, -- yes, I
4 strongly support this as a -- a new way of doing it
5 and it's in a very limited capacity under a
6 tremendous amount of scrutiny since it's the study
7 that's done in this way.

8 CHAIRMAN COOPER: So it's been moved
9 and seconded that we endorse this project. Is there
10 any further discussion? Hearing none, please signify
11 by saying aye.

12 MR. VAN DER JAGT: Aye.

13 MS. FEUER: Aye.

14 MR. CONWAY: Aye.

15 MR. GREENBERG: Aye.

16 CHAIRMAN COOPER: Oppose? Abstention?
17 Hearing none, the motion passes without abstention.
18 Thank you.

19 SECRETARY EISENHAUER: Thank you.

20 CHAIRMAN COOPER: Thank you, Brooke,
21 very -- very much.

22 MS. LERNER: Thank you.

23 CHAIRMAN COOPER: Okay. So we now
24 move on to -- to old business. And the first item of
25 old business is to discuss where we are with our

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2 pediatric agitation workgroup. And I'm going to ask
3 Dr. van der Jagt if he would take the lead on this.
4 Elise?

5 MR. VAN DER JAGT: Sure. So we had a
6 -- give me just one second here, I got to pull post
7 something up on my screen here. So we had a small
8 group, an agitation subgroup that was put together to
9 discuss the crisis that we are currently seeing
10 across the country with behavioral emergencies.

11 And there were a number of us -- us on
12 that group including Dr. Vera Feuer, who is a
13 psychiatrist, Dr. Jennifer Havens, psychiatrist, Dr.
14 Pam Feuer, Jason Haag, Dr. Cooper, myself, I'm
15 missing a few people probably.

16 MR. BERRY: And I was part of that
17 group.

18 MR. VAN DER JAGT: Dr. -- Dr. Bruce
19 Berry, I think was on there, right? Anyway, so we've
20 met a number of times and we ended up looking
21 particularly at the E.M.S. provider and how they
22 would interface with behavioral emergencies.

23 So we spent a -- a -- a long -- a
24 large amount of time discussing what would be -- be
25 brought to the table in terms of management of these

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2 behavioral emergencies that is for an agitated
3 pediatric patient.

4 And in doing that Dr. Havens and Dr.
5 Vera Feuer especially, had been very involved in
6 developing consensus -- consensus guidelines on this,
7 basically what's called the beta guideline for the
8 emergency management of agitated children and
9 adolescents.

10 And so a large part of our discussions
11 were how do we take this -- this -- these guidelines
12 -- these consensus guidelines, and bring it not only
13 to the E.D., but in particular to the E.M.S.
14 providers.

15 So then, after a number of meetings,
16 we then pulled the A.L.S. collaborative protocols on
17 P.S.P. 3.4.1 behavioral emergencies for agitated
18 patients. And maybe, Amy I'm wondering if you could
19 put that up there so that everyone can kind of get a
20 sense for this.

21 And so what I'm going to present is
22 some suggestions for altering this -- this protocol.
23 Obviously, this is a very, you know, preliminary
24 process because we would have to look at it, we would
25 have -- it's -- this is I think, for discussion

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2 primarily, Dr. Cooper. Is that correct?

3 CHAIRMAN COOPER: That is correct and
4 we're -- we're going to -- to get the input of the
5 committee to --

6 MR. VAN DER JAGT: Right.

7 CHAIRMAN COOPER: -- propose some
8 potential changes to the -- to the -- this -- this
9 protocol, which we would then presumably approve at
10 our next meeting. And then, that information will be
11 forwarded to SEMAC for presumably their approval at
12 their -- at their meeting which we plan to follow our
13 own.

14 MR. VAN DER JAGT: Uh-huh. Correct.
15 Right. So -- so if you see this -- if you can stick
16 with that first section there, Amy, the C.F.R. and
17 all provider levels. We really felt that there
18 needed to be something a bit more specific to these -
19 - these -- this -- this area.

20 And I am going to be suggesting a
21 couple of things for discussion a number of things
22 for discussion. I'm reading a little bit from my own
23 crib sheet on this so -- so that you'll know exactly
24 what it is but this is from the committee.

25 So then, for example, I'm just going

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2 to go through this and read some of these ideas that
3 we are trying to put into this. So the first bullet
4 point, which is a call for law enforcement, we will
5 just add as deemed appropriate, because we know that
6 there is a judgment that has to be made there.

7 We also, by the way, we took the term
8 'police' which you'll see in the lower parts of this,
9 and we made it just one term law enforcement because
10 there are some potentially negative or positive
11 connotations with police and so we felt that that was
12 a better term.

13 But then especially under verbal de-
14 escalation, where it says utilize interpersonal
15 communication skills, we really felt that starting in
16 that area, there needed to be more specific guidance
17 to this and we did discuss a lot, you know, what
18 should be in training versus what should be in the
19 protocol and gave it a lot of thought.

20 But we did feel that it was a very
21 specific thing so for -- and I'm going to read again
22 some of these to you for your consideration. I'm
23 sorry, I don't have the document to put in front of
24 you, but just a consideration because it is a
25 discussion -- open discussion point. So that under

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2 verbal de-escalation --
3 MR. VAN DER JAGT: -- say by one
4 person, others keep quiet and then ask the caregiver
5 and/or the child/youth about very specific things,
6 specific event that might have triggered the
7 agitation, usual ways to calm the patient and ask for
8 his or her assistance as appropriate, psychiatric or
9 developmental, behavioral autism kind of diagnoses,
10 medications that usually help or worsen the patient's
11 behavior.

12 And then, we did look at three boxes
13 that were in the consensus guidelines, which we
14 thought we would add under key points at the bottom
15 but they really relate to behavioral and
16 environmental techniques that might be used. And we
17 thought that it would be helpful to put those under
18 key points in the protocol.

19 We added that keep the caregiver with
20 the patient, if this has a calming effect, when
21 knowing very well that sometimes it has the opposite
22 effect. Keep the patient comfortable, warm with
23 avoidance of triggers of agitation, and only after
24 all those very specific guidance, it's almost like a
25 checklist, you know, are done, should there be a

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2 consideration of restraints. We know that that is --
3 restraints can be -- can be very difficult, but we
4 also know that at times they are necessary.

5 And if the patient ends up being in
6 law enforcement custody and/or is handcuffs, then
7 it's clear the law enforcement officers should
8 accompany the patient to the ambulance, to the
9 hospital but they -- the E.M.S. has -- has to be able
10 to immediately remove any of these restrictions for
11 taking care of the patient.

12 And then, the patient, again, has --
13 can you move that down a little bit, Amy, where it
14 says E.M.T. advanced, a little bit beyond that, yeah,
15 under this paramedic, right there.

16 So as we -- the patient must not be
17 transported in a face down position, which is
18 basically coming up from the -- from under the key
19 points of consideration. The other thing is that we
20 had a lot of discussion on the precise medications
21 that would be recommended and the group that we put
22 together categorically, again, looking at the -- also
23 the beta recommendations which is national, is that
24 Ketamine is not recommended and instead, we felt it
25 was best to put in the protocol that under medical

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2 control, considerations would be a midazolam was some
3 of the dosing.

4 Haldol and Diphenhydramine because
5 these are agents that are carried on ambulances. And
6 they are also the drugs that are by and large will
7 take care of a variety of etiologies for these
8 agitated behaviors.

9 So again, there is a few boxes. We
10 can give you the reference. Maybe Amy can send that
11 around at some point. That would be really helpful,
12 I think. But I would -- I'm going to stop right
13 there and certainly have any of the committee members
14 discuss this any further.

15 And particularly very indebted Dr.
16 Havens and Dr. Vera Feuer for their very, very great
17 expertise in this area. So I'm turning --

18 CHAIRMAN COOPER: I'd like to --
19 pardon me.

20 MR. VAN DER JAGT: I'm turning it back
21 over to you.

22 CHAIRMAN COOPER: Thank you.

23 MR. VAN DER JAGT: Yeah. And one
24 thing, our -- if you bear with me. I'm dealing with
25 an emergency and I have to call a 911 number again.

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2 Okay. So if you can bear with me, and just keep
3 going on with the discussions, that would be
4 wonderful.

5 CHAIRMAN COOPER: Sure. I'd like to
6 join Dr. van der Jagt in -- in thanking Doctors Vera
7 Feuer and Jennifer Havens for their incredibly
8 important inputs to this -- this project.

9 I think all of us recognize that that
10 a -- when an agitated child, particularly a young
11 child is not the same as a large teenager anymore in
12 excited delirium for which Ketamine may be an
13 appropriate agent.

14 Rather, I think the -- the gist of the
15 document is and the process that it builds off the
16 work that's been done by the child psychiatrist is
17 really focused on verbal de-escalation techniques
18 primarily and use drugs really not quite as a last
19 resort, but certainly, after all verbal de-escalation
20 techniques have really been exhausted.

21 I think it was felt that Ketamine was
22 probably not the appropriate drug for most children
23 that, you know, that midazolam Haldol and
24 Diphenhydramine were much more appropriate drugs.
25 And that -- for that reason, you know, those -- those

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2 drugs were -- were included in our discussion in
3 place of -- in place of Ketamine.

4 And as Dr. Riley indicated,
5 understanding that verbal de-escalation techniques in
6 kids may be somewhat unfamiliar to many of our
7 prehospital care providers. We felt that providing
8 probably a little bit more guidance than usual in the
9 -- in the protocol would be, you know, would be the -
10 - would be appropriate.

11 So that's sort of the thrust behind
12 the the direction that have been taken. What -- what
13 our plan would be at this point is to -- prior to our
14 next meeting, is to share a straw man of the proposed
15 modifications to the current protocol with you all,
16 so that we can get your -- your input and hopefully
17 get the -- that -- that revision approved at our --
18 at our next meeting.

19 But at this time, I just like to ask
20 anyone involved in the committee, not just the
21 working group that put this together, but anyone on
22 the E.M.S.C. committee to chime in with your
23 thoughts, are we on the right track, do you feel that
24 the comments that Dr. van der Jagt has made and a
25 little more detail than I've made.

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2 Not to mention the general direction
3 and, you know, that I outlined it. Are we on the
4 right track? So please, anyone from the committee
5 that has -- has some thoughts on this, please don't
6 hesitate to speak up.

7 MR. CONWAY: This is Conway. Just as
8 a point of interest, there will -- there is going to
9 be an upcoming publication. I believe it's going to
10 be in Peds Critical Care Medicine, or it may be in
11 Critical Care Explorations.

12 But it's going to be a vast exhaustive
13 overview of pediatric sedation, neuromuscular
14 blockade education, basically, an A to Z review of
15 the pharmacology of all of these agents. It was
16 initially going to be unveiled in several weeks in
17 Puerto Rico at our annual meeting, that was canceled
18 yesterday.

19 So I'm not exactly sure when this will
20 come out in the journals, we were aiming for February
21 or March, but it's got all of the delirium scores for
22 infants, children, so people that are just not
23 comfortable with this topic, it will be an exhaustive
24 encyclopedia of everything you ever wanted to need or
25 know. So I'm just putting that out there as an

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2 educational tidbit.

3 CHAIRMAN COOPER: And do you still --
4 are we a part of the group that put that together?

5 MR. CONWAY: So I was actually one of
6 the reviewers, the editors, and I'm the chancellor of
7 the college where all the guidelines come out. So
8 I've seen it multiple times, yes.

9 CHAIRMAN COOPER: Do you think it
10 would be possible to get a -- or get the college to
11 allow us to review a -- a final draft or document
12 even if it has not been published so we can learn
13 from it and not make any mistakes in putting this
14 protocol out?

15 MR. CONWAY: Probably not, but I will
16 ask. They're pretty --

17 CHAIRMAN COOPER: Thank you so much.

18 MR. CONWAY: -- they're very stringent
19 on these guidelines.

20 CHAIRMAN COOPER: Great. I just --
21 the reason -- the reason I mentioned this is only
22 because SEMAC will not be meeting again until the
23 fall. And if we miss that opportunity to get this
24 before SEMAC in April and, you know, the chances
25 we'll be able to, you know, get anything done really

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2 before the end of the year are pretty slim.

3 And at the present time, our only
4 option in this protocol is Ketamine. And as you've
5 heard from our discussions, those do not seem to be
6 the most appropriate drugs for children, basically,
7 young children who are agitated.

8 MR. CONWAY: Agreed. And I will -- I
9 will make the call and we'll see where we go.

10 CHAIRMAN COOPER: Thank you very much.

11 MR. VAN DER JAGT: Can I have a quick
12 question? Go ahead first, go ahead first.

13 MS. FEUER: No, I was just gonna say
14 maybe we can send, Ed, just some of the suggestion
15 that the sub-committee came up with and to just take
16 a look at them to make sure that they don't look, you
17 know, polar opposite from what you've read in the --
18 in the review. Because if it doesn't come out before
19 the S.E.C.M. meeting, that's been changed, what, till
20 --

21 MR. CONWAY: April.

22 MS. FEUER: -- late April, I think.
23 Yeah. Virtually so. So the timing is it's
24 troublesome.

25 MR. CONWAY: You know, we -- we put it

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2 in for the journal long in advance. So I think it
3 will probably stay -- it was the February issue, I
4 think they wanted it to come out. But I'll check --
5 I'll get back to either you Vera or Art.

6 MR. VAN DER JAGT: And Dr. Conway,
7 just a quick question about that also. So the
8 article you mentioned, really it just sounds like a
9 fairly comprehensive overview. Is it geared
10 primarily to E.D. and inpatient? The reason is
11 because this protocol, of course, is for out of
12 hospital.

13 MR. CONWAY: Right. So --

14 MR. VAN DER JAGT: We struggle a
15 little -- we struggled a little bit with that only
16 because also in the beta recommendations, there were
17 multiple drugs. There were all different kinds of
18 etiologies.

19 You know, and it was fairly
20 complicated, and I'm -- so I'm just wondering the
21 direction of the article you mentioned.

22 MR. CONWAY: So obviously, it's for
23 critical care, but it's an exhaustive overview for
24 anybody that wants to look up any of the score,
25 anything that's -- that's available. But again, the

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2 focus as you're aware, is for the critical care unit.

3 But again, we get called to use these
4 drugs all the time in the E.R. To our psych E.D. to
5 help our colleagues over there.

6 MR. VAN DER JAGT: Sure. Okay.
7 Great. Thank you.

8 CHAIRMAN COOPER: Let me just say
9 that, you know, we will be happy to get the, you
10 know, the -- you know, the conceptual points out to
11 everyone. You know, a specific protocol that -- can
12 only be distributed, after it's been appropriately
13 vetted by the Department to the committee.

14 I will follow Amy's and Ryan's
15 guidance on this, but I think that the general
16 concept probably could be shared unless I'm -- unless
17 I'm wrong about that, Amy.

18 SECRETARY EISENHAUER: I will find out
19 what the process is for sharing proposed protocol. I
20 know the documents that we've been working on has
21 draft and all of that all over it. But I will check
22 on that.

23 And, if appropriate, we can share the
24 draft. Otherwise, I'm happy to share all of the
25 background documents that have kind of been

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2 accumulated just so that if people are -- are
3 curious, they can read, you know, the beta documents
4 and see all the other work that kind of went into
5 making these suggestions.

6 MR. CONWAY: And Amy, certainly in the
7 past, we have shared some drafts of things. We were
8 going through the A.L.S. protocols so to get input.
9 And this has been vetted fairly extensively by a sub-
10 committee already, so it just seems like it would be
11 very helpful to see it in paper because, you know,
12 with wordsmithing and trying to be very specific, you
13 know, maybe that would help at least.

14 SECRETARY EISENHAUER: Of course.

15 CHAIRMAN COOPER: Any other comments
16 regarding the general thrust of the -- of the --
17 where we are with the progress and we'll go from any
18 of the committee members.

19 I'm presuming then we have the
20 committee's, you know, agreement to proceed in the
21 direction that we've outlined. Is there any
22 objection to that? And then, hearing none, that's
23 what we will do.

24 And we appreciate your -- your input
25 and are particularly appreciative of your bringing

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2 the attention of that document and we look forward to
3 your help in, perhaps, getting it to us earlier than
4 others might be able to see it, if that is possible.
5 Thank you.

6 Okay. So moving on to the next item
7 of Pediatric Sepsis Initiative and again, van der
8 Jagt, if he will take the lead on this. This, I
9 think, would be a pretty short report because, you
10 know, we're not -- we haven't gone quite as far with
11 the Sepsis initiative as we have with the agitation
12 initiative.

13 But then, we will fortunately have a
14 report from Division of Quality and Patient Safety
15 within the Department as to where we are with respect
16 to the Pediatric Sepsis Initiative. And make sure
17 our hospitals are participating. Elise, please.

18 MR. VAN DER JAGT: Yes, and this will
19 be like you said, Dr. Cooper, fairly a short report.
20 We have actually met several times, also a group of
21 people from this -- from our E.M.S.C. advisory
22 committee.

23 So what we started off by doing is by
24 looking at the 2020 Surviving Sepsis Guidelines,
25 which were just recently came out, and then, to look

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2 and see whether we needed to change anything,
3 particularly in the pre-hospital protocol.

4 So as we went through that, that went
5 around a few times, some suggestions that we made
6 regarding that. This is back late in the fall. And
7 then as we were working through that we recognized I
8 think that one, the -- one of the issues came up was,
9 well, how many patients does this really going to
10 impact?

11 You know, how many patients truly have
12 a severe sepsis, septic shock, or now it's called
13 sepsis with organ dysfunction, you know, that this
14 would be relevant for, that was number one. So the
15 information about that was unclear.

16 And the second thing is, with the
17 advent now of a new approach, which combines a sepsis
18 and M.I.S.C., which you'll hear about in a second in
19 a new data set, which is primarily outcome based. It
20 became, I think, aware -- we were discussing at least
21 that maybe what we should do is to consider what kind
22 of data might be shared with us from that data set.

23 So that could inform what we might
24 advise with respect to management in the pre-hospital
25 care arena, in E.D. and et cetera, all the areas that

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2 E.M.S.C. is involved.

3 So that is where we are, what kind of
4 data do we need? How much of a problem is this? And
5 then, that relates then can we develop the energy to
6 putting some change -- mild changes in the current
7 E.M.S. protocols because we know that that process is
8 quite laborious, obviously. But does necess -- we
9 want to make sure it's up to date.

10 So I think that that sort of
11 summarizes my understanding of this, Dr. Cooper.
12 Certainly anyone else from the Committee can feel
13 free to respond if I've missed or left anything out.

14 CHAIRMAN COOPER: All I will say, at
15 least, in addition to what you have already outlined
16 is that our focus really remains on the earliest
17 possible recognition of -- of sepsis for our E.M.S.
18 colleagues in the field.

19 For reasons that should be clear to
20 all of us and the sooner we start treatment, the
21 better the outcome. And that's really been very
22 clear from the data that's been amassed over recent
23 years. Any other comments?

24 Hearing none, then, we'll move on to a
25 report from the Department. Is our -- is or

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2 colleague from the Division of Quality and Safety
3 with us?

4 MS. OSINAGA: I'm here, Dr. Cooper.

5 CHAIRMAN COOPER: Wonderful,
6 Wonderful.

7 MS. OSINAGA: Hi, everybody.

8 CHAIRMAN COOPER: There you are. Hi.

9 MS. OSINAGA: Yes.

10 CHAIRMAN COOPER: Okay. Good to see
11 you. Thank you for joining us. It's Dr. Osinaga for
12 those of you who do not know Dr. Osinaga, I've met
13 her recently, and you are very, very good to have her
14 and her colleagues from the Division and the Office
15 of Quality and Patient Safety with us today. And I
16 know that they will have even more for us at our next
17 meeting later this year. So please, go ahead, Dr.
18 Osinaga.

19 MS. OSINAGA: Thank you, Dr. Cooper,
20 and hello, everybody. Dr. Cooper said my name is
21 Alda Osinaga, and I am one of the Medical Directors
22 in the Department.

23 I specifically work within the Office
24 of Quality Patient Safety. I'm the Director of the
25 Clinical Center and it's within my center that we

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2 have the Sepsis Care Improvement Initiative.

3 And I understand that -- that we have
4 spoken at this meeting before about this Sepsis Care
5 Improvement Initiative, but I have not been present
6 at those -- those meetings. I've been at O.Q.P.S.
7 for about a year, or actually now it's been more than
8 a year. It's been a year-and-a-half actually. I
9 didn't even realize how time has gone by.

10 Prior to working in O.Q.P.S., I worked
11 in the Office of Health Insurance Programs and
12 Medicaid Policy, and we did a lot of work
13 concurrently with O.Q.P.S. I worked really closely
14 with Dr. Friedrich and Dr. Alicandro who I imagine
15 are the two who spoke to this committee in the past,
16 and so they are no longer here but I work on the same
17 project that they did.

18 And so I might be repeating some
19 things that you all know, but since I don't have the
20 background of what you know, I just want to make sure
21 that we're speaking from the same -- from the same
22 baseline so that my updates -- updates make sense.

23 I don't have any slides to present
24 today and so if anybody has any questions, at any
25 point, just -- just let me know. So we, again --

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2 CHAIRMAN COOPER: Dr. Osinaga?

3 MS. OSINAGA: Yeah.

4 CHAIRMAN COOPER: May I interrupt from
5 here for one minute?

6 MS. OSINAGA: Uh-huh.

7 CHAIRMAN COOPER: Just for your
8 information, most of what we heard in the past as the
9 committee were reports from Dr. Friedrich and Dr.
10 Alicandro about the sepsis data itself, you know, in
11 fact, Sepsis summaries that we -- the data findings
12 from -- from the project.

13 And there is another group of which
14 you are familiar with maybe that -- that is an
15 advisory group under your -- your office that has
16 actually had the responsibility of commenting on
17 specific changes or directions that you want the
18 pediatric as a part of this program to take.

19 Our role has been to be educated by --
20 by the Department in this area and to offer, you
21 know, a sort of thirty thousand foot view suggestions
22 rather than maybe five or ten thousand foot
23 suggestions to the Department, okay?

24 MS. OSINAGA: Okay.

25 CHAIRMAN COOPER: Let's go to our --

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2 what is in our role?

3 MS. OSINAGA: Okay.

4 CHAIRMAN COOPER: Thank you.

5 MS. OSINAGA: Thank you. And so I
6 actually don't have any data to present today. And
7 this is a good -- we'll explain why we don't have
8 data to present today.

9 So the Sepsis Care Improvement
10 Initiative, the goal is to decrease sepsis mortality
11 rate deaths due to sepsis. And in 2014, regulations
12 were passed that the Department collect data from
13 hospitals about sepsis cases, but not all sepsis
14 cases, about severe sepsis and septic shock.

15 And we collect those for all -- all
16 patients, for both pediatric patients and for adults.
17 And the hospitals send us this data and so that we
18 can look at mortality, we can look at mortality per
19 hospital, we can publicly report that and then we can
20 give that data -- data back to the hospitals.

21 And so we've been focused mainly on --
22 on hospital care and what is going on in the
23 hospital. I know here, we're speaking about beyond
24 hospital in the spectrum. So this is a good place
25 for us to sort of try to think about outside of the

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2 hospital what to do about sepsis.

3 So we had traditionally been getting
4 the data by having the hospitals go in and look at
5 chart extractions. They would go into patient's
6 charts, look for the -- the data that we were
7 requiring them to send to us and send it back, but
8 we've changed that.

9 We've changed the data extraction
10 method. We're not asking hospitals anymore to go
11 into charts, we're asking them now to submit things
12 electronically to us. And we're doing this for two
13 reasons.

14 One, it's not as resource intensive.
15 And I think when COVID came in, we saw that there
16 were, you know, there are just other priorities that
17 the hospital has to do and at times like this, how
18 can we make things that are so -- that aren't so
19 resource intensive.

20 So electric data extraction can do
21 that for us. And we also think that's the way to
22 standardize things. So everybody identifies sepsis
23 in the same way, everybody identifies diabetes in the
24 same way.

25 And so we have produced that that's

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2 the sepsis new -- sepsis data dictionary, this is a
3 new way of doing things. And we have just started
4 collecting data for that starting with calendar year
5 2021.

6 So we currently do not have data yet
7 for pediatric cases because the hospitals first
8 started with sending us data on adult -- adult cases.
9 So they started doing that over the summer. And the
10 first submission for pediatric cases is going to be
11 due in February, so next month.

12 And we're asking the hospitals to send
13 us these pediatric cases, starting -- going back to
14 December 2020. So we anticipate that we will have a
15 full calendar year by December 2020 to December 2021.

16 So we should be getting that data from
17 the hospitals, again, next -- next month. So we have
18 until 2019 sepsis data that was done in the old way,
19 right, the chart extraction way. We did not have
20 hospitals -- the hospitals did not have to send us
21 any data in 2020 because of COVID, we did not require
22 the hospitals to submit data to us.

23 And then, starting in 2021, we will
24 have data again, same things, severe sepsis and
25 septic shock but collected in a different way. And

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2 so this also brings up what we're -- what we're
3 getting.

4 So we're getting these sepsis and
5 septic shock cases but also asking for in the
6 pediatric, for any patient who was hospitalized for
7 COVID including M.I.S.C. I think this is what was
8 referred to, right, Dr. Benny (phonetic spelling) had
9 said that we will be getting data on sepsis, M.I.S.C.
10 and COVID patients but not all COVID patients.

11 COVID patients, pediatric patients who
12 are hospitalized. And really trying to be able to
13 use that data to see the intersection between sepsis
14 and COVID, right.

15 There are COVID patients who have a
16 sepsis syndrome. So we're trying to be able to
17 characterize, which will -- we're hoping that we'll
18 be able to look at sepsis alone and sepsis with
19 COVID. And so that is a new part of this, that we
20 did not have before.

21 COVID wasn't here before but this is
22 something that with a new data set that we're hoping
23 to get. And when we're looking at this, data that
24 we're collecting, we collect comorbidities, we
25 collect to see what -- what conditions the child came

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2 with.

3 We use that to try to see if we could
4 do with risk adjusted mortality rate calculations for
5 pediatrics. We have not done that yet in pediatrics,
6 we do that in adults. And so that's something that
7 we're trying to work out. We're working at that now
8 to try to figure out our modeling. It's another
9 announcement I wanted to make.

10 So we're looking to see if we can do
11 that. But we look to see, you know, what -- what
12 children are coming with, if they have pre-existing
13 conditions and their septic. We have asked the
14 hospitals to send us data if the -- if the pediatric
15 patient has COVID, M.I.S.C. or flu so they have other
16 diseases along with the sepsis.

17 We are looking at what treatments they
18 got in the hospital, to see if they had to get
19 dialysis, if they had to get mechanically ventilated,
20 if they needed ECMO, if they got I.V.I.G., and then
21 we're also looking at what we -- how we try to
22 characterize severity.

23 And the way that we're doing that is
24 collecting vital signs from them and collecting
25 certain blood -- blood tests, and then, also to see

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2 if there is any organ dysfunction.

3 So that's the data that we're getting
4 and, again, remember, it's it's really just to look
5 at -- it's predominantly to look at mortality. And
6 what we feed back to the hospital is we feedback data
7 to the hospitals, we're trying to make sure that we
8 do this quarterly.

9 We're creating right now what would be
10 the quarterly report. But for them to be able to get
11 their own rates of hospitalizations, their own rate
12 of mortality, and to be able to compare them to other
13 hospitals that are of the same size or in the same
14 region, and so that they are able to look at their --
15 look at their cases, look at their outcomes, but also
16 to see how they compare to others.

17 And we're hoping that data will be
18 useful to them so that they can look at it over a
19 trend. They can see what they are compared to the
20 rest of the State, compared to the rest of the
21 region. And for them to be able to use that to look
22 internally at their processes to see how they might
23 be able to improve mortality.

24 But again, what I -- again, the focus
25 here has been traditionally looking really at

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2 hospital data, to look at that and then to give back
3 to the hospital about the care delivery in the
4 hospital. But here today, we're talking about care
5 of sepsis patients.

6 Before -- before the hospital, and I
7 think even after that too, you have to think about
8 the spectrum of care after -- after the hospital stay
9 and I know that one of the things that was raised and
10 asked at the last meeting was whether we could see in
11 our data if a person was brought to the hospital by
12 E.M.S.

13 And so we did look back to see that.
14 Remember, we're taking everything, trying to abstract
15 electronically. So trying not to go to a chart to
16 see if there is an E.M.S. note or anything.

17 And when we brought this up to -- to
18 our group of folks that, you know, Dr. Cooper just
19 mentioned, we have an advisory group, but we also
20 have a group that is specifically from a coding
21 perspective and what they can pull from their
22 records.

23 They said that that information is not
24 something that's readily available at this point. So
25 in their system that they have, which they're able to

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2 electronically extract from, they don't have like an
3 easy flag that says that this person was brought in
4 by E.M.S.

5 So we don't have a good way of doing
6 that at this point, but maybe we can figure out
7 something in the future. But it definitely sounds
8 like the hospitals would have to make modifications
9 to their systems to be able to collect that data in a
10 way that is easily extractable. That doesn't require
11 going into -- into the -- into the medical record.

12 So just -- just so, again, where we're
13 at with this is we have a new way of collecting data.
14 It's electronic extraction. We have not received any
15 data yet from pediatric cases, but we should be
16 getting in February.

17 The data is both on severe sepsis and
18 septic shock, but also COVID and M.I.S.C. And again,
19 the outcomes are for mortality, we're going to see if
20 we can collect and start making a risk adjusted
21 mortality model for pediatric patients. So let me
22 stop there and see if anybody has any questions.

23 MR. VAN DER JAGT: Dr. Osinaga, this
24 is Dr. van der Jagt --

25 CHAIRMAN COOPER: I'm sure we'll have

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2 questions to follow, thank you. Elise, please go
3 ahead.

4 MR. VAN DER JAGT: Yeah. Just this --
5 this last point, I think is a really important one.
6 I know we've talked a little bit about this in our
7 other -- other discussions.

8 The issue of E.M.S. and hospital data,
9 which now includes E.D. data. I just would like to
10 at least go on the record saying, I think that that
11 is a very important piece of information because we
12 are trying to catch kids with septic shock, you know,
13 organ dysfunction with sepsis as early as possible
14 and the frontline person is really often the E.M.S.
15 provider.

16 So as we look at things like, you
17 know, changing protocols, looking at training, of
18 education about this, trying to do the very best we
19 can, as soon as we -- as that's recognized, there
20 needs to be a linkage between those two outpatient, I
21 mean, E.M.S. data sets and the hospital dataset.

22 It's very reminiscent of about
23 fifteen, twenty years ago, when we were looking at
24 just hospital sets, and we did not have a linkage to
25 emergency room datasets. And then there was a whole

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2 data linkage that was developed, even in our own
3 region in Upstate New York, we developed a
4 probabilistic linkage kind of data to try to figure
5 out how we would do this.

6 Well, that's resolved now because E.D.
7 and hospital now are together, but I would like to
8 us, to like your particular group -- to really
9 consider this very seriously. Whether that linkage
10 can be established, even if it is just started out as
11 a pilot.

12 I just think, I cannot under --
13 overemphasize the importance that I think this is for
14 the patients that we're dealing with pediatrics.

15 MS. OSINAGA: Now, that the electronic
16 -- almost all pre-hospital care reports are now
17 electronically collected data wise, and one of the
18 fields in that data collection is hospital
19 transported to.

20 So maybe there is some way to use that
21 linkage going from the E.M.S. data to the hospital
22 data and then linking up the patients that way.

23 So I don't know -- I don't know how
24 they enter -- how the different databases react with
25 each other yet, but certainly, I think that might be

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2 something to consider.

3 And this is all that Chairman -- we
4 have -- we have a field that allows us to know if a
5 person was transferred from hospital to hospital, if
6 they came from a nursing home, if they came from a
7 home but so -- but in that not the details of if they
8 were brought from the home by, right, by E.M.S.

9 And so that is something that we don't
10 have and, you know, I don't -- I don't know all the
11 nuances between every -- the hospital systems and the
12 different -- the different ways but you're right.

13 The only way we're going to know about
14 this is, right, just to explore this a little more,
15 just to understand where -- where that data lies in
16 the -- in the hospital. And other than like the E --
17 if they're separate, and if they ever get -- if they
18 ever get combined.

19 But -- but what -- the feedback we
20 heard was that it just isn't something that they have
21 readily available at this moment. And you're right,
22 having this is not just for sepsis, right, that --
23 that piece of information is not just useful for
24 sepsis, right? It's useful for so many other things
25 if we can have that, that link.

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2 MR. VAN DER JAGT: But I do think
3 that, Dr. Osinaga, that you are in a wonderful
4 position to advocate for that for both adult and
5 pediatric patients that this happens because those
6 linkages are important.

7 And I think in speaking for the E.M.S.
8 system, I really feel that it would recognize that
9 the E.M.S. system is a critical part of the health
10 care spectrum of giving care to pediatric and adult
11 patients who are undergoing emergency situations and
12 emergency illnesses and injury.

13 So maybe this could be a vehicle for
14 saying this needs to be done, whether it's going from
15 the P.C.R. or the pre-hospital care record, which
16 Sharon mentioned, to the hospital or vice versa but
17 that linkage really does need to occur.

18 And we are in a wonderful position in
19 New York State having developed that sepsis thing,
20 the whole sepsis database is required. We are in a
21 great position, I think in the country to really make
22 that happen and using that as a prototype.

23 MS. OSINAGA: And I guess --.

24 CHAIRMAN COOPER: Any other comments
25 or question for Dr. Osinaga? Okay. Alda, do you

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2 want to respond?

3 MS. OSINAGA: I actually have a
4 question for the group, Dr. Cooper. I'm thinking
5 about other than having that link, right, that data
6 link of knowing which cases, because the overall goal
7 with, I think of having -- be able to know that
8 someone was brought in by E.M.S. would be to see what
9 the outcomes were if someone was brought in by E.M.S.
10 versus someone who wasn't and then also if there were
11 any differences in between that.

12 So that would be your overall outcome
13 there. But just what I wanted to hear from the
14 group, if there any other data -- data that would be
15 -- that would be useful to think about -- when we
16 think about sepsis, again, what we're gathering is
17 really our look is to look at outcomes and to look at
18 mortality.

19 We've been talking also about
20 readmissions and thinking about whether we can start
21 looking at readmission. So people who are discharged
22 and then readmitted and why they might be readmitted
23 and when they were and then their outcomes there.

24 So that's something that we haven't
25 looked at, but we're also thinking about that as

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2 another outcome. I'm not sure if there is any other
3 data points that this group feels would be important
4 for your work to think about when you're looking at
5 sepsis.

6 Again, we're getting data at this
7 point directly from -- from hospital, so the hospital
8 stay but -- but we can think about broader than that
9 too. But I'm just wondering if there was any
10 feedback from the group here?

11 MR. VAN DER JAGT: Dr. Osinanga, I
12 know I'm talking an awful lot here, but one of the
13 thoughts I would have is that, you know, there are
14 outcomes, then there are also interim outcomes.

15 So that I think how a patient presents
16 to the E.D., in what condition is probably an
17 important consideration. You know, the patient let's
18 say, for example, worst case scenario is the patient
19 comes in floridly hypotensive and febrile, you know,
20 that's a very different situation, than a patient who
21 comes in with a little bit of fever and has an
22 elevated white count, and it's sort of a little bit
23 borderline, and they get one fluid bolus, and they're
24 fine.

25 You know, so I think that, that

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2 becomes important in that if you have patients who
3 have presented, who present with their findings as
4 being in a very tenuous situation, that would then
5 reflect on the, potentially, the outcome of E.M.S.
6 management on -- on the outside, because they maybe
7 would have been able to to make that patient improved
8 by the time they got to the E.D.

9 MR. CONWAY: I might just comment on -
10 - Elise, on this. By no means all, but I would say
11 the great majority of children who are transported
12 from the field to the Emergency Department and has
13 the benefit of paramedic transport will receive
14 actually probably less fluid.

15 Actually, you know, would necessarily
16 think appropriate for first line, there is an E.E.D.
17 It's pretty good data from the pre-hospital
18 environment that in a relatively short distance,
19 limited duration, urban transports, and the amount of
20 fluid that kids get when being transported by -- by
21 paramedics have been, you know, maybe an average of
22 as little as five milliliters per kilogram, in terms
23 of a bolus.

24 And of course, if you're talking about
25 a longer distance transport, I'm excluding for the

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2 moment, you know, the -- in the hospital transport
3 teams, as that they have -- that is a very different
4 animal.

5 But I mentioned this only because as
6 we all know, you know, the data that was forthcoming
7 from the Department, you know, under Dr. Friedrich
8 and his colleagues earlier in this program really
9 focused on the fact that, you know, that fluids were,
10 you know, were the -- probably the one change that in
11 addition, antibiotics, of course, but the one thing
12 that really did improve the situation and the more
13 fluid they got, the better they get, and I'm sure
14 you're familiar with the saying.

15 And an early administration of
16 antibiotics are of course key, but that's not
17 something that pre-hospital providers are generally
18 in a position to administer. So you know, on what
19 are your ideas on how we can potentially, you know,
20 deal with those two issues, you know, the antibiotic
21 issue and the fluid administration issue, given that
22 I can't imagine a situation whereby they would be
23 given by anyone other than a paramedic under our
24 current system.

25 MS. OSINAGA: And -- and Dr. Cooper,

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2 in this iteration of the data dictionary, in the
3 past, when we did data abstraction, fluids were a
4 data element that was collected. But in this new
5 data dictionary fluids are not collected.

6 One, because in the past analysis, the
7 Department was also calculating process measures.
8 And so they needed that information and now the
9 Department has just going -- moving toward outcome
10 measures, at least from the Department side to -- to
11 analyze and to collect.

12 But also, just with the data
13 abstraction to figure out when the timing of the
14 bolus -- like the fluid was and to understand how
15 much fluid was given when was something that was not
16 easily extractable to understand that from the --
17 from the E.M.R., to understand how much came out at
18 what point and at what time.

19 Often orders went in after they were -
20 - they were administered. And so the timing was just
21 harder to get from this -- from the way that we're
22 getting the data now.

23 But still, always, the data dictionary
24 is not set in stone. So it does get -- it does get
25 looked at, it does get modified. We can always -- we

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2 can always change, make -- but right now, in the data
3 collection that we're getting, we don't have anything
4 on fluids.

5 We have -- we do have an --
6 vasopressor -- a pressor administration, so we could
7 see if someone did get some vasopressors, but not
8 necessarily. And that's looking at more of a
9 severity, but not necessarily looking at fluid.

10 MR. VAN DER JAGT: Dr. Osinaga, I
11 totally agree with you. And I think looking at
12 process measures go into outcome measures is by far
13 the best way to go. I really do agree completely
14 with that. But my point was only in that the
15 condition of the patient on arrival in the E.D. is an
16 outcome of sorts, of what happened prior to the E.D.,
17 and there is how do we capture that.

18 And it would actually be most
19 important for patients who are extremely ill with
20 septic shock kind of thing, rather than just a
21 patient who has a little bit of sepsis, you know, so
22 I don't know how that could be captured.

23 And maybe some thought might be given
24 to that because it is a hospital data, of course, and
25 so it would not be the management in the hospital, it

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2 would be really related to the very condition of the
3 patient at the time of arrival.

4 MS. OSINAGA: And right now what we
5 have our vital signs. So blood pressure, heart rate,
6 respiratory rate, and we have a few blood tests. So
7 we have white blood count, blood cell count, lactate,
8 Cohex (phonetic spelling), and I think that's -- and
9 creatinine. I think creatinine.

10 And we have those on arrival and then
11 asking for two more after that so we could see if
12 there was a trend where they were normal on arrival
13 and then got worse, if they were abnormal on arrival
14 then got better, if they were abnormal, just we --
15 we're trying to figure out if we could do it that
16 way.

17 We need to figure out the picture --
18 pictures at this point, it's a vital signs and some
19 blood tests. And we're hoping that that will with
20 some time. So like I said, at some beginning, three
21 after and also max, unless it's something that we
22 were looking for a minimum.

23 MR. VAN DER JAGT: This goes back to
24 the question of what kind of data might the E.M.S.C.
25 Advisory Committee find useful from the larger data

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2 set.

3 And so, for example, let's say you
4 would take a hypotensive patients. How many
5 hypotensive patients are we talking about in New York
6 State, you know, that come in who already have a
7 diagnosis of septic shock that is based on hospital
8 data coding.

9 How many of those came in hypotensive.
10 If we find out that it's one patient out of the
11 entire State, we're not going to devote much energy
12 to it but if there are a number of patients, and
13 then, you put that together with outcomes --

14 MS. OSINAGA: Yes.

15 MR. VAN DER JAGT: -- that are death,
16 then I think that's the kind of data that might be
17 useful for us to look at. And this has been
18 particularly important because we just discussed the
19 fact that many of the ambulance agencies, only I
20 think about twenty percent of them have blood
21 pressure cuffs for pediatrics.

22 You know, so I think that those are
23 the kinds of ways that we might be able to use some
24 of that data, even if it's hospital data.

25 MS. OSINAGA: Very good feedback.

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2 Thank you. Yeah, yeah.

3 MR. CONWAY: And still with that I
4 would -- if not identified, you know, differences in
5 outcome, right, between various patient groups. The
6 next question is, of course, why, and -- and without
7 at least some very basic process measures that --
8 that's pretty difficult to get at.

9 And since the goal of this whole
10 project is impact to decrease mortality from sepsis,
11 you know, I would respectfully submit that that's
12 something that even though we have not -- we
13 recognized that there are tremendous difficulties in
14 trying to collect that kind of information.

15 You know, I think over time, you know,
16 we probably need to learn how to do that a little bit
17 better than we have in the past. That's just one
18 person's comment. I understand and, of course, we
19 need outcome based measures with that.

20 MS. OSINAGA: Appreciate that.

21 CHAIRMAN COOPER: Any other comments
22 from anyone?

23 MR. CONWAY: Yes.

24 MS. FEUER: Yes, it's Pamela Feuer.

25 Thank you for that overview, again, you know, on some

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2 of the calls. So I knew that we were going away from
3 the process data, but do you know and in light of
4 this committee and pre-hospital care whether things
5 like not just vital signs, but access are collected.

6 For example, if someone was, you know,
7 coming in by EMS, and when they had an I.V. or an
8 I.O. because, you know, without that it precludes us
9 from giving, you know, having appropriate fluid. So
10 maybe there's resources or -- or education, you know,
11 things that can go into that kind of stuff. So is
12 that being collected?

13 MS. OSINAGA: You know, we don't have
14 a variable -- we don't have a variable for that. But
15 you -- but there are possibilities to do that. So
16 we'll take that back. I'll take that back.

17 What I mean, possibilities to do that,
18 right, there is codes for that. That's maybe
19 something that we can look at. Yeah. Okay.

20 MS. FEUER: Thank you.

21 MS. OSINAGA: Thank you.

22 CHAIRMAN COOPER: Any other comments
23 or questions for Dr. Osinaga? Hearing none, I really
24 appreciate your time, Doc, and being with us today
25 here and then I hope that's said and we look forward

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2 to hearing from you a little bit later this year.

3 I know that you're in the process of
4 getting the most recent, you know, pediatric data set
5 at the -- at present time. And hopefully, by the
6 time of our next meeting you will have, you know,
7 some data to present and let us know where we are
8 with respect to the -- the, you know, the aspects of
9 a statewide data project, and if we're making any
10 progress.

11 I sure hope we are and I know you've
12 said so, so.

13 MS. OSINAGA: Yes, yes, thank you.
14 It's really nice to be able to speak to all of you.
15 Thank you.

16 CHAIRMAN COOPER: Okay. And we look
17 forward to seeing you next time. Thanks so much.
18 Okay. All right. Okay. That concludes our old
19 business wrap up.

20 Now, it's time for us to move on to
21 new business. And Alda, you're welcome to stay if
22 you wish, of course. And I think the first item on
23 the agenda is the COVID vaccine and our views as to
24 whether this potentially might be extended to
25 children younger than five. And --

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2 SECRETARY EISENHAUER: Dr. Cooper?

3 CHAIRMAN COOPER: Yes.

4 SECRETARY EISENHAUER: We have a
5 question in the chat related to this topic. So when
6 you're ready for questions, please let me know.

7 CHAIRMAN COOPER: Sure. Yeah. No, I
8 saw that. And I wondered that if that question is
9 with regard to a mandate for vaccination, and how
10 does one reconcile support of such a mandate given
11 the reports of patient and parental autonomy.

12 This is a pretty tough question, but
13 for all of us to focus on and if you recall at the
14 last -- at one of our recent meetings, I think it was
15 our last meeting, we did choose to write a letter to
16 the commissioner strongly recommending vaccination
17 for pre-hospital providers, since at the time, we
18 recognize that unvaccinated children represented a
19 potentially huge group of patients at risk, not only
20 for illness, but also transmission of the illness to
21 others around them, particularly their parents and
22 families.

23 And indeed -- and especially, I would
24 say, if their illnesses were -- were subclinical and
25 they were asymptomatic. So we all know that since we

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2 discussed this in any great detail, the C.D.C. has
3 recommended that vaccination be available for kids up
4 to age five. Previously, it was only available to
5 age twelve and now it's down to age five.

6 So we'll look for discussion on this
7 so we're open to discussion on this issue, how do
8 people feel about -- about a recommendation to the
9 Department with -- regarding vaccination of -- of
10 young children.

11 I will note, of course, the
12 Commissioner does have a strong background in public
13 health and infectious diseases, so it might be an
14 opportunity for us to, you know, get the ear of the
15 Commissioner on this issue.

16 MR. VAN DER JAGT: Dr. Cooper?

17 CHAIRMAN COOPER: Any comments from
18 anyone? Yes, go ahead.

19 MR. VAN DER JAGT: Yes, I believe we
20 did discuss this last time. And I think the letter
21 that we wrote, I believe was just as you indicated
22 it, but maybe it wasn't clear to me how it was said,
23 that we specifically did not support the mandate, we
24 supported the vaccine that it should be given to all,
25 you know, kids down to age five as I remember, at

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2 least.

3 It was not -- because we did talk
4 about this issue of mandate versus no mandate, I
5 think.

6 CHAIRMAN COOPER: I think our letter
7 was actually focused on -- on E.M.S. personnel, and
8 it wasn't focused exclusively on the kids, and that
9 is the issue before us now.

10 MR. VAN DER JAGT: Okay. Maybe I
11 misremembered.

12 CHAIRMAN COOPER: I mean, honestly, to
13 me, since I don't hear anyone else speaking, this --
14 this is a relatively easy thing for us to do, and the
15 Centers for Disease Control and Prevention, you know,
16 and, of course, the F.D.A. have -- have both
17 recommended this and approved of the vaccine for use
18 in kids down to five.

19 You know, I think, you know, there is
20 no reason that we could not as a committee have a
21 strong recommendation to the Commissioner that we
22 believe that that, you know, the Department should,
23 you know, really engage in a full-court press to try
24 to get as many kids vaccinated as possible.

25 You know, understanding that the issue

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2 of, you know, just the issue and parental autonomy
3 means that, you know, it was a -- it's is an
4 important one. You know, at the same time, you know,
5 prevention of illness among the population at large
6 is no less important.

7 Not to mention that the rights of an
8 individual. So how do people feel about that? I
9 mean, are we in a position that we might want to make
10 a strong recommendation regarding or any
11 recommendation regarding vaccination or should we
12 leave it just as an option as, you know, the C.D.C.
13 has indicated? Anybody?

14 MR. CONWAY: I think as pediatricians
15 and sitting on this committee, we owe it to our
16 patients to speak out strongly as strong advocates
17 for this -- for immunization as the data comes out.
18 I mean, we can follow the A.A.P.'s guidelines for
19 specific.

20 I mean, you got seventy thousand board
21 certified people supporting the organization and they
22 have a very strong, as we all know, political arm in
23 Washington. And I think it would do our patients
24 well to follow suit and support it the strongest that
25 we can.

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2 CHAIRMAN COOPER: Thank you. Others?

3 MR. VAN DER JAGT: I just put a
4 comment in the chat box. I strongly support the
5 vaccine. I do not support the mandate.

6 CHAIRMAN COOPER: That's essentially
7 the same position that we took last time. It was a
8 strong recommendation rather than a mandate.

9 MR. VAN DER JAGT: That's correct. I
10 do think --

11 CHAIRMAN COOPER: Is there other --

12 MR. VAN DER JAGT: -- I do think that
13 -- I do think that by however, if we say nothing,
14 that's that speaks itself. That's also a decision.
15 And I don't think we should go that route. I think
16 we should definitely strongly support the vaccination
17 piece of it. Because that's the --

18 (The meeting resumed)

19 MR. VAN DER JAGT: You know, I mean
20 personally I feel the mandate is not the one the way
21 to go, but I do want to make sure that E.M.S.C.
22 Advisory Committee is on record on saying we
23 absolutely strongly support the vaccination of -- of
24 children with this vaccine.

25 MR. CONWAY: Yeah, I agree we can't be

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2 silent about this.

3 CHAIRMAN COOPER: Go ahead, I'm sorry.

4 MR. CONWAY: I -- I -- we can't be
5 silent on this. We need to be heard. And I would --
6 although I might agree personally with the mandate, I
7 also would keep us apolitical, let's stay out of
8 political arguing and let's just put forward the
9 science let's what's do -- what's -- yeah, let's do
10 what's best for kids.

11 I mean, we -- we have a big issue here
12 with adult caretakers in the City Hospital System not
13 getting the booster shot. And my concern is, since
14 the Omni hasn't been as overwhelming, people aren't
15 as sick with the feeling starting to develop that,
16 hey, this wasn't so bad. I got it. I probably don't
17 need a booster.

18 So I'm -- I'm very concerned about
19 that as well. And -- and again, I think we need to
20 stand behind the kids and the best science that we
21 have. And I would follow the A.A.P.s
22 recommendations.

23 CHAIRMAN COOPER: Okay. Can I take
24 that as motion from you?

25 MR. CONWAY: Yeah, my motion would be

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2 that the group put forth that we strongly endorse and
3 support vaccinations for all age groups of which
4 there is supporting data following A.A.P. supporting
5 guidelines.

6 CHAIRMAN COOPER: Is there a second to
7 that motion?

8 MS. CHIMUENTO: I clarify before we --
9 we get there so is that all vaccinations Dr. Conway
10 or is that the COVID-19 vaccination?

11 MR. CONWAY: Let's go with the --
12 let's -- well, let's go with -- let's stay with the
13 COVID, let's keep it focused.

14 MS. CHIMUENTO: Okay.

15 CHAIRMAN COOPER: Is there a second to
16 that motion?

17 MS. CHIMUENTO: I'll second it, is Dr.
18 Chimuento.

19 CHAIRMAN COOPER: Very well, Dr. Fuer.

20 MS. CHIMUENTO: Sharon -- Sharon
21 Chimuento.

22 CHAIRMAN COOPER: Sharon -- Sharon,
23 thank you Sharon. Discussion. Hearing none, all in
24 favor please signify by saying aye.

25 MS. CHIMUENTO : Aye.

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2 MR. CONWAY: Aye.

3 MS. FEUER: Aye.

4 CHAIRMAN COOPER: Oppose, abstentions?

5 Hearing none, that motion carries without dissent. A

6 letter will be prepared to that effect. Thank you.

7 Amy, please refresh my memory the next item on the

8 agenda is what?

9 SECRETARY EISENHAUER: It is

10 discussion of New York State staffing shortages --

11 CHAIRMAN COOPER: Right, right.

12 SECRETARY EISENHAUER: -- with regard

13 to patients.

14 CHAIRMAN COOPER: Yes. I think all of

15 us are painfully aware of the fact that as many as

16 fifteen percent of our staff are -- you know, have

17 been intermittently out with -- with -- with COVID,

18 particularly given the enhanced transmissibility of

19 the -- of the recent -- recently identified Omicron

20 variant.

21 We're also aware that there are a lot

22 of variants that have -- that -- that -- that are

23 emerging ones from Cameroon, France and one from

24 Cyprus. And the -- the early data is not yet

25 available to tell us, you know how -- you know,

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2 pathogenetic and virulent each of these new variants
3 may be.

4 So let us all hope, pray that they
5 turn out to be less pathogenetic and less virulent
6 than -- than the variants that are currently
7 circulating among us, chiefly Delta, and Omicron.
8 But that has led to severe staffing shortages, you
9 know, throughout the State.

10 It hits pediatric units as much as it
11 hits adult units. I think adult units more severely
12 at least with our experience in New York City if that
13 is any indication. Is there anything that we -- we --
14 -- our Committee can say or do that could, you know,
15 help enhance the -- the -- our ability to surge to
16 meet demand -- sorry, Director Greenberg did earlier
17 referred to the issue of load balancing among various
18 facilities.

19 I know that, you know, the Health and
20 Hospitals Corporation in New York City, you know, has
21 -- has done a much better job with load balancing
22 this time around than it did previously. I don't
23 know about situations elsewhere in the State,
24 however. Elise, Pamela, do you have any thoughts in
25 that regard?

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2 MS. FUER: Sorry, I was just on
3 another call. Could you repeat the question briefly?

4 CHAIRMAN COOPER: The question is
5 basically, is there anything that our Committee can
6 do to assist our pediatric colleagues elsewhere in
7 the State. And where staffing shortages that -- that
8 they may be experiencing due to the, you know, the
9 enhanced pathogenicity of the Omicron variant? Sorry
10 -- yeah, that's right the pathogenicity, that's
11 right.

12 MS. FEVER: I mean, one thing -- and I
13 think many of us are and in certainly the intense
14 groups and staff resources for practitioners who may
15 not see as many patients or didn't see as many
16 patients to start with -- with, you know, protocols
17 or -- or recommendations for treatment, you know, in
18 some of the outside places.

19 But as far as providing actual
20 staffing, I don't think so, we're all struggling even
21 the non H.H. hospitals are struggling with both
22 physician, and nursing, and respiratory therapy
23 resources.

24 CHAIRMAN COOPER: I know we're all
25 struggling, yeah exactly, I mean, I don't know that

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2 it would be terribly helpful to try to set something
3 up, you know, particularly since we all expect the,
4 you know, the -- you know, the Omicron has peaked
5 shortly over the next, you know, few weeks, at least
6 according to the information that we're all
7 receiving.

8 I don't know if there's any -- there
9 would be any value in our trying to, you know, as a
10 Committee address the staff shortages in some way.
11 Any thoughts? I see Pamela's raising her eyebrows
12 and saying maybe not.

13 MS. FUER: I don't have any solutions,
14 but I do want to mention that E.M.S. is also being
15 similarly affected because not only E.M.S. providers
16 out with COVID or exposure to COVID, but we also have
17 many of our E.M.S. providers who are now working
18 part-time jobs helping in the emergency departments.

19 And then on top of that, we have
20 prolonged delays at the hospitals so the -- the crews
21 can't get back into service. So -- so the
22 complications are not just the hospital level, but
23 out in the -- out in the field as well. And again,
24 no solutions right that I can think of.

25 CHAIRMAN COOPER: Okay. I don't know

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2 that -- I don't know that there's a lot this
3 Committee can do at this particular point. Again,
4 particularly since, you know, we expect the Omicron
5 peak to subside over the next few weeks and we have
6 no idea what's going to happen with these new
7 variants that have been identified in Cameroon,
8 France, and Cypress.

9 Let's just pray that -- that they
10 prove to be something manageable, okay. Okay. So
11 since we have no solutions only hopes and prayers as
12 to the rest of the world, I think we need to move on
13 to our next item of new business which is base
14 discussion of inner facility transports.

15 And Amy, can you refresh our -- our
16 minds as to the -- the genesis of this particular
17 agenda item?

18 SECRETARY EISENHAUER: Sure, so this
19 is related to pediatric patients that are being
20 transported from maybe a local area hospital, but
21 they need -- maybe there's no pediatric department or
22 maybe they were brought there as a critical patient
23 as, you know, critical access.

24 And now they need to be transferred to
25 a larger facility for whatever further care they

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2 might need, and the related transportation to get
3 there. So obviously, at that point, probably an
4 ambulance would be involved and what would be
5 appropriate.

6 And obviously, we have members from
7 all over the state and from different arenas in the
8 healthcare system, and maybe what experience they've
9 been having seeing patients after them being
10 transferred.

11 CHAIRMAN COOPER: Any thoughts,
12 colleagues? I'd be particularly interested in
13 thoughts from areas outside of the Downstate area
14 where transport times tend to be longer and, you
15 know, and inner facility transport capabilities are
16 potentially more limited.

17 MR. VAN DER JAGT: You know, I think
18 one of the things is that -- this is Dr. van der
19 Jagt. One of the things that we probably don't have
20 as good of a handle on is how many transfers actually
21 occur between -- let's say, facilities that are from
22 B.L.S. versus A.L.S. versus specialty transfers, ...
23 transfers.

24 I know that our emergency department
25 often gets calls and they just get transported by

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2 A.L.S. or B.L.S. sometimes depends on where they're
3 coming from and what the situation is. But I'm
4 wondering if that data is available, and whether that
5 would be any -- of any help.

6 CHAIRMAN COOPER: It would certainly
7 be a reasonable starting point. Amy, do you think
8 that it would be possible to get at least a, you
9 know, a -- a first look at this data for our next
10 meeting?

11 SECRETARY EISENHAUER: Potentially for
12 the next meeting, yes. Our -- we have stolen Jacob,
13 from doing data informatics work and many, many
14 things in the office for today to help me because
15 Peter is deployed with the National, I got back last
16 night.

17 And Alex is pulling data for -- for
18 the Nash and all of those units. So right now, the
19 data informatics team is a little crazy, but I'm sure
20 by April, we could get Peter to find some
21 information. If you would let me know what you're
22 interested in specifically, so we can pull the most
23 accurate data for you that will be exceedingly
24 helpful.

25 CHAIRMAN COOPER: I think we probably

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2 need to convey that, you know, a conference call
3 amongst folks interested in -- to this data perhaps
4 to - to discuss what data might be the most useful, I
5 certainly think the data that has been suggested is a
6 reasonable starting point. And that I think we
7 probably need a, you know, more in-depth discussion
8 than we really have time for in this particular
9 meeting.

10 Does anybody have any additional
11 thoughts at this point?

12 MS. CHIUMENTO: Would it be possible
13 Amy to send us a list of the data points that are now
14 being collected on P.C.R.'s?

15 SECRETARY EISENHAUER: There are many,
16 many, many, many data points. I can -- I can send
17 you the NEMESIS documentation for you to review, but
18 it is not in English in any way, shape, or form.

19 CHAIRMAN COOPER: It is not what, Amy?

20 SECRETARY EISENHAUER: It's not in
21 English, it's in data-ese, so --

22 CHAIRMAN COOPER: I see.

23 SECRETARY EISENHAUER: -- made up
24 word. But yeah, so -- so to look at it, it's not
25 like name, address, birthday, you know, phone number,

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2 like age of patients, right? It's not written out
3 like that. It's written out kind of more like a
4 computer algorithm. So again, I'm happy to share it.

5 You can review it if you happen to be
6 a data aficionado, but I don't know that it's going
7 to be very clear about what it's looking for or not
8 or any of that.

9 MR. BERRY: This is Bruce Berry. Just
10 wondering if -- I mean, if we're looking at data,
11 maybe you just started something as simple as, you
12 know, pediatric patients within our facility
13 transports across the state broken down by region.
14 And maybe, you know, especially centers outside, you
15 know, Albany Med, or, you know, so on and so forth.

16 I know, in our region, most of our
17 pediatric patients go to U.V.M. in Burlington, so,
18 you know, maybe an origination or destination
19 location that includes those areas and just start
20 there with the number that we're talking about
21 overall.

22 MS. CHIUMENTO: Okay.

23 MR. VAN DER JAGT: I think also, Amy,
24 if I'm not mistaken, obviously, I see in the records
25 when I look at patients who've been transferred from

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2 another institution to the P.C.R., it looks like it
3 contains both the starting point which is a hospital
4 as a facility, and the ending point.

5 So you want to get -- those are the
6 ones that facility to facility transports, those are
7 the patients, it seems like that isn't a P.C.R. and
8 to do that in counties. And that would give us also
9 an assessment of whether or not, you know, a smaller
10 hospital transports to a larger community hospital,
11 let's say not to a medical center.

12 Because that -- you know, that
13 translates into the -- and what happens to those
14 kids, you know, is that the right transfer, is it
15 not, that kind of thing. And that would be a
16 starting point facility, like where I said facility
17 to facility. And I'm quite sure that those are in
18 the P.C.R.'s because they have to have a starting
19 point and an ending point.

20 SECRETARY EISENHAUER: Okay. Is --
21 who would like to be involved in this discussion, or
22 think about it and email me in the next day or so?

23 CHAIRMAN COOPER: Any other comments?
24 Okay. Well, then I think we are now on to updates
25 from our sister committee within the division or --

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2 or the bureaus -- bureau of ... medical services ...
3 and others within the department, which we
4 collaborate. Amy would you be kind enough to ask our
5 colleagues in order to give their brief reports?

6 SECRETARY EISENHAUER: Sure. So first
7 is injury prevention, and that's Amy Jagareski.

8 MS. JAGARESKI: Hi, everyone. This is
9 Amy Jagareski. As Amy Eisenhauer mentioned, I work
10 in the Department of Health in the Bureau of
11 Occupational Health and Injury Prevention. So we
12 have just a couple updates specific to child
13 passenger safety activities that we're working on
14 currently.

15 The first is that we're supporting a
16 child passenger safety for school bus training, which
17 is from the National Highway and Traffic Safety
18 Committee. This is going to be happening on February
19 23rd, and this is going to be a pre-offering part of
20 the New York Association for People Transportation
21 Conference, which is happening in Albany.

22 We're currently also waiting on
23 executive deputy clearance for the script for a child
24 passenger safety roll call video. And this video
25 module will be covering Vehicle and Traffic Safety

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2 Laws surrounding child passenger safety and it's
3 meant for law enforcement as a training to help them
4 understand and better interact with caregivers during
5 traffic stops.

6 So as I mentioned the script is in the
7 clearance process, but we're hoping to get that
8 produced in spring. And then, the last update I have
9 is that we're currently evaluating our child
10 passenger safety publications, which are available
11 and free on our website, and these are printed
12 materials.

13 So we're going through and evaluating
14 what needs to be ordered for this upcoming year. And
15 any evaluation that needs to be done as far as
16 translation services, and that's all I got.

17 CHAIRMAN COOPER: Thank you so much.
18 When is the next meeting with the injury
19 implementation group?

20 MS. JAGARESKI: So the Injury
21 Community Implementation Group, the next meeting
22 isn't scheduled yet. We're actually in the process
23 of hiring a core State and Injury Prevention Program
24 Coordinator. And so we just finished interviews with
25 them and I just called references this past week or

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2 two.

3 So we're hoping to hire someone within
4 the next week and then their first assignment will be
5 starting the organization of that, so hopefully
6 February, if not March.

7 CHAIRMAN COOPER: Okay. Thank you.
8 Amy, next -- our next -- any questions for Ms.
9 Jagareski? All right. Hearing none and the next --
10 next group?

11 MS. EISENHAUER: The next group is
12 Family Health and that is with Dr. Christopher Kus.

13 CHAIRMAN COOPER: Is he with us today?

14 SECRETARY EISENHAUER: I'll check.

15 CHAIRMAN COOPER: You said Chris Kus,
16 right?

17 SECRETARY EISENHAUER: Yes, we're
18 checking.

19 CHAIRMAN COOPER: Yeah, I don't see
20 him on the Webinar.

21 SECRETARY EISENHAUER: Right. Yes, we
22 confirm, he is not here. So we will move on to
23 Health Emergency Preparedness, the Central Office
24 with Kate Butler as a party. I know that she has
25 some obligations with the E.O.C. so she may also not

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2 be here.

3 CHAIRMAN COOPER: Okay.

4 SECRETARY EISENHAUER: How about Drew
5 Fried from the Long Island region, same office. I
6 don't see him either. He was here earlier. He may
7 have had to jump off. I know that a lot of us are
8 pulling double duty and --

9 CHAIRMAN COOPER: Yeah.

10 SECRETARY EISENHAUER: -- working in
11 different centers. Mark Philippy did call me earlier
12 this morning. He has a -- a personal matter out of
13 State. And he asked if maybe you, Dr. Cooper would
14 kind of give an update on the SEMAC and SEMSCO
15 generally going over what we discussed.

16 And he did mention the Pandemic Triage
17 Protocol that we had kind of discussed.

18 CHAIRMAN COOPER: Yes, thank you.

19 SECRETARY EISENHAUER: I can share
20 what documents they had.

21 CHAIRMAN COOPER: Yeah, that would be
22 great. I would have to say that the major item on
23 the -- the SEMAC, the Medical Standards Committee and
24 SEMAC agenda and the one that consumed by far the
25 most time at the most -- at our most recent meeting,

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2 which was just last week one week ago today was the
3 Pandemic Triage Protocol.

4 As you recall, this Pandemic Triage
5 Protocol was put into place about two years ago,
6 almost two years ago at the beginning of the COVID
7 pandemic. It was pretty controversial at the time,
8 but as time went by and as, you know, our experience
9 with SARS COVID-2 increased, and treatments improved,
10 and so on and so forth.

11 You know, the -- the need for Pandemic
12 Triage Protocol seems somewhat, you know, less urgent
13 than it had in the past. However, because of the
14 increase in -- in, you know, the number of
15 hospitalizations of late with the Omicron variants,
16 the department ask SEMAC to take another look at this
17 -- at this protocol.

18 A lot of discussion went back and
19 forth on this protocol. And we were at one point
20 trying to at the Medical Standards meeting to develop
21 a pediatric version of this protocol. In the -- in
22 the end, however, the group decided and SEMAC
23 ultimately supported the original protocol that is to
24 be activated by regions or by region on a -- on a --
25 a bi-weekly basis.

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2 In other words -- in other words, if a
3 REMAC recognizes these, you know, the need for
4 implementation of the Pandemic Triage Protocol in
5 that region. And we -- we do so and the protocol is
6 in place or -- or implemented for a period of two
7 weeks, at which point it has to be reconsidered and
8 to see if it's still applicable.

9 So if we can, Amy just run through the
10 steps of the protocol and as you can see, it begins
11 with all patients must be screened for symptoms. But
12 before that actually happens, the -- the provider who
13 is caring for that patient are expected to don
14 appropriate P.P.E. before initiating close contact
15 with the patient.

16 And of course social distancing is --
17 you know, is encouraged. And then the next question
18 is, does the patient have any signs or symptoms of
19 influenza or an influenza-like illness, which of
20 course, could be any of the COVID -- were caused by
21 any of the COVID variants.

22 So if the patient has a temperature of
23 greater than a hundred point four Fahrenheit or a
24 subjected fever, if the thermometer isn't available
25 or any of the symptoms you see listed, such as upper

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2 respiratory congestion shortness of breath, a
3 gastrointestinal distress, sneezing, coughing,
4 headache-like fatigue, okay, then one moves on to a
5 patient assessment.

6 If the answer is no, patients are
7 treated according to standard, basic and advanced
8 E.M.S. treatment protocols. So if one doesn't have
9 one of those symptoms, and then moves on to patient
10 assessment, okay. If the -- if the patient is over
11 sixty-five years of age has respirations greater than
12 twenty-two, oxygen saturation less than ninety-five
13 percent, heart rate more than a hundred and ten,
14 systolic blood pressure is less than a hundred ...

15 If the question -- if -- if any of the
16 answer to that question is yes, if you could scroll
17 up just a bit, Amy continue treatment protocol and
18 transports patient in accordance with, you know, the
19 E.M.S. policy. It's also noted to contact medical
20 control with really difficult or unusual situations.

21 Now, if you go back just a smidge,
22 Amy, you'll see that E.M.S. is looking at patient
23 assessment although it's not as good perhaps as you
24 would need. A patient under fifteen years of age,
25 pediatric vital signs are supposed to be substituted

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2 for the vital signs you see listed in that box, okay.
3 Which I think some of some of us found
4 too cumbersome because it implies the need to look
5 elsewhere for the vital sign but you are presuming
6 pediatric vital signs are, you know, are -- are not
7 abnormal, okay. Then one should obtain a relevant
8 medical history, you can see that the medical history
9 here with the exception of immunocompromised is more
10 adult oriented.

11 And then, you know, in the box below
12 that if the patient has secondary underlying medical
13 conditions other than -- or in relation to ... And
14 again, the congestive heart failure, at-risk
15 population. So all of these assume the question is
16 if the patient has any of these or they're presumed
17 to be risk factors, okay.

18 As well as if there is something, you
19 know, a potentially higher risk medical history
20 including underlying medical conditions, you know, if
21 consultation with medical control is deemed
22 necessary. It is carried out and on transport in
23 accordance with the current, you know, E.M.S. policy.
24 Now scroll down, Amy to the last section again of the
25 document if you will, okay.

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2 So the concept here is that a patient
3 who meet high risk criteria, but are not sick, okay,
4 or sufficiently sick to be transported, okay. That
5 these are patients that may meet non-transport or
6 treat-in-place criteria. And if that is the case the
7 -- the provider is obligated to provide the patient
8 with the COVID-19 hotline number for the department
9 and a patient information packet.

10 But if a patient does insist on
11 transport, medical control is to be contacted for
12 regional guidance. So this protocol is, as you can
13 see, very much adult oriented. And a specific
14 request was made by SEMAC for us to look at this
15 protocol and determine how it could be modified, you
16 know, to be more pediatric specific.

17 And so in the interest of time, you
18 know, and because this is everyone's -- so most
19 everyone on this committee, this is your first look
20 at this triage protocol. I think again, it would be
21 worthwhile, Amy if we put together a conference call
22 of individuals involved in -- or interested in the
23 pre-hospital pandemic triage issue, and came up with
24 potential modifications to this -- this document that
25 could be printed out at our next meeting and shared

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2 with SEMAC prior to their next meeting in April.

3 So I'm going to ask anyone who has an
4 interest in this to please contact Amy and suggest
5 any change with respect to the benefits in the
6 transport group. I know it seems like we're forming a
7 lot of little groups here. But you know, all in all,
8 all the good work is, you know, for any organization
9 that's done in Committee, and I think that that will
10 be the same here.

11 For those who are interested in
12 pandemic triage I think should please let Amy know
13 and we'll get together a conference call in the next
14 couple of weeks to look at this -- at this document.
15 Any preliminary thoughts at the moment?

16 MR. HEXEL: Dr. Cooper, Doug Hexel
17 here, can you hear me?

18 CHAIRMAN COOPER: I'm sorry, who's
19 speaking?

20 MR. HEXEL: Doug Hexel.

21 CHAIRMAN COOPER: Hi, Doug.

22 MR. HEXEL: Hi. I -- I want to speak
23 to this a little bit, not -- not specific to the
24 topic of -- of pediatrics. I work in a very high
25 volume agency, we -- we transport close to fifteen

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2 thousand patients a year. We actually used this less
3 than fifty times.

4 The -- the way that it's written is
5 such that -- that probably, I mean, I can't actually,
6 I was trying to put together the data, you know,
7 looking at our pre-hospital care records, but like
8 ninety percent of the patients we see do not fit the
9 criteria for non-transport, whether, you know, they
10 have a -- a history of hypertension, that -- that's,
11 you know, now criteria that they -- the have to be
12 transported.

13 On top of that the -- the packet that
14 we -- that we give them from Department of Health, we
15 flip it over on to the back it says, if you have any
16 of these symptoms, call back again and you will be
17 transported to the hospital and of those people that
18 we did not transport, a huge number of them ended up
19 calling back within an hour or two, or, you know,
20 sometimes four or five hours to be transported.

21 So you know, it -- it was a -- a great
22 idea and -- and did attempts to use it when -- when
23 the, you know, volume was extremely high. But it
24 really -- it was not as effective I think as -- as
25 the hope was.

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2 CHAIRMAN COOPER: Good information.

3 Any other comments? I think this is a really
4 important opportunity for us to consider this -- this
5 issue, you know, the -- it is likely that at some
6 point that apparently with respect to COVID-19 ...
7 the distribution of the ... children, you know, yet
8 severely affected.

9 It is that -- it is likely that at
10 some point in the future there will be, you know,
11 some ... So I think this is a really important
12 exercise for us to go through. And, you know, I
13 think that a robust discussion about how this
14 protocol should be modified or a potential, you know,
15 ... you know, should be developed ... a pretty
16 serious concern.

17 And something of issue you know with -
18 - without any ... and SEMAC have invited us to do so
19 and I think that, you know, our invitations for SEMAC
20 ... Amy, should set up a conference call ... issue
21 and we can report back in the next meeting, hopefully
22 developed ideas ...

23 Any further comments on that from
24 anyone?

25 MR. VAN DER JAGT: Dr. Cooper, this is

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2 Dr. van der Jagt. There is a question in the chat
3 from Dr. Feuer.

4 CHAIRMAN COOPER: Yeah, I -- I'm
5 sorry, my computer just knocked -- knocked me out of
6 the -- of the -- of the screen, I'm just checking on
7 that right now.

8 MR. VAN DER JAGT: Okay. I can just
9 tell you what it is, it -- it's says -- she says, is
10 this suggesting non-transport for peds under this
11 assessment?

12 CHAIRMAN COOPER: Potentially, yes, I
13 mean, it could, okay. I -- I think that's -- you
14 know, that's part of the whole issue. The whole gist
15 of the protocol was both for adults and children when
16 this was put forward, although clearly ineffective
17 dealing with the adult population because kids
18 weren't getting sick with the Alpha variant at least
19 at the beginning..

20 The idea was to reduce the burden of,
21 you know, of busy mess in hospital emergency
22 departments and critical care units. And so that
23 would be the, you know, the general idea here is to
24 identify those patients who might not need to be
25 transported.

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2 But then again, you know, our group
3 may feel that -- our group may feel that that's --
4 that something that isn't right, we may feel that all
5 kids who meet specific criteria, you know, are --
6 ought to be transport. But I would just not, you
7 know, that's I think for a small group to take a look
8 at.

9 MR. VAN DER JAGT: I think it is a very
10 difficult thing, potentially because -- for
11 pediatrics, because, you know, you could say you
12 could screen out a certain patient who has come in
13 with isn't a rash, and the family is really concerned
14 about it.

15 And we've seen many of those kids who
16 come into the E.D. and then turns out to be non-
17 accidental trauma type situation, you know, so it's -
18 - those are the kinds of things that we're going to
19 have to be very careful about that we don't
20 inadvertently, you know, say, you don't have to
21 transport this patient because the complaint seems so
22 minimal.

23 So I think we would have to struggle
24 with that.

25 CHAIRMAN COOPER: That's why I think

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2 we need, you know, a small group to look at this in
3 greater detail than we have time for now.

4 MS. CHIUMENTO: One thing you might --

5 CHAIRMAN COOPER: Sharon did you want
6 to -- Sharon, go ahead.

7 MS. CHIUMENTO: Yeah, one thing you
8 might want to do is reach out to Mark Philippy. I
9 just heard on the news last night that here in
10 Rochester, they're actually going to have a nurse --
11 a sort of nurse triage team are working with nine one
12 one and specifically the City so it would be A.M.R.
13 patients primarily.

14 So Mark Philippy being their -- their
15 director, or whatever he is these days might have an
16 idea of the algorithm they're using and whether or
17 not they're using it for triaging children as to
18 whether or not they stay home or whether they get
19 transported to a hospital.

20 So you know, we might just reach out
21 to him and see if he has any input as to what they're
22 using. What those -- what those nurse triage is
23 using.

24 CHAIRMAN COOPER: Sharon, would you be
25 willing to take on that please?

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2 MS. CHIUMENTO: I can try to reach
3 him, yes.

4 CHAIRMAN COOPER: That would be great.
5 Pamela, did you have any additional thoughts?

6 MS. FEUER: Other than I think there's
7 probably a very small number of kids that shouldn't
8 be transported if they actually call E.M.S. to come
9 to the home. So I would find a protocol very
10 difficult to come up with and be of -- I think of
11 increased risk to kids. So I would like to leave
12 them off of it, you know, under fifteen.

13 CHAIRMAN COOPER: Fair enough.

14 MS. FEUER: That's my initial
15 impression, so.

16 CHAIRMAN COOPER: I will say at least
17 our experience here, you know, the E.R. is deluged
18 with kids who have a -- and have essentially no other
19 symptoms, and maybe a snuffle or something along
20 those lines, and they get tested, they're positive
21 and they get sent home, you know, right away.

22 And I'm sure that's happening, you
23 know, in other places as well. It doesn't mean that
24 they shouldn't be transported, you know -- you know,
25 necessarily, okay. But I think it's an issue that we

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2 should -- we should discuss.

3 MS. FEUER: I -- I mean, that is true.
4 The amount of treat and release in most E.R.s is way
5 up right now for COVID. And it could be any other
6 virus. But I think the nuances and especially this
7 period, we -- we talked about croup COVID, there's
8 been a lot more upper respiratory obstruction in
9 younger kids and stuff.

10 And I think those nuances are tough
11 for any other hospital, you know, team to make an
12 assessment of, so -- you know, and because every kid
13 will have abnormal vital signs of fever, almost every
14 kid so.

15 CHAIRMAN COOPER: Well, that's why we
16 need to talk about that range and then, you know, and
17 again, they asked us, so I think we should, so we
18 will. Okay. I think I would -- I would think that
19 that was probably the major issue that came out of --
20 out of SEMAC a week ago.

21 Amy, please refresh my memory, if you
22 think there's anything that -- else that we need to
23 discuss from SEMAC today?

24 SECRETARY EISENHAUER: So Mark also
25 mentioned the health -- the health initiative that

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2 they are kind of getting off the ground. And then,
3 of course, he mentioned our discussion of the P.D.
4 Dose, which we already discussed.

5 CHAIRMAN COOPER: We've already
6 covered that, yeah. That was approved by SEMAC by
7 the way and I think was mentioned earlier. Okay.
8 STAC is not meeting until next week -- not -- I'm
9 sorry, not next week, I think next month at this
10 point, I think I got a note from the Committee was --
11 was just put off by a few weeks.

12 So I don't have -- I have nothing, you
13 know, additional to report from STAC. And yeah, I
14 think that -- that was it if I'm not mistaken, Amy,
15 there's no one else right or did I miss something?

16 SECRETARY EISENHAUER: The Pediatric
17 Trauma sub Committee of STAC so Dr. Prince I guess.

18 CHAIRMAN COOPER: I don't -- if he's
19 still on, I didn't see him when I looked through the
20 list last time. I think he has dropped off, yeah.
21 And as I say STAC has not met since the last time we
22 met, so -- and they're not meeting for another few
23 weeks.

24 All right. Well, I think we have
25 completed our -- our published agenda. Is there

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2 anything else anyone wants to bring up at this
3 particular point with -- with the children with
4 emergency conditions in New York State. Hearing
5 none, then I think we are done for the day.

6 Our -- our next meeting has not been
7 set yet, we're going to set it sometime in March to
8 give us enough time to get any of SEMAC ... SEMAC.
9 Amy will be working on that, I know in the next week
10 or two and so with that I -- we are in a position to
11 give you back some actual minutes of your day.

12 SECRETARY EISENHAUER: Do we have an
13 adjournment?

14 CHAIRMAN COOPER: And -- what Amy?

15 SECRETARY EISENHAUER: A motion for
16 adjournment.

17 CHAIRMAN COOPER: Yes, of course. We
18 have a motion for adjournment?

19 MR. CONWAY: I so move.

20 CHAIRMAN COOPER: Ed Conway, second?

21 MR. VAN DER JAGT: Second the motion.

22 CHAIRMAN COOPER: Discussion? All in
23 favor?

24 MR. BERRY: Aye.

25 MR. VAN DER JAGT: Aye.

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2 MR. CONWAY: Aye.

3 CHAIRMAN COOPER: Thank you all very
4 much. Great to see everybody again, I wish everyone
5 a blessed escape from the pandemic as soon as
6 possible. And we'll see all again in March, okay.
7 Thanks again everyone for your participation.

8 (Off the record 3:48 p.m.)

9 (The proceeding concluded.)

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1 1-11-2022 - EMSCAC Meeting - WebEx

2 STATE OF NEW YORK

3 I, ANTHONY MCCLAIN, 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 hereof; that
6 the foregoing typewritten transcription consisting of
7 pages 1 through 124, is a true record of all proceedings
8 had at the hearing.

9 IN WITNESS WHEREOF, I have hereunto subscribed
10 my name, this the 20th day of January, 2022.

11 ANTHONY MCCLAIN
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