10-12-2021 - EMS-C Meeting

NEW YORK STATE

DEPARTMENT OF HEALTH

WebEx

EMS-C COMMITTEE MEETING

DATE: OCTOBER 12, 2021

TIME: 1:10 p.m. to 3:53 p.m.

CHAIR: ARTHUR COOPER

Reported by Janet Wallravin

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APPEARANCES:

RYAN GREENBERG
PETER BRODY
AMY EISENHAUER
BRIAN WIEDMAN
BRUCE BARRY
CHRISTOPHER KUS
DANIEL CLAYTON
DONNA KAHM
DREW FRIED
ELISE VAN DER JAGT
JACOB DEMAY
JENNIFER HAVENS
KATE BUTLER-AZZOPARDI
MARK PHILIPPY
PAMELA FEUER
SHARON CHIUIMENTO
JOSE PRINCE
VINCENT CALLEO
BROOKE LERNER
NICKOL O'TOOLE
JOSEPH PATAKI
PETER DAYAN
KEVIN ALBERT
DOUGLAS HEXEL
AMY JAGARESKI
ALICIA BROADBENT
VERA FEUER
GEORGE STATHIDIS
RITA MOLLOY
JASON HAAG
DOUGLAS HEXEL
LINDA EFFEREN
ED CONWAY

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(The hearing commenced at 1:10 p.m.)

THE REPORTER: On the record.

MR. GREENBERG: Good afternoon everybody, welcome to the E.M.S. for children's ... We are just setting the recording now and just a reminder for everybody, both being a virtual meeting and that there's a stenographer on, please make sure to announce who you are.

This is Ryan speaking. To start things off, I am sitting next to Amy off camera, just because the camera faces one direction. So I will make sure to say my name prior to each time in order to allow the stenographer to know who is speaking.

MS. EISENHAUER: Awesome. So go ahead, Dr. Cooper.

MR. COOPER: In terms of taking the attendance, do you have that on the -- on the screen, or do you want to do a formal roll call?

MS. EISENHAUER: I'm going to do a formal roll call.

MR. COOPER: Okay.

MS. EISENHAUER: All right.

MR. COOPER: So go ahead.

MS. EISENHAUER: Okay. So we will start -- so also to clarify, we have voting members,

and then there are other individuals that were still in the vetting process for, and I'm going to call them second and I will delineate that. So for voting members, Dr. Arthur Cooper?

MR. COOPER: I'm here.

MS. EISENHAUER: Dr. Elise van der Jagt?

DR. VAN DER JAGT: I'm here.

MS. EISENHAUER: Thank you. Dr. Kevin Albert?

DR. ALBERT: I'm here.

MS. EISENHAUER: Thank you. Bruce Barry?

MR. BARRY: I'm here.

MS. EISENHAUER: Sharon Chiumento?

MS. CHIUMENTO: I'm here.

MS. EISENHAUER: Dr. Edward Conway? Okay. So Dr. Conway is not present. Dr. Pamela Feuer?

DR. FEUER: Present.

MS. EISENHAUER: And then Dr. Jose Prince?

MR. PRINCE: Present.

MS. EISENHAUER: Great. And then Lupricia Bailey is not present. She emailed me and

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said she had another work commitment so she's not able to make it today. And those are all our voting members, and we have quorum, seven of nine are present.

So for the second part of attendance, I just want to call the other members that are joining us so that they're up to date. Dr. Tiffany Bombard? Dr. Vincent Calleo?

MR. CALLEO: Yup, I'm here.

MS. EISENHAUER: Awesome, thank you. Dr. Jennifer Havens?

MS. HAVENS: I'm here -- I'm here, Amy.

MS. EISENHAUER: Thank you. Dr. Matthew Harris?

MR. COOPER: Amy, Dr. Harris texted me before the meeting. He will be joining us a little late. Thank you.

MS. EISENHAUER: Sure. Thank you. I know Douglas Hexel is attempting to get into the meeting. He's in? Doug Hexel?

MR. HEXEL: Yeah, I'm here.

MS. EISENHAUER: Thank you. Chief Pataki?

MR. PATAKI: I'm here.

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MS. EISENHAUER: Thank you. And Nickol O'Toole?

MS. O'TOOLE: I'm here.

MS. EISENHAUER: Thank you. Okay. That is the roll call. I will give it back to you, Dr. Cooper.

MR. COOPER: Sure. Thank you, Amy. Are there any guests with us today that we would like to ask to say hello?

MS. EISENHAUER: We do have several guests, and some of them will be giving reports later in the meeting. Dr. Brooke Lerner and Dr. Peter Dayan from PECARN are with us. Amy Jagareski from BOHIP is here. She is new to her role and it's the first time for her joining us, so welcome.

Dr. Christopher Kus is here and will be leaving and coming back. Kate Azzopardi from Office of Health Emergency Preparedness. Drew Fried from the Long Island Office of Emergency Preparedness. And then George -- and I'm sorry, I'm going to say your name probably wrong, Stathidis, and he is from the Sepsis Initiative, and he'll be giving us an update on what they're working on later in the meeting.

And also, I would like to note that

Donna Kahm and Alicia Broadbent who managed the PECC program are here with us today as well.

MR. COOPER: Thank you and welcome everyone. Hope you all had a nice summer. I think we all hoped that we would be together this fall in person, but that little virus that's been causing so much trouble decided otherwise. And here we are on mute -- it's not on mute, sometimes unmute, but on video. So we're happy to have everyone here, and thank you all who made the time in your busy days to join with us.

We have a pretty full agenda today, and Amy really hit the ground running, as you probably know, starting a little bit earlier this year.

And so I anticipate that this year is going to be quite a bit busier than last. Thanks, Amy, for all you've done for getting -- getting us back on track. And so without further ado, let me get into today's agenda, and we'll begin with approval of the minutes. Has everyone had a chance to review the minutes?

DR. VAN DER JAGT: This is Dr. van der Jagt, Art and Amy, there are -- I looked at the minutes and they look generally fine. There are some

minor things in there that are always there, like something isn't caught quite right by the person who's taking the minutes based on the language.

I don't know if that counts as anything we have to change, but there are some errors in there.

MR. COOPER: We'll consider those technical edits, and at least if you would make those known to Amy that'd will be very helpful. Thank you.

DR. VAN DER JAGT: Will do.

MR. COOPER: Any other additions -- additions, deletions corrections? Hearing none, then may I have a motion to approve?

MS. CHIUMENTO: Motion make to approve minutes.

MR. COOPER: Second?

DR. ALBERT: I'll second --

MR. COOPER: Anyone?

MR. PRINCE: Second -- second.

MR. GREENBERG: Please state your name to --.

MR. PRINCE: Sure. Second. This is Dr. Jose Prince.

MS. CHIUMENTO: And motion was made by Sharon Chiumento.

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MR. COOPER: Thank you, Sharon and Jose. Discussion? Hearing none, all in favor, please signify by saying aye.

MS. CHIUMENTO: Aye.

MR. PRINCE: Aye.

DR. VAN DER JAGT: Aye.

MR. COOPER: All opposed? Okay. Ryan Greenberg, it's up to you.

MS. EISENHAUER: Just before Ryan jumps on, I didn't realize that Dr. Vera Feuer is also with us. She's been helping us in the pediatric agitation subcommittee. And she's really been a great help, and I wanted to recognize that she is here also as a guest. So thank you, Dr. Vera Feuer for joining us today. And now I will turn it over to Ryan.

MR. GREENBERG: Hi everybody, and we can actually change the camera -- cameras support here for a second. Sorry, bear with us one second here. Ma'am, can you pull it?

(UNIDENTIFIED SPEAKER): There he is.

MR. GREENBERG: Well, I turned on my other camera too, so if you can ... you'll see me there too.

And now you know where the exit is in

the event that anybody needs to leave. So thanks for joining us today, I'm excited to, you know, be back and having these meetings again. Just wanted to touch on a couple things on what's going on in the bureau. Obviously, we've been very pandemic focused. I -- I would say probably the biggest misconception at this time is that people believe that, you know, for every -- I mean for us a little bit that the pandemic has ended.

And that, you know, we have all this time to get back to our normal function. Unfortunately, the Department of Health said it's not necessarily the case. We're still very much pandemic focused in a number of different initiatives, particularly right now, you know, whether it be the vaccine, vaccine boosters, and also just hospital coordination, management, and -- and capacity.

So within the Bureau of E.M.S., on the E.M.S. side of things, we have continued to focus on pandemic response as well as also providers and CART providers being out there and -- and functioning in their normal day-to-day functions, but as well as a series of additional functions as well as ... community care medicine and different outreach

programs that are going on on that side. So we're excited to see that that is, you know, moving forward.

Currently right now, something new on our side in that community paramedic world, which is primarily being used for the vaccination front, testing front, but we do have community paramedic programs that cover just over about half of the counties in New York State, and we are doing a push right now for community paramedics in the remaining areas that are not covered.

This is really helpful. Their -- the community paramedic programs are often working with the local health departments under different initiatives, again, they're dominantly around the pandemic response, and, you know, working to hopefully, you know, get us back to some sense of norm. So we, you know, it's been a very positive experience on that front.

We continue to also monitor, like I said -- sorry, on the E.M.S. front, just continuing on that side, with education and certification, things are moving well. We are back to printing cards, which we were holding off on for a period of time during the pandemic due to logistics and certain

things.

We have seen, you know, our providers maintaining. We've seen our providers that has gotten extensions choosing to maintain their certification. So that's, you know, a positive thing that sometimes it's a little bit hard to tell with the extension.

There are a series of new E.O.s that are currently out, and those E.O.s allow certain functions that we've been doing to continue along with our E.M.S. certifications, along with our community care medicine program, as well as that, you know, how we operate and allows us to be fluid with the -- the current pandemic. So that's been a very positive thing as well.

One of the other -- on that -- on the trauma side, things are, you know, moving well, on the trauma side. I'm not sure if Dan's going to be reporting on anything later, ... turned that way. But we do continue well on that front there -- the staff meeting is tomorrow. They'll be talking about a number of initiatives as well as a number of concerns that are out there.

The biggest concern that comes out there right now is just I.C.U. capacity and hospital

capacity across the board. One of the things that E.M.S. is also running right now is the E.M.S. surge -- or not E.M.S.C., the statewide systems operation center, which is running anytime at a hospital or nursing home or any building's having a problem, whether it be with staffing and equipment or something else, they're able to call in to the ... and to, you know, work for assistance towards them.

Obviously, with vaccine mandates and different things going on, there's been, you know, an influx in requests for assistance and information. And so, you know, that has been really, you know, kind of a priority of the bureau right now, and that's being primarily overseen by Deputy Director ... who is doing an outstanding job on that side.

But it is, you know, kind of one center and then we work to navigate each of those requests that come in, and the problems you get issues, or even in some cases, just situational awareness, the appropriate program.

As things go up and down on our roller coaster of a ride here and hospital capacities, we do also maintain and continue regular communications with the hospital associations throughout New York. And one of the things that we do watch for is also

that E.R. capacity, hospital capacity, and then, you know, depending on what's going on pediatric capacity as well.

So those are things that, you know, we look at and, you know, and kind of take a look at their current stat on a regular basis and determine if there's anything we need to do. Then in those areas where it really does become problematic, we also work with those hospitals to help load balance or balance patient modes coming in from the ... as needed, follow in order to, you know, try and make sure that our patients can get the appropriate care at the best location possible.

So in addition to that one, you know, we do have a couple of new -- the -- the one or two new trauma centers who will possibly be looking for accreditation in the near future of provisional status that we are evaluating.

However, we do not have any new pediatric trauma centers that have ... situational awareness to this group. And I think that is about it right now, particularly with everything going on. I'll keep my report short, and just wanted to do a set up to or ... folks, to Donna and Elisa who's done a phenomenal job on the PECC program.

We did also apply for additional funding for the PECC program, but -- and Amy is going to talk about that one, so I won't get too far into that one. But again, we do continue to go after additional initiatives and opportunities that they do come forward, not always accessible in all of ours.

But if you do hear of anything amongst this group of opportunities that we might be eligible for that would help expand any of the E.M.S.C. initiatives. Please don't assume that we know about them, often it is the case of, you know, maybe something is passed from your desk because of the organization you're in, and maybe your organization isn't interested in it. But it's something that on the state level we might be able to and to respond to. And that's all I have. I'm happy to take any questions, comments or concerns.

MR. COOPER: Thank you, Ryan. Any -- any questions for Ryan this afternoon? Okay. Well, hearing none, then it's time for Amy to give us the -- the program grant update. Amy, please. Thank you.

MS. EISENHAUER: One more the other way. Awesome. So thank you, Ryan. And thank you, Dr. Cooper. So the E.M.S.C. grant report, and I'll start with the extra grant opportunities since Ryan

brought it up. E.M.S. for children at the federal level had some funds left over, and they were able to give four grants to four different programs.

And after speaking with them, there was quite a robust response. They were not able to give me an exact number, but they said that many, many grant programs, statewide programs applied, and all had very robust grant applications. And so four states did get awarded that extra money and it was for rural response, post pandemic.

And -- so to increase PECC programs either out of hospital or in hospital, focusing on areas that might not have as many resources. And some of that was, you know, just having access to health care, or you could focus on mental health and wellness for children.

So unfortunately, we did not get awarded that extra funding, sadly. But as Ryan mentioned, Donna and Alicia are still on the job for our PECC program. And in a moment, I'm going to give them a second to just talk about some of the work that -- that they're doing to get us even more PECC around the state.

So also, as part of our regular grants, we are in the process of hiring a data

informatics team member that is solely for E.M.S. for children. So this team member would work with our current data informatics team, Peter Brody and Jacob and Alex.

So this team member would work with them to pull whatever data we need to help us with surveys, and -- and any other data needs that we might have. So if you know anyone who would like to come to Albany and work with us and loves data informatics and pediatrics, we'd love to have them apply.

Also, as always, we're continuing our efforts in education, so as many of you know and many of you have joined us, we are continuing to support the Vital Signs Academy. And we have two classes each month for pediatric specific education that we sponsor, and we are also sponsoring a preconference at the vital signs conference in just one month.

So if you know people that are going to be there, tell them to come on Thursday morning and join us. Several of our members are going to be on a panel on pediatric agitation. So I believe that's Dr. Havens, Chief Pataki, and there's one other person, Dr. Calleo, and we'll be talking about pediatric agitation and E.M.S. and then also taking

questions from the audience, so that'll be the first portion.

And then the second portion will be an entire skill session on safe transport of pediatric patients. So with some of the grant money last year, we bought a variety of E.M.S. pediatric restraint devices to transport patients in, so we'll be ruling those out.

And we have myself, and I believe five other educators, Doug Hexel, who's here at the meeting, will be one of them. Five other educators and have six skill sessions to demonstrate a variety of -- of scenarios and devices for the folks at that precon.

So please, if you know anybody who'd like to come, there are limited spaces and they should register now. So we are also supporting that from our grant funding.

Let's see. Before I turn it over to Donna and Alicia to talk about the PECC program briefly, E.M.S.C. at the federal level, due to the pandemic and stresses on everybody, has added a year on to this grant package. So they are releasing the documents, I believe in the next few weeks for us to submit our yearly budget for that. But we don't have

to do the competitive grant application until next year, so they were -- they were kind enough, and I think that they also -- they also are a little stressed trying to get everything together and work with COVID response for kids. So to save everybody some added stress they extended it.

Let's see. I think that's everything on my notes for new things going on in the grants. Donna or Alicia, would you like to comment on anything related to the PECC program?

MS. BROADBENT: This is Alicia. Donna and I are both here. So thanks for having us. To date, we have a hundred and ninety-nine agencies in New York State --

MS. EISENHAUER: Alicia?

MS. BROADBENT: Yeah? Can you hear me?

MS. EISENHAUER: Can you -- we can, but you're very low. So I don't know if you need to move closer or if you can --

MS. BROADBENT: How about now, is that --

MS. EISENHAUER: Yeah, that's much better.

MR. COOPER: Tell Donna to move from

her desk, can you just sit in Donna's seat, it'd probably even better.

MS. BROADBENT: You know us too well.

So we do have hundred and -- a hundred and ninety-nine agencies in New York State that are currently having a PECC program. The PECC workforce development collective is currently happening with the E.I.I.C., and there are quite a few people in the state, I believe it was over fifty that are participating in that.

And Amy was able to get a list of the people in that and the -- some of the individuals weren't registered as PECCs, so I did reach out to them to get them -- to urge them to sign up to be a PECC. So I'm still waiting to hear back from them.

Donna and I will both be attending the Vital Signs Conference, so we're excited to be there and be at the E.M.S.C. table. And it will be my first conference, so I'm excited to go, Donna's not ... but I -- I'll be excited to be there.

We are meeting continuously with Amy. We have a standing meeting every month, so that has been great. And then lastly, just in our area, we have been working with some of the -- our E.M.S. agencies in the local school districts to try and get

the school children vaccinated for COVID. So that's kind of what I have to report. Thank you. Are there any questions?

MR. GREENBERG: I -- I have one question for you, which is, what is it from this group that you might haven't asked for that we'd be able to help you as the council in order to increase those numbers?

MS. BROADBENT: I would say that ...

MR. GREENBERG: Can't hear you.

MS. BROADBENT: They have the agency sent them over.

MR. GREENBERG: I can't hear her. Can you hear her?

MS. EISENHAUER: Yeah, we can't hear you. I think what you're saying is to ask the agencies that you're involved with to sign up and -- and apply to be PECC, Pediatric --

MS. BROADBENT: Yes.

MS. EISENHAUER: -- Emergency Care Coordinators. So spread the word.

MS. BROADBENT: Spread the word, ... website, we're willing to talk to anyone about it so.

MS. EISENHAUER: So to answer Dr. van der Jagt's question, it is a part-time position, but

exclusively dedicated to E.M.S.C. projects. So that would include pulling -- pulling data from the E.M.S. -- the E.M.S. repository, from E.M.S. charting across the state for, you know, whatever we might need to supplement, you know, projects with the subcommittees or supplement any grant work I might need to do.

Also, they would help me with the surveys, so we most recently -- and I'll give a short report on this in a short bit. The N.P.R.P., so that's the hospital-based survey, they would help me with that, they would also help me with the E.M.S. survey, which is coming up in January.

So every year, I have to go through and update all that information, make sure it gets out, have contacted those people, periodically make phone calls if the survey is not completed correctly. So it's not just, you know, an email blast, it does involve quite a bit of work to get that completed.

So it is a part-time position just because, you know, it's not just the salary that we have to pay. And as you are all aware, the grants is not that large and must support many things and, you know, my desire is that, yes, we need staff, but we also need to have money for programmatic work.

DR. VAN DER JAGT: Amy, this is Dr.

van der Jagt, ... going back -- going back to that section -- intersection, is the part-time position going to be filled completely with the -- the tasks that you have to do with the grant, or will there be some of that part-time position that could be devoted to something new -- new data collection, whatever we decide at some point, you know.

So that's kind of important because otherwise it's -- it's helping you, but it -- if we wanted to do something, in addition, then does that not part of it?

MS. EISENHAUER: Part -- part of their role would be to pull data and information for projects that we are working on across the grant. So for example, if we needed data for the pediatric agitation subcommittee, in the subcommittee we would decide what kind of data we're looking for.

And then they would go in and pull all of that, and they'll report for us. So both.

MR. COOPER: Okay. Amy, anything else from you, or is that the --

MS. EISENHAUER: That is the end of my report unless there are other questions.

MR. COOPER: Well, hearing none. Thank you so much. So I think our next item on the

agenda is to hear from our pediatric education subcommittee.

MS. EISENHAUER: So Dr. Havens, and I believe also Dr. Vera Feuer are going to share the work of the pediatric agitation subcommittee with us.

MR. COOPER: Great. Dr. Havens, Dr. Feuer, please take it away.

DR. HAVENS: Thank you. Good afternoon, everyone. Sorry to see you in boxes instead of in person. So we've -- our subcommittee has been working on developing some standardization in how we approach the management of agitation in kids and adolescents.

And we are adapting -- working on an adapting a consensus guideline that was done by the emergency psychiatry, child psychiatry committee at the American Academy of Child Analysis Psychiatry. There are consensus guidelines for the management of agitation in adults, but there were none that had been published in kids.

So Ruth Gerson and colleagues did the systematic reviews they needed to do and put together a set of guidelines that we think would be useful, particularly if simplified to the E.M.S. committee. And the guidelines do a couple of really important

things, and I'll speak globally and then let my colleague Dr. Vera Feuer talk more about this.

One, is they --

MR. COOPER: Dr. Havens, can you speak a little bit more loudly, please? Can't quite hear you.

DR. HAVENS: I'm sorry. Okay. I'm sorry. How's that?

MR. COOPER: A little better, thank you.

DR. HAVENS: Okay. So the guidelines do a couple of things. One, they really emphasize trying to understand the etiology of the agitation, because that drives the choices that you make, particularly when it comes to medication management.

And the second large portion of the -- of the pathway is really about how to verbally de-escalate effectively, and how to address needs that may be agitating kids that you can help with, so that you don't need to medicate the kids. And I'll ask my colleague Vera, who has been very busy in implementing these in her institution at the Northwell System in New York to talk a little further about this.

DR. FEUER: Thanks, Dr. Havens. So

yes, the guidelines have been published a few years ago, and they really are for the management of acute agitation in any medical setting. I think the biggest adjustment that will be necessary, and we had discussed this and are currently convening a group to review the guidelines to adjust it to the prehospital setting, given that the medications that are on this guideline, many of them are not available on the E.M.S. trucks, so we are working on adapting that piece.

But like Dr. Havens mentioned, the guidelines really help us by reminding people about what are the different mean etiologic groups that drive agitation in kids and how to approach each, including what are some red flags for other issues that might be going on with them, such as in delirium, to how to manage an autistic kid and how that's different from managing, you know, another child with a behavioral out -- behavioral outburst.

So the committee thought that the two most helpful things that might guide and standardized treatment in the prehospital setting is adapting these guidelines and adopting them for use by the prehospital teams.

And also we are working with the

national group to develop verbal de-escalation education materials, because verbal de-escalation is one of those things that is very difficult to teach. So we thought using standardized patients and educational videos might be a good way to approach some education around that, and that would be the other recommendation from -- from the subcommittee.

So I think our formal recommendations are forthcoming, but we wanted to bring to you as a general discussion that the -- these are the guidelines that we're looking to adopt and adapt.

DR. HAVENS: And just one -- one last thing that we've discussed, which we want to think through, but also present to you is, how do we -- how do we train our prehospital staff to really work with the majority of the kids that we see in -- in behaviorally agitated states are not actually delirious or intoxicated, most of them are traumatized.

And -- and that's when verbal de-escalation can be extremely useful. So what do we need to do to prepare people in the field to conceptualize that properly, and to actual -- actually have the technical and linguistic skills to de-escalate those kids safely. So we're also

thinking about it, so a trauma informed approach to agitated kids.

MR. COOPER: Thank you, Dr. Havens and Dr. Feuer. I have just a quick question and a comment and -- and then we'll open it up to others. The question is, when do you think we can expect a first draft of the -- of the prehospital guidelines to be ready for distribution among the committee members?

The comment is, it seems to me that given the fact that we do the vital signs conference every year, and the fact that -- that we were able, you know, to hold sessions that are perhaps a little bit longer and more in person than -- than the things we can do over the -- over the internet. I'm wondering if maybe for not this year, of course, because we're too -- we're too short, but maybe next year we could think about to doing a session at the Vital Signs Conference on, you know, de-escalation sedation, maybe with some role plays, that could be videotaped and made available through the, you know, the -- the methods on our disposal via the Bureau for others to view even if they can't attend Vital Signs.

So if ... in your response to the question and the suggestion. Thank you.

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DR. FEUER: Yeah, thank you. I mean, I guess I can start and Jenny can weigh in, but as far as the first question, so we drafted the first version of it, we're vetting it with the group that had created the initial guidelines.

We do want to include, and I'll be working with Amy, some folks from, you know, medical leadership from prehospital providers -- prehospital adaptations did as well. But I'm hoping within the next month or so, we can finalize it, because it should be fairly straightforward.

And then as far as the second part, you know, I -- I do think that's a great idea. I think, you know, simulations and using simulations is a great way to educate and teach. And the videos are a great way to educate and teach.

So I think, you know, I'm happy to figure out a way that we can help with that. We do use simulations at our institution to teach verbal de-escalation to our staff. So certainly, I think doing that is very worthy, and then distributing the videos later for those who cannot attend, I think is a great idea.

And I don't know, Dr. Cooper, if you missed it, I said for the first question, probably

within the next month or so, I'm hoping they'll have the draft available for review.

MR. COOPER: That would be great.

Amy, when is our next meeting? December, right?

MS. EISENHAUER: Probably January.

MR. COOPER: January, okay. All right. Cool. All right. So if you guys could have it for us by then, maybe a month before so people have a chance to review it that would be spectacular.

Any other questions or comments for Drs. Havens and Feuer?

MR. PHILIPPY: Dr. Cooper, it's Mark Philippy, if I may?

MR. COOPER: Sure.

MR. PHILIPPY: So good afternoon, folks. Doctors, locally in particular where I work, but I think a growing movement within the state has been the use of mobile mental health and behavioral health teams in the community, particularly where I work in the area of Rochester, there are a number of -- number of mobile teams that we interact with on a fairly regular basis.

And they all have different bases, some are hospital based, some are community based, government supported and otherwise. It seems to me

that there may be some opportunities here to examine as well in this discussion, since they're often the first on scene but interact directly with our E.M.S. responders, has there been any discussion with any of the -- the either state or national groups that might represent those interests, and how we -- how do we integrate those as well?

DR. HAVENS: That's a great idea, Mark. Yeah, that -- the -- I don't know that it's run through a state mechanism, I think that's county. I think the mobile crisis programs are usually driven through the county mental health, you know, authorities, but that's a really interesting idea to have --

DR. FEUER: Right?

DR. HAVENS: Yeah, that's what I mean, but the money -- that -- there's lots of different models, but the one I'm most familiar with in New York is O.M.H. money coming to --

DR. FEUER: Uh-huh.

DR. HAVENS: -- New York City D.M.H. So but they -- they, you know, hopefully, those are usually clinical teams, so they have some more backgrounds hopefully in managing agitated kids then, you know, the run of the mill person would.

But I actually think everybody could really use a good sense of what you're dealing with when you're dealing with like, an angry, hurt, you know, kid and -- and we've done a lot of work in our system with trauma informed care, both in hospitals and in the juvenile detention centers, just educating the adults, you know, about how to understand the kids' problems, and how to talk to the kids when they're in those states.

So I think that's probably useful for everybody who runs into a crisis with a child. That would require -- Amy, that would require some coordination with O.M.H., I would think, and maybe down to the county level. But even if -- even if we piloted it in a place -- a smaller -- smaller place than New York, like Rochester, where we had some involvement of -- of those folks also would be very interesting.

MR. COOPER: Amy, do you think we can potentially, you know, reach out to O.M.H. and -- and see if it's a possibility of opening up a dialogue?

MS. EISENHAUER: Yes. I already have some contacts at O.M.H. The beginning of the subcommittee was at -- at this point, because it -- it has only been a few months, and we have only had a

few meetings, was to figure out what E.M.S. and even E.D.s might need.

And so we were starting there, and I think that the next step after -- after the algorithm and the -- the suggestions are completed, would be obviously to share it among our committee. But then also to work with C.M.S. and ... and then other stakeholders, whether it be at the state level, or whether it be more locally at the county level, which probably would be where Mark is referring to where E.M.S. providers and clinicians that are out in the field would meet and work together. So definitely part of the larger plan.

MR. COOPER: Great, thank you. Any other questions for Drs. Havens and Feuer?

DR. HAVENS: I just -- Dr. Cooper, I just wanted to tell everyone that New York City is -- has been rolling out this model through Health and Hospitals, the public hospital system where it's called BeHeard. These are behavioral health response teams that are triaged through nine one one, and they are putting together E.M.S. folk and a social worker from H&H and F.D.N.Y. to respond to behavioral -- what our behavioral health calls instead of sending the police to them. So it's

actually going very well, and we -- they've had some really good situations where they were able to help people, but it's an in --interesting model.

MR. COOPER: Great, thank you. Other questions or comments?

DR. VAN DER JAGT: So Dr. Cooper, this is Elise van der Jagt again. Just to piggyback on what Amy was saying. I think our -- in that committee a question really came up in this draft suggestions were that once the model is determined, that beta model, that we need to sort of -- we need to not sort of, we need to look at our collaborative protocols or A.L.S. protocols or B.L.S. protocols to see what portion of that needs to be included in that as an enhancement of what we currently have.

And then secondly, that we had also discussed spreading that out to emergency departments around the region, since those are the two areas that are going to be, you know, working together usually. E.M.S. ... kids in, E.D.s receiving.

But the idea would be is even things like, you know, could it be a laminated card, this is what you do when you get a person who was partially being controlled with a behavioral approaches, communication approaches in the outside.

But then how is that continued in a continuity fashion within the emergency department. So that needs to be maybe probably -- probably formalized once that's determined how that is to be done.

MR. COOPER: Good point. And -- and after we have a chance to review the -- the documents in -- in our next meeting, perhaps the -- the next set would be to involve our colleagues from ... in the discussion, and as you say, Elise move towards incorporation of any and all of the -- of the material into the collaborative protocol. Great suggestion and follow on. Thank you so much.

MR. COOPER: Any other comments or questions for Dr. Havens or Feuer? Okay. Well, thank you very much. Then, we will now move on to the next item on the agenda, which is pediatric sepsis subcommittee report. I think we have someone from the sepsis group with us today.

MS. EISENHAUER: That would be Dr. van der Jagt.

MR. COOPER: Isn't -- I thought I saw --

MS. EISENHAUER: This is for the subcommittee report. There is somebody from the

Sepsis Alliance who's going to give us a report --

MR. COOPER: Yeah.

MS. EISENHAUER: -- from -- from their group later in the meeting.

MR. COOPER: Oh, okay. I see. Okay. I think that's what we intended by the pediatric sepsis report, Amy, so I don't know that we have anything further at this time. There has been some turnover in the office of quality and patient safety, as we know. But I'm -- I'm happy to hear that we have a report from Mr. Stathidis. Am I saying your name correctly, sir?

MS. EISENHAUER: So --

MR. COOPER: A little bit later on?

MS. EISENHAUER: Yes.

MR. STATHIDIS: Yes. It is George Stathidis. Yeah. That's -- that's correct.

MS. EISENHAUER: Yeah. So –

MR. COOPER: Stathidis. Thank you -- thank you. Yeah. Go ahead, Amy.

MS. EISENHAUER: So the report right now is from the pediatric sepsis subcommittee from our group -- from our -- that -- that we've been having meetings. So that would be Dr. van der Jagt. And then, the Sepsis Alliance is going to be with our

sister -- our sister team, and that'll be later in the meeting. So we're going to have two report.

MR. COOPER: Okay. Okay, very good. Thank you.

MS. EISENHAUER: Yeah.

DR. VAN DER JAGT: All right. So then I can --

MR. COOPER: Ready?

DR. VAN DER JAGT: yeah, that's fine. Can you hear me?

MR. COOPER: Yes.

MS. EISENHAUER: Yeah.

DR. VAN DER JAGT: Yeah. Okay. And so I just learned from Amy that there is a very long process to approve PowerPoints, like eight layers, I think she said I think, and it wasn't -- or eight weeks ahead of time or five weeks ahead of time. And it wasn't quite ready. But I will talk from some slides that I've made for this. And at some point of this, we'll also look at the algorithms. The -- the advant -- the collaborative protocols.

So this is then a report from the sepsis subcommittee. If you, as you looked at the minutes from the -- the April meeting, you will recognize that we had -- there was a committee

appointed. The members of that committee were Bruce Barry, Dr. Conway. Amy was not as a staff person, Pam -- Dr. Feuer was on there. Joseph -- Joe Pataki and myself, and Dr. Feuer and myself are co-chairs of that committee. We have met, I believe, at least two times. And I'm giving you some report on some of our thinking of that.

The charge from the April meeting was looking back at that was just to review the current New York State basic and advanced pediatric sepsis algorithm, and then to suggest some updates consistent with the new 2020 pediatric sepsis recommendations. And then also to consider on edu -- the educational needs that might be necessary for especially the prehospital care providers. That's as near as I come to sort of what our charge was.

I have to admit that I think the first meeting we had, we weren't -- we couldn't quite remember what our charge was. And so we -- we did talk a little bit a number of things. But this is really what we were supposed to do. The -- we then started really talking about -- a little bit about data. And this is a little bit, Amy, about what you said a data person, this is what I was thinking about, you know, what is the scope of the problem?

Do we spend a lot of effort on this particular entity?

And we actually talked about a few data search -- sources. One was the prehospital care record, the E.M.S. record, and it was actually Joe Pataki. He looked at that nine eleven linked P.C.R.s in New York City to see whether we could identify the numbers of patients that might come in with septic shock, or, at least, organ dysfunction associated with sepsis.

He gave that a first go, and it was just really quite difficult because the things that are noted on the P.C.R.s are very general. For example, fever, respiratory rate, heart rate. Well, it can really be many, many different things, and so that makes it very difficult to perhaps use the P.C.R.s. and there may be missing data. So that was, we thought, maybe, that isn't the best way to go in terms of looking at the scope of the problem.

The second as -- way of looking at this was we thought through, was should we go to the New York State substance registry. That would identify septic shock cases in pediatrics, and also on what's now called organ dysfunction associated with sepsis. That is a database. It would probably

be a better option. But of course, you would have to look backwards to see if what -- how many of those patients began in the E.M.S. world.

Either way, it would need to be some data mining to see what that is and whether -- whether the question is really, do we need that data to move forward? And -- or should we approach the New York State sepsis group that they could release some of that data to us because it already is being collected.

Let me just print -- print out the whole thing. And then maybe we could open it up for questions just like the previous committee report. We then, as a group, thought it would probably be best to focus on prehospital care algorithms as we had briefly said at the April meeting, and to remember that E.M.S.C. deals with preventive, we're not going to go into prevention of sepsis.

E.D. care, in-patient care in general form, PICU care, and then rehab or follow-up from patients who had sepsis. But we felt that prehospital care, E.M.S. providers not only in particular, and then focus on E.D. care would be the best way to go with that. That just really brought us back to the algorithms.

And then looking at the algorithms, as -- as many of you know, we spent a lot of time over the last few -- number of years to develop pediatric components of both the basic life support and the advanced life support algorithms. I then looked through them, because that was where we sort of left at the last time, looked through them to see if there are any suggestive changes, and I think there are some that would be suggested.

And I can share that protocol or unless you want to do that, Amy. I know you have them as well. If you could put up the pediatric sepsis shock hypoperfusion algorithm from the collaborative protocols, that would be great. Tell me when it's up there because I can't -- not sure that I can see.

MR. GREENBERG: We're just pulling that up right now. Just give us one sec.

DR. VAN DER JAGT: Okay, that's fine. Oh, there it is. Good. Okay. So -- so again, this is -- these are just some suggestions that certainly -- these are my personal suggestions because we had not gotten to the point of vetting this all in the committee, so there may be other ideas.

So this, if you could get us to where

we are, scroll up just a little bit, Amy, if you wouldn't mind. So that you can see that this is -- this is really related to pediatrics. There is a separate one for adults. So at the top above the word criteria, it says, "shock, sepsis shock, hypoperfusion pediatric."

So there's a couple of things there. So for example -- there. Thank you very much. But so the -- some of them is -- are just terminology. So the terminology are things -- I'm sorry. This is not the pediatric one. It's the next one. There you go. Perfect -- perfect.

One thing was to -- we are really looking at patients who have sepsis associated with organ dysfunction. And so there probably needs to be some recognition of that that sepsis should probably be changed to sepsis with organ dysfunction. And then, it probably also needs to be put in there, I think in big capital letters, add septic shock before that second, like bullet point before poor perfusion, so it really stands out that this is really what we're looking at is cardiovascular organ dysfunction, septic shock, which are the -- is the situation where kids will likely require fluids in particular, at very -- very rapid transition to a -- a facility

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outside of that. Same thing with, as you move down here where it says A.B.C.s and vital signs under C.F.R. and all provider levels, is to bold blood pressure.

And then again, these are just formatting things, advise the destination that the patient may have the organ dysfunction with septic shock and immediately need to advise the destination hospital for that. More importantly is at the very end of this under paramedic, you have to remember that the 2020 recommendations are now recommending buffered solutions, and they are recommending ten to twenty milliliters per kilogram of -- of a fluid bolus. So that is a -- a formal recommendation and that is somewhat different. Whether or not that is feasible is another whole question, because although L.R. is typically recommended, certainly in E.D.s now, whether or not that is feasible on the outside is -- is another question, but certainly the amount to be given per kilogram.

I've also suggested -- keep going, if you wouldn't mind, Amy. On the next section of this, there are some -- if you go -- yeah, a little bit further. Thank you. If you see there -- there is nothing mentioned about length base tape determined

weights, that would be an important consideration, I think, in this especially since we're talking about liters per kilogram. And that would be an additional bullet point. I also think that the cardiogenic shock that is in that first bullet point under key points, we're really talking about septic shock primarily. And either way, a septic shock or cardiogenic shock, cardiogenic is often a part of septic shock, but septic shock is what we're looking at, there needs to be a consultation with medical control.

And then the blood pressure aspect of this, in this particular section, I think it seems a little bit cumbersome. To me, I'm also not an agreement with some of the blood pressure, so that for example, the blood pressure less than seventy for two years and older is certainly not what PALS teaches.

But we're talking about less than seventy for one year, below one year of age. And then, this less than sixty -- or less than two years of age, that is not what's recommended. It's usually less than -- than a month. And then, you have that whole section below that on hypotension. So this whole area of blood pressure, I think, needs to be

corrected a little bit. But I know that Dr. Feuer had some thoughts about that as well.

So -- so anyway, so this is a -- beginning to look at the -- the algorithm more in detail. And the committee, I think has to come up with some very specific recommendations to -- to change something in these collaborative protocols. And I know that's an entire process that -- for that to be changed. So we have to be careful that it's not just a word format. We have to have content, I think is most important.

And then lastly that we were going to explore, we have spent a fair amount of time talking about this is what about the educational component of this. Just like in the previous committee discussion about agitation on what to do with that for children, it's also a question of what actually is being taught in -- for E.M.T.s, all the way from basic E.M.T.s for first responders, all the way to paramedics. What is being taught about septic shock in children? How to identify it? And how to rapidly get those patients to definitive care? So that we had not addressed. And Charlie, we did discuss a bit like in vital signs, a conference kind of thing, that we could develop a module for that. That would be helpful.

But I think we have a little bit more exploration to do, what's feasible, and what has more a long-term impact. And that's the end of my report. We have some more work to do. I am happy to have others from the committee talk about this as well.

MR. COOPER: Thank you, Elise. Any questions for Elise or Dr. Pamela Feuer?

DR. FEUER: No, just to --.

MS. CHIUMENTO: Hi.

DR. FEUER: Go ahead.

MR. COOPER: Sharon, go on.

DR. FEUER: Go ahead.

MS. CHIUMENTO: Okay. Yeah. Just -- this is Sharon Chiumento. Just a couple of comments. One thing was that ... is not carried by, I don't know if any of the E.M.S. agencies. But most E.M.S. agencies only carry normal sailing. So that might be something that, you know, if you do believe that that is necessary, that -- that would need to be looked at further.

And the other thing is that, it's interesting when you looked at the blood pressure criteria. It was correct down below where it had the table, but it was incorrect in that one line. So I think there was just something that was out of sync

between those two areas on that same page.

DR. VAN DER JAGT: And I'd agree with that, Sharon. It seems to be a little bit of a contradiction or it wasn't consistent at least, yeah.

MR. COOPER: Are there -- Pamela, did you want to speak?

DR. FEUER: Yes. Hi, Dr. Pamela Feuer. So first of all, Sharon, I agree with you that if normal sailing is the only thing available, we don't have to rock the boat for prehospital care. I think that's very re -- reasonable to go with that. But the surviving sepsis campaign and the new pediatric algorithms are meant to simplify fluid and vasoactive management for children looking at a broad range of facilities, so this was meant to be an international support.

And there are those places without pediatric intensive care or airway management, you know, which makes me think of the more prehospital setting or the rural setting in New York. And then, of course, hospitals with, you know, full service, pediatric I.C.U. capabilities.

And regarding the whole blood pressure tables, the surviving sepsis campaign really means to simplify this by describing hypotension with three

criteria only. For blood pressure less than fifty for children under twelve months, less than sixty for one to five years, and less than seventy, systolic for over five years.

I mean, knowing and even in the B.L.S. protocol that we have, the algorithms, that sometimes blood pressure is very difficult to get. So if that's not available they say, or define hypotension, you know, and septic shock -- or septic shock with hypotension as the presence of three World Health -- or three World Health Organization criteria.

Cold extremities, prolonged capillary refill greater than three seconds, and weakened fast pulse. And I think those are things that are, you know, already looked at, in the things. And I'm wondering if we could kind of mesh those things to simplify what the prehospital care is. And it's all in diagnosing septic shock.

And the other thing is the notification to the destination hospital or the dispatch is using the terms, I have septic shock and hypotension, you know, and -- and maybe then the direction that the patient goes can be determined. So those were my comments of that. But that -- that does -- that would take a big overhaul of these

algorithms.

DR. VAN DER JAGT: Dr. Feuer, if I could also comment on that? The -- actually, in the algorithm for the surviving sepsis, those parameters of blood pressure are specifically mentioned to be used in limited resource settings, not in settings where I.C.U. levels could be -- could be gone to.

DR. FEUER: Right.

DR. VAN DER JAGT: So I think then the -- so that'd be like, you know, you're in the middle of Africa somewhere and you're in a mud hut village, you are not going to give an extra amount of fluid because, you know, you don't have any resources. So -- so I guess maybe the question would be, is -- if in New York State we are in rural areas, let's say, are we going to consider that a limited resource setting, which typically we have not, versus, do we -- do we say that these are really, you know, not in the -- New York State doesn't have those kinds of settings, like maybe you're in the North Country, and you're, you know, you're totally away from things. So I think the context of the surviving sepsis algorithm, which is also was endorsed by F.C.C.M., you know, is to be very carefully interpreted. How do we do that, because less than fifty, for example,

is pretty low in our usual standards here in the United States.

And so that's the only rejoinder, I would say, to the -- to those comments. I -- it confused me, to be honest, initially, when I first saw it because it's -- it doesn't immediately come to mind that these are for limited resource settings. But I think they -- they currently are so --

DR. FEUER: But I do -- I mean I -- that -- I agree with that. But I also know how difficult it is to get pediatric blood pressures.

DR. VAN DER JAGT: Right.

DR. FEUER: For many --

DR. VAN DER JAGT: Right.

DR. FEUER: -- for many children.

DR. VAN DER JAGT: Right.

DR. FEUER: And -- and so I've seen it happen even in hospital, you know, that -- that folks have a hard time getting it. So, you know, our goal is to get people to determine if there's organ dysfunction, you know, hypoperfusion, and then to at least start the fluid boluses, ten to twenty, you know, per kilo. So I think getting caught up in all the numbers is -- is -- can be problematic in the tables.

DR. VAN DER JAGT: And one of the things that I remember, this is now years ago, and I know that Dr. Cooper probably will remember, Dr. Kepes (phonetic spelling) from -- my goodness, probably the eighties and nineties, he was a trauma surgeon. From him, he designed the pediatric trauma score. And in the blood pressure criteria for that is, he had some criteria on palpation of pulses distally correlating with certain levels of systolic blood pressure. And I can certainly pull that out, but I think that is something that we probably should maybe consider because blood pressures are so difficult to attain in the field. And some places don't even have the right cuffs. So we have a -- a dilemma, but probably something we should discuss as a committee to see where we come with this, so that we can bring you a recommendation, Dr. Cooper, for the committee to consider how we might change it. The blood pressure issue is a huge difficult area, but we do have to address it somehow.

MR. COOPER: Yeah. Clearly, I think your group needs to come back to the committee with a more formal recommendation. You're taking time to share your thought process this afternoon. I think it's been very helpful, but I think at this point, as

you point out, you know, Elise and Pamela, we -- we are ready, I think to put together a more formal recommendation and -- and start to move it through the -- the process.

Elise, I'm sure you know that Dr. Cushman in Rochester is deeply involved with the collaborative protocols and --

DR. VAN DER JAGT: Right.

MR. COOPER: -- certainly getting it by and locally, you know, for the changes will be not only doubtful, but absolutely necessary to move these, you know, without particular difficulties with SEMAC. So let's plan on, Jane, if we can have something for the, you know, for the January meeting. And the meantime, is there -- are there any other questions or comments for Drs. Van Der Jagt and Feuer? That would be Pamela Feuer as opposed to ... Feuer. Now, I didn't know there was another Dr. Feuer, but there is.

DR. PAMELA FEUER: And -- And we're both at Northwell, so --

MR. COOPER: Well, hearing no other comments. You know, let's move on to the next issue, which is the National Pediatric Readiness Project survey update. And I think that one's from Amy.

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MS. EISENHAUER: So quickly, in the chat, we had come to a consensus that for some continuity, we would have George give his report from the sepsis initiative. So that kind of we're -- we're in the same -- same mindset instead of chopping things up. So we'll let him jump in here. And then after that, I'll give the pediatric readiness report. So George, if you'd like to give your report now?

MR. STATHIDIS: Yes, thank you. Just checking, can you hear me?

MS. EISENHAUER: We can hear you.

MR. STATHIDIS: Wonderful. Great. Thank you again, for having me today. So I'm George Stathidis. I am a quality initiatives manager in the Office of Quality and Patient Safety. And one of the programs that we administer in my office in the Sepsis Care Improvement Initiatives. So I'll just start, we've been collecting data in the Sepsis Care Improvement Initiatives since 2014.

At the start of the pandemic back in, say about February 2020, we became aware of several direct -- or several quality and nurse abstractors and other abstractors that were being used to abstract clinical census data as part of the Sepsis Care Improvement Initiative being pulled to direct

care to care for patients during the pandemic. And so, as a result of that, we decided to pause our data collection for -- for sepsis. And so during the -- the pause that we -- that we initiated there, we decided that we needed to do our best to recognize what was going on with sepsis and COVID. And we realized that there is -- there is some clinical overlap between severe sepsis and severe COVID-19.

And because of that overlap, we decided that we needed to rethink our reporting. And so we decided that we needed to move away from a manual data abstraction which, again, was highlighted by the fact of people being pulled to direct care who were doing manual abstraction. And -- and we really wanted to do our best to -- to be able to update our data collection, and -- and focus on not only sepsis, but the -- the COVID-19 cases that also had clinical overlap with severe sepsis and septic shock. And so that led us to doing a -- an electronic data abstraction data dictionary. And so we have currently, in process of collecting adult severe sepsis, septic shock and severe COVID-19 cases, we actually are closing our data collection portal next week. It will be our second data collection period

that we have completed for the adults. And pediatric data collection actually will begin in January of 2022. For the pediatric population, we're going to be collecting severe sepsis, septic shock, also COVID-19, and MIS-C cases.

And we're going to be collecting those cases going all the way back to 2020. So that will be a retroactive data collection, at least for the first reporting period. Again, our intent is to eliminate the need for manual chart abstraction, to allow hospitals to use their I.T. systems to abstract the necessary data.

And they're still going to be submitting their data through the IPRO portal, which is something that they've always done, hospitals have always done. Really, our goal is to collect structured data of COVID-19 cases, and to really try to identify those best -- best practices in terms of care and treatment for sepsis and for COVID-19 where there is that overlap.

And then, also to be able to separate COVID-19 from sepsis data, so that when we do go and look at our data, we know exactly what we're looking at here. So currently, as I said, adult -- adult data has been submitted already.

We actually do not have the summary statistics available for the adult data collection yet, but we are working on doing that for adult. And we hope that adult -- and we hope that by the time pediatric data collection begins, we'll have that information readily available. And -- and be able to come back at a future date to this committee and give an update.

And what I can tell you is that we've been working with our Pediatric Sepsis Advisory Committee, which I know some of you participate on, to really kind of determine what changes we needed to make to our data dictionary. As we're moving away from manual abstraction, we are working towards collecting data based on I.C.D. codes and diagnosis codes, and really have -- have changed the way we're collecting data, but hope to not lose the detail of the data that we've collected in the past.

And so I'll just give you some of the inclusion criteria here for the pediatric population. One of the changes that we've made is the age at the time of admission for pediatric popular -- pediatric patients. It used to be eighteen and older, but we've now actually updated it to be twenty-one and older at the time of admission.

The inclusion also requires that -- that patients were admitted in the inpatient. In other words, that they are not just seeing as E.D. or observation. And our inclusion criteria also requires a diagnosis of severe sepsis, septic shock, COVID-19, or MIS-C. And that's all based on I.C.D. ten codes.

And for COVID-19, it's for all COVID-19 patients that are admitted to the hospital. And there's no severity indicator needed for pediatric collection, which does differ from our adult data collection.

For adult data collection, there is a requirement that -- that the patient comes in with COVID-19 as well as an organ dysfunction. And that is not something that we're -- that we are requiring for pediatric population.

So with -- with those changes, we do expect to see many more cases, of course, come into our portal here than in the past.

We do have some new variables that we're -- that we're collecting. And I don't think that we have time to go through every single variable, but we are -- I'll give you a few here that we're collecting, including Kawasaki, cystic fibrosh

-- cystic fibrosis, adrenal gland disorder, and congenital heart defects.

In addition, we're collecting patient information with, you know, standard demographic information, information on admission and discharge which includes, you know, dates of admission and discharge and outcomes as well. In addition to transfer information, transferred in, transferred out from facilities.

We're also looking for present on admission information. And that's for comorbidities that are identified at the time of or before arrival to the hospital. And again, these are defined by I.C.D. ten codes. I should say that we've provided I.C.D. ten codes in a -- a large appendix in a C.S.D. file, kind of like a spreadsheet for all the I.C.D. ten codes that -- that -- that hospitals should submit to the department.

And -- and for these present on admission, it's a yes or no whether or not these -- the comorbidities are present on admission. So the idea is if an I.C.D. ten code is in the hospital E.H.R., that will be flagged as a yes, and if not, that will not be reported to the department.

So again, we're looking for a COVID-19

virus positive and whether actually patient comes in has been exposed. We are also looking for that exposure COVID-19. Also looking for infection with resistance to antimicrobial drug, whether or not the patient is flu positive. And information on suspected source of infection. All of this again, based on I.C.D. ten codes.

Some of the treatment variables that we will be collecting as well include ... anticoagulation medications, dialysis, mechanical ventilation, high flow nasal cannula, non-invasive positive pressure ventilation. At the time we started putting the dictionary together Remdesiver ... was also one of the few available treatments.

So, you know, we'll -- we'll likely be updating these treatments at a time progressive. These are specific to the COVID-19 treatment, of course, and also include things like ECMO, vasopressors, I -- I.B.A.G., ... -- I meant treatment with immune modifying medications during hospitalization. We're also collecting outcomes at hospitals during hospitalization and at discharge, including cardiovascular outcomes, myocarditis secondary to COVID-19, ischemic stroke and acute coronary syndrome.

During hospitalization, we're also looking for I.C.U., and for P.E.D.V.T. for outcome, but we're also looking for those cardiovascular outcomes, the -- also looking for dialysis, mechanical ventilation and neurological outcomes.

So importantly, also looking for severity variables to make sure that we're adequately reflecting the health status of the patient. And also to help with improve risk adjustment for patients. So, you know, this includes lab values and I.C.D. ten C.M. definitions. And we're also collecting service variables.

In terms of severity variables, we're also collecting organ dysfunction. And there are, you know, we're looking at central nervous system -- system, hematologic, hepatic, renal, respiratory and cardiovascular severity variables here that we're collecting. And again, all of these are defined by I.C.D. ten codes and are submitted through the portal, through IPRO.

And again, just -- just talking about when we will have data on this new data set, we -- we hope to have data from the time period of -- it's actually from December 1st, 2020 through the end of this year, beginning collection in January of 2022.

And we hope to have some data available back to hospitals, which is the first place the -- the data goes in early 2022 for pediatric population and -- and for adults, as well, as we move through this.

And so I know there was a -- a mention earlier. I just wanted to let everyone know that we do have data currently available. This would be from the -- the prior naval ... abstraction process. That data is currently available up through the end of 2019. And I think, you know, we -- we do have a process set up where that data can be requested, and we'd be happy to, you know, talk about any data that we have that's available, and happy to collaborate on any, I think getting any of that data that's available, you know, to you through that process. So happy to talk about any of the -- any of the material I just went through or any other questions that -- that anyone has?

MR. COOPER: Thank you so much, George. Do we have any questions or comments for George? It was a lot of information. George, in future, just F.Y.I., what we've done in the past is we've had the opportunity to be briefed on the most recent updates in the, you know, from the office of quality and patient safety in terms of the, you know,

the reports that are forthcoming from the -- the sepsis registry.

And I hope that in the future, we'll be able to continue that. I realize that that requires, you know, getting the slides to Amy sometime before the meeting so they can be vetted, even though they've already been vetted, obviously, by the department if you're presenting publicly.

But -- but, you know, our -- not all of our -- of our group is intimately involved with the such initiative ... as others. And -- and those updates, I think have been pretty helpful for -- for the group, you know, as a whole.

So if going forward you're going to be with us to present the data, it would be great if we could, you know, have a -- you know, the latest and greatest updates from, you know, from that -- from your division as we've done in the past. Any other questions?

MS. EISENHAUER: Hey, Dr. Cooper, I just -- this Amy Eisenhauer. I just wanted to jump in on that. George did have slides. But again, it does take some time. So just for everybody's understanding, really quickly, I developed the agenda eight to six weeks out. At six weeks out, I need to

have all the slide decks or any other documents that are going to be presented in a meeting, so that all of that can go through approval through our executive deputy clearance. So as Dr. van der Jagt had mentioned that it's several layers above me. And honestly, I just got this agenda that I put in about five weeks ago approved last night.

So for -- for reference, if there -- yes. I see your face, Dr. Albert. Yes. So -- so just for future reference for anybody, if you do have things that you want to share, and we do want you to share, I do need to have that at least six weeks in advance so that I can prepare it. I can prepare the associated document. And I can obtain the signatures and approvals that I need from well above me.

So just as reference for everybody, George, did have slides, but I had to tell him, no. Because they did not go in with the packet. And then just a question for George from Dr. Pamela Feuer, who is your medical director?

MR. STATHIDIS: The medical director in the Office of Quality and Patient Safety, is that the question? Just want to make sure. We -- we currently have two medical directors in the Office of Quality and Patient Safety; Dr. ... and Dr. Linda

Efferen. And I just want to get back to Dr. Cooper. Yes, Dr. Cooper, I would be very happy to present in the future and come back with any data we have, any reports that we have, we'd be delighted to do that. And, you know, we'll definitely hope to get in touch with Amy a little bit sooner to be sure we have slides as well for a future presentation.

MR. COOPER: I believe -- I believe Dr. Efferen is on -- is on the call. Dr. Efferen, do you have any -- anything to add to what's been said so far?

DR. EFFEREN: No. I -- I think George distilled an enormously complex project into a very compact though complex presentation. I think the only other caveat I would add is, as we were reviewing and looking to the future, there is a shift in what we will be reporting. We moved away from what our work traditionally or originally process measures, and really now are taking a more commonly adopted approach to looking at outcome measures.

But we're very encouraged, hospitals have been very actively engaged in developing their ability to report, it's gone, knock on wood, remarkably well. And we look forward to sharing the old version of the data. But just to prepare you,

the new version will have different measures that we -- we're collecting.

MR. COOPER: Great. Thank you for that -- that additional insight. We'll look forward to at -- at some point in a more formal way of reviewing with -- with you and your team the differences between the old and the new. And -- and I know that will be very, very helpful for all of us. Any other questions or comments for George or Dr. Efferen?

DR. VAN DER JAGT: This is Dr. van der Jagt. I have a question that I think is a very important one, actually. As we are looking at the spectrum of care of pediatric patients, Dr. Feuer and I just had mentioned and talked a little bit about the pediatric sepsis piece of it. Would it be possible to put in the pediatric data dictionary a variable that says whether or not the patient is brought in by E.M.S.? Currently, that is not the case. So there is no linkage between the inpat -- E.D. and inpatients pediatric sepsis cases and the link to the outside. We want E.M.S. to really get these kids to the hospital very quickly, once they're identified there, and there is no linkage between the two.

So I would advocate that this is an opportunity for us to get that linkage by putting a variable in there. I just looked at the pediatric data dictionary that we have, and there's only -- there are only variables in there if the patient comes from another hospital. It is not a variable from an E.M.S. provider.

MR. STATHIDIS: Right. And -- and at this point in time, we do not have that in there, you are correct about that. And it's something that we can definitely take back and -- and explore. I -- I don't see why we would not be able to collect it. I think the only issue that --that we may have might -- might come from hospitals in terms of being able to grab that electronically. Though I do believe it's possible, and it's something that I think we'd all be willing to explore.

DR. VAN DER JAGT: We have been playing for decades of not being able to link these two areas of care. And I think this is an opportunity, sort of a test case, this is a specific syndrome that we're looking at, but I think drawing that E.M.S., important E.M.S. community into the -- into the care spectrum, I think, would be a -- a really excellent thing to do.

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MR. STATHIDIS: Thank you. And we will definitely take that back and look into it.

MR. COOPER: Yeah.

MR. STATHIDIS: Thank you.

MR. COOPER: Speaking -- speaking as the chair of the committee, I heartily endorse Dr. van der Jagt's suggestion. You know, it should not be terribly hard to collect that information. Most -- most hospital -- emergency department records include, in the initial triage note an indication as to when the patient was brought in by E.M.S. or by some other means. So that -- that information is almost always in the medical record. So I don't think it would be that hard to -- to, you know, to really gather that data. Thank you.

Any other questions for Mr. Stathidis or Dr. Eff -- Dr. Efferen? Okay, well, thank you all for very robust discussions on these issues, and I think now, Amy, I guess we can go to the survey update if -- if you're willing to do so. Thank you.

MS. EISENHAUER: Of course. So jumping back to the national readiness pediatrics assessment. So just for some reference, there are two surveys that E.M.S.C. at the federal level puts out. One of those is annually for E.M.S. agencies to

assess if they have a PEC at their agency. If they do pediatric specific scenarios training, how many calls a year do they have that include pediatric patients, et cetera.

And then there is also one -- and there is now some debate. Previously, it had been every three years, and now they're talking about every other year. And I think that E.M.S.C. and the E.I.I.C. and NEDARC who is the data informatics arm of -- of E.M.S.C. are still in discussions about that. Because the survey is a little bit unwieldy to do every year. But they do want to collect more often than every three years had -- had been the practice in the past.

So the survey just occurred starting in May, and they extended it out, it ended July 31st. So what they do is they send out several letters, and emails to whoever the pediatric contact is at the hospital, and it goes to all the E.R.s. So we have a hundred and ninety-five currently on the list here in New York State.

And essentially, it assesses their pediatric readiness. So do they do training? Do they have a pediatric champion in the E.R. that handles those things? Do they have pediatric sized

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equipment, et cetera? And it is -- and -- and then also some -- some numbers. So earlier in the year when we -- when all of -- and so this is all the statewide partners, not just New York, but all fifty states, Puerto Rico, D.C., everybody, and I believe Guam, everybody was concerned about the ability to gain the eighty percent across the board, across all the state partnership, because of COVID, and the waves of -- of treating patients, et cetera. And I'm sure all of you are aware with staffing limitations and -- and such. And I know some of you are more acutely aware than others.

So that was across the nation that was a concern. They still decided to do the survey, because it had not been done in about three years. And across all the states and the territories and D.C., there was a seventy-one percent response rate. So they were looking for eighty percent, so the data can be quality data, and actually be looking at a number of responses.

But it was seventy-one percent and NEDARC just put that number out. They're still cleaning the data. So that will be available January or February. New York State, after -- after there were some difficulties with the survey and they had

to shut down the electronic portal, there were paper responses, so they have just finished loading all the paper responses in.

So for those of you at hospitals that have to do that unwieldy process and scanning and faxing, et cetera, after their team put all that information in, New York State was at thirty-eight percent. So thirty-eight percent of our hospitals during COVID did respond to the survey. So thank you to them. And if you are here, thank you very much.

So it was not a robust response, which is kind of what we expected. The smaller states or the states with less hospitals, obviously, typically did better, they fared better because less people to have to respond. The other larger states also had less robust response rates.

However, that said, I know that previously, Dr. Cooper, and probably many of you had worked on looking at this data and to do more work with it in the past. And the hope was that the data this time would be robust enough to continue that work with updated data.

NEDARC is working on -- and this again, would be January or February, after they finished cleaning this data and get the E.M.S. survey

that starts in January up. So just like with the PECS, if you have E.M.S. agencies that you work with, if you could encourage them to complete that survey when it comes to them, I would appreciate it because that's what people I have to call, and better data for us.

So NEDARC is putting up a tool, and it's typically for hospitals to be able to redo the assessment on their own to check their score, to see if their pediatric readiness score has improved, gotten worse, stayed the same, after they put some measures in. But NEDARC --

MR. COOPER: Amy, I think you're muted. Something happened.

MS. EISENHAUER: How about now?

MR. COOPER: Still can't hear.

UNIDENTIFIED MALE SPEAKER: ... Good on this end.

UNIDENTIFIED MALE SPEAKER: I can hear.

UNIDENTIFIED MALE SPEAKER: I can hear okay.

MS. EISENHAUER: It must be on your end.

UNIDENTIFIED MALE SPEAKER: I can

hear.

MR. COOPER: I can hear everybody else.

MS. EISENHAUER: Okay, how about now?

MR. COOPER: Yes, I can hear you now. Thank you.

MS. EISENHAUER: So NEDARC and, I don't want to use the word insinuated, but off the top of my head that's the word I have. NEDARC has insinuated that we could do our own statewide survey in between years of the official N.P.R.P. So that is another opportunity we may have in the future once things have slowed down and staffing is better and, you know, people, you know, have the time to sit down and accurately report on a survey of this kind.

MR. COOPER: Okay, well, some good news -- some -- well, some good news. Let's hope that we can, you know, pull some chestnuts out of the fire here the next few months and probably not a lot of say at this particular time. We'll wait for the final results from NEDARC and then at least we'll have a nationwide data to -- to look at.

And Amy, and you and I and Ryan will continue our discussion with how we can go forward from here. Any questions about that? Hearing none.

Okay. Let's now move on to new business we'll speak about the -- our education committee. Amy, who is going to give a report for education?

MS. EISENHAUER: So while I was working on vetting, I got to get into the -- into our bylaws, and in the bylaws, we were supposed to have a standing education committee. And many of our other subcommittees have a heavy emphasis on education for E.M.S. providers and E.R.s.

So this is in the new business to discuss the formation or reformation, however we want to phrase it, of an education committee, or subcommittee.

MR. COOPER: Okay, comments, thoughts? I mean, it seems to me at the moment that we have -- we have a lot of projects going on, all of which are going to require some degree of education of our prehospital providers. We have talked about, you know, about education for prehospital providers in the context of the E.M.S. Academy that sponsored every -- every couple of weeks. So it's not as though this isn't going on, okay, the education is going on.

And we've all directly and indirectly alluded to it, but I'm thinking that perhaps we could

formalize it in some way that -- that makes sense. I don't know how to proceed from here. My sense is to ask someone, you know, who has a strong interest in prehospital education. I'm looking at someone right now who that might be. She is smiling, to see if she might want to lead that group. But how do others feel about -- about formalizing that in our -- in our process?

Any objections to doing that? Well, I don't hear any objections to doing it. So I guess we're doing it. And we're thinking of asking Sharon Chiumento if she might take on the task of, you know, coordinating that -- that -- that educational process together with Amy and all our other educational partners, and Amy, is that something -- Sharon is that something you're able to take on?

MS. CHIUMENTO: Sure, I can help out with that, yeah. No problem. And since I'm basically teaching E.M.T. classes and PALS classes and all kind of things now, seems to make sense.

MS. EISENHAUER: Thank you, Sharon.

MR. COOPER: Okay, ... thank you very much. And if you want to join with Sharon, Sharon, you're free to identify willing collaborators who are -- who share your passion in this area to help --

help you out with the -- with the work of the committee.

MS. EISENHAUER: May --

MR. COOPER: Okay.

MS. EISENHAUER: -- may I also -- may I also make some suggestions of -- of people --

MR. COOPER: Of course.

MS. EISENHAUER: -- who might choose Sharon? Doug Hexel is in the process of being vetted. But he is a paramedic educator and a national speaker. And Bruce Barry is also a paramedic educator here in New York State and a national speaker. So they would be great additions to the subcommittee if you'd like to use them.

MS. CHIUMENTO: If they're willing, I'd be glad to have them.

MR. HEXEL: I will gladly help in any way I can.

MS. CHIUMENTO: Great.

MR. COOPER: Great. Thanks guys.

MS. CHIUMENTO: Thank you.

MR. COOPER: All right. So then the next item on the agenda is our COVID education. And Sharon, I think that's something that probably would be a first great task for -- for your group to take

on. So does anybody have any additional comments about COVID education for our prehospital providers at the moment?

MS. EISENHAUER: I do. Amy Eisenhauer, I do.

MR. COOPER: Sure.

MS. EISENHAUER: Dr. Matthew Harris, might be -- I know that he's not here, and so in his absence, I would not like to volun ... him anything, especially since he's new.

MR. COOPER: I think he is here. I think he joined us --

MS. EISENHAUER: Oh.

MR. COOPER: -- if I'm not mistaken. I could be wrong. He was going to.

MS. EISENHAUER: So just briefly, he's going to do a session for Vital Signs Academy on pediatric sepsis and inflammatory disorders. So he might be a great asset to this project as well.

MR. COOPER: Okay. I don't actually see Matt's name on the list. He has been texting me, so I thought he was on. But anyway, so yes, please ask Matt to join that group. Thank you, Amy.

And now, moving on to E.M.S. vaccination related to pediatric patients. I think

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that we had intended when we held our -- held our conference call on setting up the agenda to think about this as a committee.

I think there have been some things that happened since we had that meeting, in terms of, you know, initiatives from the Governor's Office and the Commissioner's Office and so on. But I welcome anyone at the moment to speak their mind on behalf of E.M.S. providers vaccination to protect our pediatric patients and so on. I'm sure this is the topic that is not at all controversial.

MS. CHIUMENTO: I can tell you that there's been some recent problems here in Rochester because the -- the document that came out from the state to the counties only listed advanced E.M.S. providers and paramedics -- advance E.M.T.s and paramedics. However, the document that -- that they -- that was sent out by the Department -- Department of Health, Ryan sent out, was -- list E.M.T.s as being acceptable vaccinators.

So some place there's a disconnect communication wise between various entities, and so I know I have an E.M.T. who vaccinated back when it was -- during emergency times, and then he couldn't. And now you know, he's in a limbo, because one group says

yes, he can, another group says no, he can't. So he's just been observing and not -- and not actually vaccinating. So I think they have something to think about.

The other thing that I think we need to think about is if we're starting to do the five to twelve-year-old group pretty soon, that's going to be a much more problematic group, I think, for non-experienced people to be vaccinating. So I think there would need to be a lot more guidance in that area. I know even with the nurses I vaccinate two days a week at -- at one of our local centers. And -- and several of the nurses don't even feel comfortable with doing young children.

So I think there needs to be some guidance or at least some look at that -- those particular situations.

MR. GREENBERG: Hi, everybody. So it -- it sounds like it's two very different conversations. And I'll -- I'll touch on the vaccinator one and why it's been an essentially an on and off switch for a lot of E.M.T.s.

So for starters, just to understand a little bit of terminology and regulation, so in the world -- in the New York State world of regulations,

advanced emergency medical technicians is actually what's written in our statute and our regs, and the advanced emergency medical technicians are anything above the E.M.T. basic, so that include the advanced E.M.T., the E.M.T.C.C. and the paramedic.

In addition, the federal government and Prep Act was just put together specifically outlined advanced E.M.S. providers, which would include the A.M.D. E.M.T.C.C. and paramedic. So in our first executive order, we allowed E.M.T. basic to vaccinate, that is what allows them to vaccinate and to form, you know, to work in a pod and so on and so forth. And it also let our community paramedics to work in a non-pod setting and to go out and to do community vaccination programs and homebound patients.

When the executive orders expired, legal, with the Bureau of E.M.S., reviewed the Prep Act and determined that we can continue to allow those advanced level providers, so E.M.T.s, E.M.T.C.C.s and paramedics to continue to vaccinate under the Prep Act, and that allowed them to continue to vaccinate.

The most recent executive order that came out then starts to again allow that greater

population to vaccinate, but they're still working on a couple of things, you know, again, the way these -- these orders came out for starters, but that would most -- that brings back that E.M.T. to being able to vaccinate again, as well as, you know, the question has come up related to flu vaccines, and that's still at the paramedic level.

I would also agree with you in the younger population, as we start to get to the -- into that five to nine population ... as well, you know, and this is strictly a, you know, Ryan Greenberg perspective on this one. But -- but it is still ... you know, they are different, especially when it comes to, you know, needles and vaccinations to children at home, and they will specifically ask when they have to go to the doctor's office, will there be any needles today?

And if the answer is yes, getting them into the car is even a challenge let alone into the office building. So yes, it does take a different, you know, skill set, I think in some type of, you know, just how to approach it, and in some senses will probably take some additional training on how to deal with pediatric patients and their concerns and just the -- the emotional aspects that come to it

both for the patients, and I would, you know, I feel like it also, as you mentioned, but of the parent, you know, who are going through that and, you know, it could take time, you know, get upset in the process of their child being upset.

What is it like, you know, and just working as a clinical provider, you know, when you have those pediatric patients, half of your patient is a pediatric patient. The other half of the patient is the family members around the pediatric patient --

MR. COOPER: Sure.

MR. GREENBERG: -- who absolutely affect, you know, how worked up or upset the patient gets at that time. So you know, that is on that side. In regards to E.M.S. pro -- well, let me stop there and say that any additional questions, we have a big screen at the other end of the room that's why I keep looking that way. But any additional questions that I can answer related to vaccinations and why that is, you know, back and forth and kind of move forward from that side?

MR. COOPER: Well, Ryan, this is Art Cooper. I have one question, and on -- on behalf of the committee, is there anything that we can do, I

think to assist you in, you know, convincing the department that as many of our prehospital providers as possible should be vaccinated because they do interface with the public on a regular basis.

I think that -- I'd be surprised -- I'd be surprised if there was anyone on the committee who disagreed with that notion.

MR. GREENBERG: So I'll switch to that in one second. But are there any questions about giving vaccinations? And then I'll -- I'll go to the other part on E.M.S. being vaccinated. I think that's a no.

MR. COOPER: I only brought it up now because in order to be doing the vaccination, you got to be vaccinated. So that's another matter.

MR. GREENBERG: Yeah. So the other component, which, like you said, about the E.M.S. providers being vaccinated, currently, right now, there is no mandate requiring E.M.S. providers to be vaccinated. As many of you know, the healthcare mandate, which does require healthcare providers within -- not even just healthcare providers, but staff within certain facilities, hospitals, nursing homes, several others, the requirement as of September 27th that they have to be vaccinated.

E.M.S. kind of falls a little bit in limbo in that regard. So E.M.S. providers that are tied to one of those facilities are required to be vaccinated as well as E.M.S. providers that are affiliated with any of those facilities. So the affiliated is really up to the individual hospitals for interpretation of who they feel are their affiliates. But many of our hospitals have turned and said, well, the transport company that worked with us, or other partnerships that are around there are affiliates and, therefore, need to be vaccinated as well and has required those organizations and, you know, some communities in the various providers have to be vaccinated.

We have not seen a mandate, there's -- you know, we've heard some things from the federal government of possibly coming down of all, you know, E.M.S. providers who provide that additional or received federal funding would have to provide that -- would have to be vaccinated. However, there's also some things or some different conversations that have happened after that -- that it says it doesn't look like even in the federal requirements that they will still require E.M.S. providers to be vaccinated.

You know, when we look around in the

E.M.S. community, you know, it's running about the same as what we see in the state, you know, from the few agencies that we've told and, you know, kind of on that side, and, you know -- you know, similar to our other healthcare environments, so it, you know, it does kind of follow the communities often of which that mean the agencies within, and you're seeing everywhere from, you know, that sixty percent to ninety percent per agency, depending on what's going on, on -- on having that vaccination.

So, you know, there's, you know, like everything else in healthcare right now, you know, the mandate coming down with, you know, have an impact on the -- on the community and, you know, on -- on E.M.S. and functions and some operations. And I think right now, it's a little bit of a waiting game to, you know, see what federal government comes up with and that mandate comes from that.

MR. COOPER: That gets back to my question. Is there any help we can give you in convincing your -- your -- those above you in the department that we think this is a good idea?

MR. GREENBERG: I mean, you are an advisory panel, if you feel, you know, and I would say if the -- if the -- if the counsel feels strongly

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about one opinion, or you know, in one way or another and the pros or cons of it, then we would always encourage you to, you know, share that communication, we're happy to share that -- you know, we will make sure that gets to the commissioner so that, you know, understands where it's coming from, and possibly a different perspective.

You know, often we hear, you know, well, we think all healthcare providers should be vaccinated in this because you're taking kind of a different angle of the pediatric patients. So you know, I would really -- as the Chair that's up to you and we will make sure to relay your -- you know, your communications ... with the counsel ...

MR. COOPER: I'll just throw this over to the committee. How do we feel about advising the commissioner to call for, you know, universal vaccination of E.M.S. providers?

DR. CONWAY: This is Ed.

MR. COOPER: I know you --

DR. CONWAY: This -- this --

MR. COOPER: ... so -- Ed Conway?

DR. CONWAY: Yeah, is this not already a mandate?

MR. GREENBERG: It is not a mandate

right now in New York State.

DR. CONWAY: I think it should be, I agree with Art.

DR. VAN DER JAGT: What would be -- This is Dr. van der Jagt. What would be the impact of that on E.M.S. providers? Is there some resistance to that at all by E.M.S. providers in any way, so that there's no loss of workforce, which is one of the issues?

MR. GREENBERG: So I'd probably defer to any of the E.M.S. providers who are also on this call in -- in this impacting and what they feel would happen within their organization.

MR. PATAKI: Hi, Ryan, it's Joe Pataki. I'll jump in on this one and say, there would be a pretty significant impact to the E.M.S. population if we did a mandatory vaccination on my personal, not representing the fire department or anybody else's that I -- I feel that people should be vaccinated.

However, we would have a significant impact, speaking of New York City, if we did recommend this mandatory vaccination.

MR. COOPER: Others?

DR. ALBERT: This is Kevin Albert.

I'm on a --

MR. COOPER: Go ahead, Kevin.

DR. ALBERT: I interface a lot with E.M.S. and fire -- E.M.S. and fire in search and rescue. And I can say that a fair number of the people that I interface with are not -- I'm not sure it's the majority are not vaccinated, but it's a significant number that are not vaccinated and have a strong feeling about that. I don't know if it's strong enough that they would stop participating. But it's something that they feel strongly about.

But as with Chief Pataki and everyone else I agree, you know, it's a wise -- it would be wise if everyone were vaccinated, and of course, I'm vaccinated. But there's those people out there who have that strong feeling about it.

MR. COOPER: I've just gotten the text from Matt Harris, who is on the call, although I don't see him listed on the screen, indicating that he fully supports this initiative, and indicating that at Northwell E.M.S., virtually none of the providers stepped away from their positions after the vaccine mandates for E.M.S. was put into place.

That is one of the different situation I think that perhaps one Kevin deals with because,

you know, the Northwell E.M.T.s, I think are paid professionals and -- Kevin, if I'm not mistaken, you ... with volunteer professionals, is that right?

DR. ALBERT: That's correct. They're all -- all volunteers.

MR. COOPER: Yeah.

MR. GREENBERG: And it is not --

MR. COOPER: ...

MR. PHILIPPY: Dr. Cooper, if I may, Mark Philippy.

MR. COOPER: Mark, go ahead. Sure.

MR. PHILIPPY: Thank you. So obviously, from the -- the various hats that I wear, I have a great deal of concern about this as well. I too, am vaccinated, and I do believe that it is vital for our providers to understand the reasons behind this. I think education is certainly the best way versus mandates.

And we've had some luck with, you know, continuing to pound out the education from various reliable sources immunology and giving people the -- the medical reasons behind this. Where I do share the concerns of my colleague in New York City is that a large number of our staff have made it very clear that should there be a mandate, they will be

leaving the service, and part of that goes hand in hand with the overall effects of COVID on our workforce.

People are tired, people are afraid, people are -- are -- are quite -- quite honestly not sure that they even want to continue doing this to begin with. And I think they're looking for that final straw that may be the reason that gives them to -- to leave the business. So anything we can do to encourage, educate and -- and really make the case that this is a good thing for everyone short of forcing it down their throat, because unfortunately, I think that's the thing that may be the final straw.

I have sixty-five percent of my staff vaccinated, and I will -- I will be devastated by losing thirty-five percent of my staff. So I -- I don't know what answer there is beyond continuing efforts to just basically badger folks to do the right thing. But there are still a lot of medical professionals who smoke. And there's no doubt in anyone's mind that smoking kills.

So I just -- you know, I -- I get to that point where I look at this and I go, you know, everyone's got to make decisions so that's my two cents. Thank you.

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MS. EISENHAUER: This is Amy Eisenhauer. I just wanted to jump in and kind of piggyback on what Mark just mentioned about education and information. I'm not sure if they're still on the call, but about three weeks ago, Donna and Alicia had one of their E.R. doctors and had a short webinar with information. Donna and Alicia, are you here? Maybe one of you can speak to kind of how that went.

MS. BROADBENT: So we did, we held a webinar, we have an F.Q.H.C. down here in Olean that has a rural family medicine residency program with U.B.M.D., so that we had a couple of their administrators and their resident physicians come. There were six physicians. And people submitted questions beforehand. A lot of it was about general, like, I don't want to say myths, but information they received about the vaccine from face blogger, you know, not credible news sources.

So the doctors just kind of -- it was very informal, no real presentation, just more of a conversation. We did record it, and it is on our website. I could post the link in the chat, but the providers that did attend did have good feedback and some of them did say that we had the people there that had already been vaccinated, they just were

interested in finding out more. But those that were a little apprehensive before they did respond to our survey and say that a lot of them did decide to get vaccinated, which was great. And I'll put that --

MS. EISENHAUER: Thank you.

MS. BROADBENT: -- link in the chat for you.

MS. EISENHAUER: Thanks, Alicia. And I think that maybe that would be an opportunity, perhaps on a more local level with any of you who are physicians, or folks that you know that -- that work as, you know, E.M.S. medical directors, maybe to have a -- a casual or informal conversation, but then also for those that change their mind or -- or have that information that wants to get vaccinated, have those available or have vaccinators there to -- to give the vaccinations right then when they decide. Just a suggestion.

MR. GREENBERG: So, you know, and -- and just to sum up what I think, you know, others have already said, but I'll just reiterate. It is a little bit --

MS. EISENHAUER: State your name.

MR. GREENBERG: Sorry, it's Ryan.

Thank you. It -- it is a little bit of a unique situation, and this doesn't make me one side versus the other, I think everybody should be vaccinated, but this a unique situation because it is a volunteer -- a significantly volunteer basis well, to where, you know, as others have mentioned, we don't know what that impact would be for the person whose job is in jeopardy, losing a job, their payroll, you know, the -- the way they support their family and other things versus a person who volunteered and may have, you know, particular stance on the situation and, you know, may say, I just won't volunteer for next year or two until this goes away or fill in the blank.

And especially in, you know, some of the rural parts and rural counties that we have, what is the impact of that on the E.M.S. systems. You know Mark spoke about, you know, our city populations and just, you know, where he is located, but I think we probably if we were to just look at the state and some of our, you know -- you know, vaccination rates are in -- by county, we could see a more significant hit in some of our rural counties which, you know, as of today already has a -- a fragile E.M.S. system probably.

MR. COOPER: Well, does anybody -- go

ahead ...

MS. MOLLOY: All right, this is Rita Molloy. I certainly --

MR. COOPER: I can't hear you. Hi, Rita, can you -- can you identify yourself additionally?

MS. MOLLOY: Rita Molloy. I'm responding to your feelings about having people be vaccinated that are riding out on the E.M.S. ambulances. It's important to me to know that people are being -- can you hear me?

MR. COOPER: That people what?

MS. MOLLOY: That people are being responsible to the health of others when they are in the business of delivering healthcare. And I think that with all of the mutations that we've had and all of the breakthrough COVID cases, I think we have a very poor conception of how many breaks or cases there are, because locally here on Long Island, I tried this weekend to get a test kit for a family member and/or an appointment to get tested, it was nearly impossible.

This spread is really significant. And I wouldn't want to think that we, as providers, in any capacity could be spreading it to others. So

I would strongly encourage all of the mechanisms that we have for education, encouragement, you know, I understand mandating they drive away some of the volunteer workforce, but it's really concerning to think that our efforts to help people are really helping to spread this virus, because you can be asymptomatic and bringing it into the homes of others. And we do give such direct care.

So I wouldn't want to give everybody a buy on not, you know, accepting responsibility for the roles that they play. We all are in this, you know, to help each other. So I'm with you, I -- I would like to see everyone vaccinated, I'm certainly vaccinated, I had a breakthrough case, quite honestly, that at first I wasn't even sure was a breakthrough case, because I have allergies. But I got myself tested and so it's -- it's very prevalent.

And -- and I'm concerned, because over time, the mutations that are evolving and changing may become completely vaccine resistance, so there's a bigger picture in here. And -- and I don't -- I don't have the answer, but I'm strongly in favor of anything that we can do to get providers to be vaccinated.

MR. GREENBERG: And that's the other

thing that hasn't been spoken about to, just as another option for you, Dr. Cooper, and you know, we are seeing in some areas, and other things where they're either, you know, vaccine or tested on a regular basis. And, you know, that might be the option that maybe this group, you know, wants to look at.

But, you know, I think it's up to the group to make that recommendation, and then, you know, up to the group to decide what they would want to do. And then, you know, like I said, we're happy to pass along any communication.

MR. COOPER: Thank you. You know, it -- it sounds to me like we're -- we're all in agreement that vaccines are something that we should offer without any question. I think we're all in agreement that E.M.S. providers who interface with the public on a regular basis fully have a -- you know, an ethical responsibility, you know, to protect their patients above all else, which, of course, would suggest that, you know, they should be taking the vaccine.

We also know, from the available science that, you know, the more -- the more folks who are vaccinated, you know, the -- the less chance

of new -- new mutations airing and spreading. So I think all of these are, you know, relevant points, but at the same time particularly in our rural areas, where -- which are largely staffed by volunteers, we -- we don't know the effect of the vaccine mandate in -- on those providers.

We certainly could not make a rule that -- or asked to a rule that provided one standard for one set of providers and one for another. And I think you know the one thing we can all agree on is that, you know, we would -- we would like to advise the Department to use, you know, any and all of its methods to, as strongly as possible encourage all E.M.S. providers to be, you know, to be vaccinated.

And certainly, to insist that those who are going to be vaccinating kids, or any other large group of individuals, you know, need to be vaccinated themselves, both to protect themselves and their own families, as well as patients who are coming in for vaccines. Is that a -- is that a position that all could live with or -- or not?

I mean, I can't make the motion, but I'm just trying to lay out what I've heard of, you know, in terms of -- in terms of the conversation that took place just now. Does anybody want to make

a motion?

DR. ALBERT: I was just going to add -- I was just going to add that, you know, that seems appropriate to say, we all agree that being vaccinated is the right thing to do, but stop short of saying it must be done, it must be done, because we realize the consequent -- there may be fallout from it in some areas.

DR. VAN DER JAGT: I agree with --

MR. COOPER: Is that a motion?

DR. VAN DER JAGT: -- Dr. Albert. I agree with Dr. Albert with that, if that's a motion, that we would recommend vaccination for COVID for all E.M.S. providers, and not mandate it, just -- just that we recommend it, and even that would be at least for our committee would be, hopefully say something.

DR. CONWAY: So the way I think, this is sort of like a guideline, right? We do the research, we review the literature, we put the best ideas forth. I mean, there's strong support out there that immunization makes a difference. So perhaps we can strongly recommend, the same way we would, you know, if we decide -- look at the sepsis guidelines, right? It took us forever to come out with those. We suggest, we recommend.

I think that there's enough data that we can strongly suggest something like this, and we can take a vote, and if anyone wishes to abstain or vote no, and then we can state that, it'd be nice to say that the E.M.S.C. committee ... unanimously feels strongly -- strongly recommends.

But make it like a scientific. It's -- there's a picture out there on this, this is whatever, and we can respect people's beliefs and leave it there. I mean, I work in the city hospital where it was mandated, and it came down to the twelfth hour, but a significant portion of our staff stepped forward and got immunized in the -- in the countdown period, I guess.

There's still a small subgroup, and they're still on leave, administrative leave. They're not employed, they're not getting salary, they're not getting health benefits. They're not eligible for COBRA and whatever, and people did make choices. I don't know what will come of those other groups but other H&H hospitals in the city have seen the same thing.

MR. PRINCE: This is Jose. If I could just add, I think the statement would maybe benefit from commenting on the fact that it's geared towards

the safety of the children that the E.M.S. community is serving, who are not able to be vaccinated themselves, if they're under twelve at the present time, and likely under, you know, five for a prolonged period of time.

So I think that might be an important part of the justification for why E.M.S.C. would specifically speak to this.

MR. COOPER: All right. I'm going to try to restate the motion or the key points of the motion, as -- as I understand it. First, I'm just going to ask if the banker and second during the motion ... except what I hear is friendly amendments from Dr. Conway and Dr. Brent, yes?

DR. ALBERT: Well, I -- I would just point out, you know, in relation to what Dr. Conway said, what had been mentioned earlier, that there is perhaps a difference between a rural E.M.S. pro -- volunteer provider and an employee in the city, and that there are some E.M.S. providers who are volunteers who already may feel overwhelmed and in a rural area, if a small number of them, even if it's a small number, decide to retire from their volunteer position, it can have a much larger effect on the infrastructure in that area.

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MR. COOPER: Dr. Albert, I -- perhaps I misunderstood. But I thought you -- in what I took, as you're making the motion, that we recommend strongly that people be provided, that that was your position. Is that not your position? I'm sorry, if I misunderstood.

DR. ALBERT: No, I -- I agree. I think it would be wise to make that recommendation. I was just pointing out that there are areas, I think, in rural New York, which already are having difficulty with coverage and cross coverage where if there's a small number of people who come out of that circulation of service can lead to the larger, you know, collapse of that service that's provided. That's all.

MR. COOPER: Okay. Well, I think we can -- I think that's understood. I think that's why people are going for a recommendation rather than a mandate. Not that we have the power to do any of that. But it's up to the commissioner and the governor, of course.

To re -- to try to restate the motion again, as I understand it, we're suggesting a strong recommendation that all E.M.S. providers be vaccinated. A strong recommendation that all E.M.S.

providers be vaccinated, that we link that to the science, that we linked that to the fact that -- that it's, you know, likely to be protective, not only for the individual himself, but, or herself, but also his or her patients, particularly his or her young patient.

Is that a -- is that a recommendation we can all live with? I see a lot of nodding heads. So Amy, I'll try to --

MS. EISENHAUER: Doc -- Dr. Cooper?

MR. COOPER: Yes.

MS. EISENHAUER: Is there a specific verbiage for this, and I know that we want to include the science, and we want to include the protect children. Do we have a specific, maybe two sentences for the motion?

MR. COOPER: Well, it's hard for me to come up with that on the fly while I'm also chairing the meeting. I'm just trying to en --encapsulate what everyone is saying.

MS. EISENHAUER: Yes.

MR. COOPER: Well, I'll try. Okay. The -- resolve that the E.M.S., the Children Committee recommends that the state of New York through its Department of Health and executive

branch, strongly recommend universal vac -- COVID vaccination for all E.M.S. providers to protect themselves and their families as well as their patient. Does that work for everybody?

DR. VAN DER JAGT: One thing I would --

MR. COOPER: ...

DR. VAN DER JAGT: Yeah. Dr. Cooper, one thing. It might be --because we are an E.M.S.C. Advisory Committee, the very end of that statement, we might want to say, especially the children. So that would take into account Dr. Prince's comment.

MR. COOPER: Well, I think I did include the children in that. Maybe I didn't.

DR. VAN DER JAGT: I think you said patients and -- and just general patients, and that's why I wanted to point it out.

MR. COOPER: Oh, I'm sorry. Okay. That's fine. Thank you. As well as the children. To me, you know, all patients are children, you know, what can I say?

MS. EISENHAUER: Okay. And the motion was made by Dr. Albert?

DR. ALBERT: Yes, I'll make that motion.

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MS. EISENHAUER: And then do we have a second?

MR. COOPER: The second is by Dr. ...

DR. ALBERT: There you go.

MS. EISENHAUER: By doctor -- who did the second?

MR. COOPER: Seconded by Dr. Prince.

MS. EISENHAUER: Second by Dr. Prince.

MR. COOPER: Started by Dr. Conway and forthed ...by Dr. Price.

MS. EISENHAUER: Okay. And then I will read the names, and if you agree, say yes. If you don't agree, say no. If you abstain, please abstain. Dr. Cooper?

MR. COOPER: Yes.

MS. EISENHAUER: Dr. van der Jagt?

DR. VAN DER JAGT: Yes.

MS. EISENHAUER: Dr. Albert?

DR. ALBERT: I vote yes.

MS. EISENHAUER: Bruce Barry?

MR. BARRY: Yes.

MS. EISENHAUER: Sharon Chiumento?

MS. CHIUMENTO: Yes.

MS. EISENHAUER: Dr. Conway?

DR. CONWAY: Yes.

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MS. EISENHAUER: Dr. Pamela Feuer?
DR. FEUER: Yes.

MS. EISENHAUER: Dr. Prince?

DR. PRINCE: Yes.

MS. EISENHAUER: And Rita Molloy?

MS. MOLLOY: I vote yes.

MS. EISENHAUER: Okay. The motion is carried unanimously.

MR. COOPER: I think, Amy, in our letter of conveyance to the commissioner regarding this motion, you know, the concept that the -- the Department might use all of it, you know, methods to, you know, provides us with information to the larger world in whatever ways, you know, educational ways were spoken about quite a -- a bit. We can -- but I think we can handle that in the letter. Okay.

MS. EISENHAUER: Okay.

MR. COOPER: Well, thank you for the very robust discussion, everyone. We'll move on now. It's three twenty-four. We're only ten minutes behind. But I think we recaptured ten minutes, because we got our report from the Office of Quality and Patient Safety already.

So let's move on now to updates from D.O.H. partners, just their advisory committees and -

- and friends from the larger outside world. We'll begin with -- with a -- a brief statement from Drs. Brooke Lerner or Peter Dayan regarding Pediatric Emergency Care Applied Research Network.

MS. EISENHAUER: I believe, unfortunately, Dr. Dayan had to go to work in the E.R. and Dr. Lerner was not able to stay past three. They did express --

MR. COOPER: Okay. Right.

MS. EISENHAUER: -- their regrets at not being able to stay later. But they would like to join us again next meeting to discuss their work at PECARN. And so they --

MR. COOPER: Well, that's fine. I -- I will --

MS. EISENHAUER: Yes.

MR. COOPER: -- give a brief statement of their -- their -- their thoughts on this. They approached me a month -- month-and-a-half ago. As you know, the federal E.M.S.C. program which funds our program here in New York State also funds the Pediatric Emergency Care Applied Research Network, which is a national network of about twenty to twenty-five emergency departments organized into five regional nodes.

Some of those emergency departments are actually E.M.S. services. Dr. Lerner has the node that deals with the E.M.S. services. Dr. Peter Dayan leads one of the nodes that deals with emergency departments in our region. And the purpose of this network is to -- is to, in effect, develop protocols and vet them through a rigorous internal process that facilitates their receiving funding from -- funding from outside sources.

And of course, the purpose of having this research network is to gather as many cases as possible, because critical pediatric illness, thank God, is relatively -- relatively rare. And in order to gather -- gather enough data, therefore, to generate enough statistical power to determine what the best treatments are, it's necessary to have a multi-institutional research network.

And I think Drs. Lerner and Dayan wanted to introduce their relative projects or nodes to our committee, and let -- let them know of, you know, let us know of their existence and, you know, ask us to assist them in whatever ways, you know, we can. So I think that was the short of their reason for wanting to join us today.

Amy, do you have anything to add to

that?

MS. EISENHAUER: I do not.

MR. COOPER: Okay. Great. I won't take any questions because they're not here to answer them on that one. Let's move on to Amy Jagareski from the ... intervention group.

MR. PRINCE: I was going ask her, if you don't mind, if there is an opportunity for me to go, I may have to step away for a few minutes so I just -- when you see it --

MR. COOPER: Oh, all right. All right. Amy, would you mind if Dr. Prince went ahead talking about the pediatric trauma subcommittee?

MS. JAGARESKI: Nope. I don't mind. Please go ahead.

MR. COOPER: Okay. Jose, go for it.

MR. PRINCE: Okay. Thank -- thanks, Amy. I'm sorry. I -- it's a brief update. We, you know -- and I -- for our subcommittee, we have four pillars, basically. So I'll cover the report in those four pillars. For research, actually, because COVID had impacts on folks timing and availability clinically, it did create some opportunity for folks to work and research.

And so a New York State pediatric

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trauma research collaborative has been formed. The -- there is five centers that have signed on to it across the state; Buffalo, Rochester, Albany, Syracuse, and Collins. It's not in any way limiting anybody out. It was an open invite. But those are the folks that have -- have this far advanced working through daily use agreements with I.R.B.s across their institutions.

And Dr. Mary Edwards, actually, I think, has the first abstract as a result of that work, that she was working on submitting in a manuscript as well. So the research across the state in an organized fashion is taking shape in a way that we had not done in a structured of a way historically.

From a quality point of view, the New York State Pediatric Trauma Quality TQIP collaborative has continued to share data across, I believe it's now twelve pediatric trauma centers across the state. That group will be meeting in November, virtually, as part of the National American College of Surgeons TQIP meeting to review their most recent data set and look at continued improvements.

They have been focusing on child abuse screening, and the use of skeletal surveys and

definitions within the dictionary for the TQIP collaborative. So that's pillar number two.

For education, the -- a lot of the educational platforms have switched to virtual or hybrid. And, as I guess, is the case with injury prevention in different ways, and so we will try to use some of the time tomorrow at the peds STAC ... subcommittee meeting to share some of what the injury prevention folks have been doing in the virtual space in terms of still getting injury prevention messages out to kids. And obviously now, the kids are back in school, what adjustment that will mean to their -- to their work.

And then just a general announcement that from an education point of view, there's a conference on this Friday, that will look at -- that that is based out of Northwell online, virtual called Chaos, which will look at the military civilian partnership in trauma.

Dr. Nelson Rosen, who's a general in the United States Army will be the keynote speaker on Friday. Nelson is a pediatric surgeon and may be well-known to many of the members of this group as he served as the Pediatric Trauma Medical Director before me at Collins and actively participated at

STAC as a member at one point on the STAC representing pediatrics as well.

So I just wanted to offer through this media, also the opportunity for anyone to join that would like that -- that setting. That's -- that's all of my report, Art, unless there is something you'd like to add that you're aware of.

MR. COOPER: No, the STAC is -- STAC is actually meeting tomorrow. So unfortunately, we won't have any updates from -- from tomorrow's meeting until January, which will take place the day before the STAC meeting in January. So the timing is a little unfortunate, but -- but that's where we are.

MR. PRINCE: Yup.

MR. COOPER: Okay. Thank you so much. Any questions for Jose on these? Not that I have any answers. Jose has all the answers today. All right. Thanks, Jose.

MR. PRINCE: Thank you for letting me jump the line. I'm staying, but I just was worried I might need to step away. So I'm sorry.

MR. COOPER: Okay. No problem. No problem. Amy, please.

MS. JAGARESKI: Hi. Can you hear me?

MR. COOPER: We can.

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MS. JAGARESKI: All right. Hi everyone. My name is Amy Jagareski. I'm a project coordinator here in the Department of Health in the Bureau of Occupational Health and Injury Prevention. I oversee two different grants, the first being the C.D.C. Core State Injury Prevention Program, and the second being the Governor Traffic Safety Committee, Traffic and Injury Prevention Programs.

So a few different updates for the upcoming year on our work. The first being is the Pedestrian Safety Action Plan. Our current plan is coming to an end in December of 2021, and so discussions are underway for a second iteration of that. As you may know, from my predecessor's updates, that plan has always included engineering, education, and enforcement.

And in this second iteration, we are hoping to also add E.M.S. and equity to that. And then along those same lines, the Department of Health is going to be responsible for a few media buys that will run October, November to coincide with daylight saving time, and that will be on visibility. So those P.S.A.s are in the works right now.

Second update is our Pedestrian Safety Training for law enforcement coming up this year.

We've been working with the Governor Traffic Safety Committee, the New York State Chiefs of Police Association and the Sheriffs Association, and as well as their law enforcement liaisons.

We are still implementing the use of existing educational video modules on New York State Vehicle and Traffic Laws. We also have See Be Seen publications as well as our Pedestrian Safety Action Plan, which I just mentioned. So along with running those trainings, we'll also be evaluating those with a survey later on.

Next topic here we have the pedestrian safety video vignettes. These are going to be geared for students, kindergarten through fifth grade. These are going to be video modules on all kinds of pedestrian safety topics such as crosswalk safety, looking left and right before crossing, understanding traffic lights and pedestrian crossing signals, among others.

Moving on to some of our drowsy driving work. Along with the Governor Traffic Safety Committee, again, we are going to continue our stay awake stay alive public service announcement. There was a challenge put out to nine SUNY schools for students to create and produce a twenty-five second

video surrounding awareness of drowsy driving and the prevention for drivers, passengers, and to recognize drowsy driving on the road.

So finalists were selected in March and those P.S.A.s will be running shortly. Moving on to child passenger safety. The -- the Bureau has several publications which are available for order, and I can send that link in the chat. Some of those include the C.P.S. vehicle and traffic law, quick reference guide for law enforcement, as well as a warning card which will help assist law enforcement to be able to educate parents and families during normal routine traffic stops.

Along the same lines of child passenger safety, we are currently waiting for approval on a script that we have created for the Vehicle and Trafti -- Traffic Safety Law module surrounding child passenger safety. And that's going to cover everything in New York State Vehicle and Traffic Safety Law, Section 1229-C, which includes the appropriate child restraint systems for the classification of child, their weight, age, all that, identifying misuse, having a -- sample traffic stop, and other supplemental resources.

Along with all of that, we have a

couple other trainings coming up this year. One will be specifically for children with special health care needs and their appropriate restraints while in vehicles. And also, a training for child passenger safety in school buses. So along those lines, we'll also be purchasing a few different training seats, and more details on that to come.

We also have a few updates along teen driver safety. We have several graduated driver licensing law awareness materials, specific to the regions of New York, we have one for Upstate, one for Long Island and one specific to New York City. So those are being translated currently into Spanish. I think those are available on our website and additional translations are going to be done this year.

Moving on, some of the things -- or I should say some of the groups that we've been participating with are the Safe Kids regional meetings, which is led by Albany Medical Center. And we will be continuing our presentation -- our representation there from ...

And then last update, along the lines of child abuse and neglect and adverse child experience prevention, we have partnered once again

with Prevent Child Abuse New York. They're going to be continuing to host their training curriculum for health care providers and community leaders on protective factors. And then this year as well, they're going to be expanding those trainings to first responder agencies.

And that's all my updates. Sorry, that was a lot. I'll pass it back to you. Thank you.

MR. COOPER: That sure was a lot. Thank you. So complete and so thorough and so wow. So wow. All right. So any questions for Amy or for the Bureau of Injury Prevention? Hearing none, we have two more reports to go. Three more, I'm sorry. First, from Chris Kus and the Division of Family Health, and then from Kate Butler-Azzopardi, and Drew Fried, Health Care Emergency Preparedness at the state and regional level. First Chris. Thank you.

MR. KUS: Hi. I'm Chris Kus. I'm the associate medical director of the Division of Family Health, and I'll be brief. The only thing I will bring to your attention that in January of 2021, there was a bill introduced to establish the Dominic Murray Sudden Cardiac Arrest Prevention Act. And that act was to direct the Commissioner of Health

along with the education commissioner to develop information related to students who exhibit signs or symptoms of pending or increased risk of cardiac arrest.

Dominic Murray died in October 5th of 2009. He suffered a sud -- sudden cardiac arrest and collapsed on the basketball court just weeks into his freshman year at Farmingdale State College.

Now, that bill is still in committee, so nothing's happened with it, but I just would -- brought it to your attention. And that's the end of my report.

MR. COOPER: Thank you, Chris. I think this is a -- a situation with which all of us have, you know, been faced. Doesn't happen every day, but it's always tragic and shocking when it does and, you know, I think personally, I -- I hopefully see something out of this, well, because I think we don't do enough education about, you know, what the likely cause of death is on the basketball court, namely hypertrophic cardiomyopathy.

And, you know, I think if many people can be made aware of this, I think it's going to be very helpful. So thanks for bringing that up to all of us. So next, unless there are no -- any question

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... Hearing none, I'd like to move on to Kate Butler-Azzopardi. And then Drew Fried. Kate, are you still with us?

MS. BUTLER-AZZOPARDI: I'm here. Thank you, Dr. Cooper.

MR. COOPER: Thank you.

MS. BUTLER-AZZOPARDI: Office of Health Emergency Preparedness is still actively working in response for COVID-19 and the post Tropical Depression Ida response activities. And that's inclusive of supporting State Emergency Operations Center activities. We've been activated for E.S.F. Eight for a very, very long time related to COVID-19, but now we are also supporting E.S.F. Six as it relates to some of the activities after the events in New York City following the rain from Ida.

We are also maintaining the status of materials and -- and other durable medical goods such as ... at the State Medical Response Cache or the MERC. We are currently providing support to many of the mass vaccination sites and the pop-ups inclusive of some contracts staffing that we've been working with.

And lastly, our office is slowly shifting back to some of our day-to-day operations

and ongoing grant work as it relates to the Healthcare Preparedness Program and the Public Health Emergency Response Program. Unless you have any questions, that's all I have for today.

MR. COOPER: Just, you know, one, not a question, but really more of a request from the chaired committee. You know, our relationships with the Health Emergency Preparedness Department, you know, have, you know, been not as, you know, shall we say, intimate as I -- I would personally prefer, particularly being some of the people, you know, involved in ...

I'd just ask you to think about how our committee, you know, can help you, you know, with respect to Health Emergency Preparedness or pediatric emergency, and how you can help us, you know, help you get that job done. And then hopefully when you're able to do this next time, we'll have a better sense of how we can work -- work together, you know, to save more children's lives in the even of -- of a major disaster.

So that's all I have to say, and thanks for your report. Does anybody have any questions? Okay. Hearing none, Drew, do you have information to bring to us? Drew Fried, are you

still with us? Well, I don't hear Drew Fried. And -- no, he -- and I don't think I'm aware at this point -- no, I don't see him on the list, but he must have --

MS. EISENHAUER: I think he already left, Dr. Cooper.

MR. COOPER: I think he must have left, yes. He must have left. So that comes to the end of our -- our stated agenda. Does anybody have any issues that they need to bring forward or do you have anything to bring forward at this time? I think we have a pretty full plate for the next few months.

MS. EISENHAUER: Dr. Cooper?

MR. COOPER: Does anybody have any announcements they want to make? Yes.

MS. EISENHAUER: Dr. Cooper, did we hear from Mark Philippy for SEMAC and SEMSCO?

MR. COOPER: Oh, thank you. I'm so sorry. Mark, please. No, yes, absolutely. Thank you. I'm so sorry, Mark.

MS. EISENHAUER: Oh, no Problem.

MR. COOPER: Go ahead.

MR. PHILIPPY: Oh, not at all, Dr. Cooper. Actually, there is not a whole lot to report on other than we will have our meetings next week.

Tuesday will be committee meetings and the SEMAC O.B. meeting. Then Wednesday, the 20th will be the state E.M.S. council meeting. There is a lot to discuss, and certainly we have a number of topics, not the least of which is the current state of E.M.S. in terms of our staffing and retention issues.

As we mentioned earlier, there is -- there is quite the concern among all of our E.M.S. agencies and partners that the continued functioning of the E.M.S. system is -- is quite literally in peril. So we're going to have some discussions about some potential avenues we have to try and address these concerns and how we might start working forward.

I know a lot of regional levels, there is work going on between all manners of, you know, levels of partnerships, whether it's public and private government agencies and hospital systems to try and address these concerns. So rest assured, it'll be a topic of great deal of discussion and input.

I know that the SEMAC has a number of protocols, discussions that will be coming up. So hopefully we can get those moved on as well. And the folks from the Mooroo app ... will be there to

discuss how that program has worked, and some work that they're going to try and do with the regional agencies to try and update information in Mooroo and keep that alive and -- and current.

I don't believe there's a whole much else going on right now at the -- the council level, or at SEMAC, for that matter. So I'll encourage everyone to join us next week. And by all means, bring with you whatever questions and concerns you have, so that we can discuss them more fully. And I will make it brief because I know we're running toward the end of our allotted time. Thank you.

MR. COOPER: Thank you, Mark. The discussion regarding the -- what I'm hearing from you is the fragile state of the E.M.S. system. Would those be primarily during committee meetings and SEMAC meetings, or would that primarily be discussed at council meetings, for those who are unable to attend both days?

MR. PHILIPPY: Oh, good point, Dr. Cooper. So the main discussion will take place during joint meeting of the systems and our new E.M.S. innovation committee. One thing that I did not mention to this group is that we've created two new committees that are hopes to broaden our approach

to a number of different areas.

One of which is the E.M.S. innovations committee, which is looking at ways to improve the application of all kinds of different programs. Many of you may be familiar with the Centers for Medicare and Medicaid Services, introduction of emergency triage, treat and transport as a payer option, and how that may impact things such as telehealth treatment in place and alternative destinations.

So that's one of the main projects of the new E.M.S. innovations committee. We also want to engage that group in a discussion with E.M.S. systems on the current state of E.M.S., but more importantly, how do we get ourselves moving forward. So short answer to your question, it'll be a joint meeting of those two.

MR. COOPER: At what time will that -- will that joint meeting take place?

MR. PHILIPPY: That's an excellent question. And I would have to go back and see if I can find my current agenda, because I don't know that it's been quite finalized yet unless Ms. Ozga happens to be on the call, and she might have it handy.

MR. COOPER: Well, I guess, Amy, I would ask you -- I would just add that if -- if it's

possible that our committee be invited as guests to attend all the meetings of the SEMAC and the SEMSCO and that the appropriate links could be set so they can at least listen to the discussion and will be up to date with the latest and greatest with respect to E.M.S. as a whole. Is -- is that okay? Do you think we can do that?

MS. EISENHAUER: Which meeting did you want to be invited to, all the committee meetings and the SEMAC and SEMSCO meeting?

MR. COOPER: Well, I think specifically, and then I would guess by this group, I would take medical standard, the joint, you know, systems innovations meeting, SEMAC itself and SEMSCO itself would indicate meetings that I typically want to attend.

MS. EISENHAUER: I will work with them.

MR. COOPER: Thanks so much.

MS. EISENHAUER: Okay.

MR. PHILIPPY: And unfortunately, Dr. Cooper, I don't have the current agenda. So my apologies. We'll get that out to your folks as soon as we can.

MR. COOPER: No problem. No problem.

No problem. Okay. We're good. Again, that comes to the end of our stated agenda. Thank you for the -- that update, Mark. And does anybody else have any burning issues or announcements they -- they want to bring up with me. Okay. Then, Amy, I will ask, do we have a official meeting date for the next time?

MS. EISENHAUER: We do not have a meeting date yet, as the other meetings have not been set yet either. So hopefully, after we get through these meetings, and the conference, we will be picking dates for all the meetings. So I will work with Stan who runs STAC and Val who runs SEMAC and SEMSCO to have some dates, and I will get back to you.

MR. COOPER: Okay. Okay. Well, I especially want to thank the chairs of all the subcommittee who put in such, you know, incredible work to get ready for this meeting and move along our issues, particularly, you know, education and sepsis. I want to, you know, thank our health department partners. Certainly, I want to thank Sharon Chiumento for taking on the, you know, the education committee work.

Thank the committee for a robust discussion on E.M.S. vaccination. Thank Amy for all

of her incredible work in keeping us all on point and getting us all together, and so on. And of course, thank ... Greenberg for his always incredible work behind the scenes. I know as the father of two young children, he understands perhaps, as well as anyone, the importance of the ... New York State.

So thank you all for attending. And we will see you in January, and for those who have committee work in between, we'll see you before January. So thank you again so very much. Have a good holiday, set of holiday if we don't see you until January. Take care everyone. Thank you.

MR. SQUIRE: Oh, hang on. Hang on, Dr. Cooper, we need a motion. So who would like to make a motion to -- say your name.

MR. PRINCE: Jose Prince, motion to conclude.

MS. EISENHAUER: Second?
DR. Conway:.Second.

MS. EISENHAUER: Dr. -- Dr. Conway seconds?.

DR. CONWAY: Yes.

MS. EISENHAUER: And every -- everyone in favor?

ALL: Yes.

MS. EISENHAUER: Anybody not in favor? Anyone abstain? All right. Thank you so very much to everyone, and I will be in contact with all of you. And we can go off the record now. Thank you.

THE REPORTER: Okay. We're off the record.

MR. COOPER: Thank you.

(Off the record, 3:53 p.m.)

(The proceeding concluded.)

10-12-2021 - EMS-C Meeting

STATE OF NEW YORK

I, JANET WALLRAVIN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 125, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 21st day of October, 2021.

JANET WALLRAVIN

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