

1 10-12-2021 - EMS-C Meeting

2 NEW YORK STATE

3 DEPARTMENT OF HEALTH

4
5 WebEx

6 EMS-C COMMITTEE MEETING

7 DATE: OCTOBER 12, 2021

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

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10 CHAIR: ARTHUR COOPER

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19 Reported by Janet Wallravin

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3 APPEARANCES:

4 RYAN GREENBERG

PETER BRODY

5 AMY EISENHAUER

BRIAN WIEDMAN

6 BRUCE BARRY

CHRISTOPHER KUS

7 DANIEL CLAYTON

DONNA KAHM

8

DREW FRIED

ELISE VAN DER JAGT

9

JACOB DEMAY

10 JENNIFER HAVENS

KATE BUTLER-AZZOPARDI

11 MARK PHILIPPY

PAMELA FEUER

12 SHARON CHIUIMENTO

JOSE PRINCE

13 VINCENT CALLEO

BROOKE LERNER

14 NICKOL O'TOOLE

JOSEPH PATAKI

15

PETER DAYAN

KEVIN ALBERT

16

DOUGLAS HEXEL

AMY JAGARESKI

17

ALICIA BROADBENT

18 VERA FEUER

GEORGE STATHIDIS

19 RITA MOLLOY

JASON HAAG

20 DOUGLAS HEXEL

LINDA EFFEREN

21 ED CONWAY

22

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

3 THE REPORTER: On the record.

4 MR. GREENBERG: Good afternoon

5 everybody, welcome to the E.M.S. for children's ...

6 We are just setting the recording now and just a
7 reminder for everybody, both being a virtual meeting
8 and that there's a stenographer on, please make sure
9 to announce who you are.

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

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

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

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

22 MR. COOPER: Okay.

23 MS. EISENHAUER: All right.

24 MR. COOPER: So go ahead.

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

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

6 MR. COOPER: I'm here.

7 MS. EISENHAUER: Dr. Elise van der
8 Jagt?

9 DR. VAN DER JAGT: I'm here.

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

12 DR. ALBERT: I'm here.

13 MS. EISENHAUER: Thank you. Bruce
14 Barry?

15 MR. BARRY: I'm here.

16 MS. EISENHAUER: Sharon Chiumento?

17 MS. CHIUMENTO: I'm here.

18 MS. EISENHAUER: Dr. Edward Conway?

19 Okay. So Dr. Conway is not present. Dr. Pamela
20 Feuer?

21 DR. FEUER: Present.

22 MS. EISENHAUER: And then Dr. Jose
23 Prince?

24 MR. PRINCE: Present.

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

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

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

10 MR. CALLEO: Yup, I'm here.

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

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

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

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

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

23 MR. HEXEL: Yeah, I'm here.

24 MS. EISENHAUER: Thank you. Chief
25 Pataki?

MR. PATAKI: I'm here.

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

3 MS. O'TOOLE: I'm here.

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

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

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

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

25 And also, I would like to note that

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

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

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

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

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

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

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

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

11 DR. VAN DER JAGT: Will do.

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

15 MS. CHIUMENTO: Motion make to approve
16 minutes.

17 MR. COOPER: Second?

18 DR. ALBERT: I'll second --

19 MR. COOPER: Anyone?

20 MR. PRINCE: Second -- second.

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

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

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

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

5 MS. CHIUMENTO: Aye.

6 MR. PRINCE: Aye.

7 DR. VAN DER JAGT: Aye.

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

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

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

22 (UNIDENTIFIED SPEAKER): There he is.

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

And now you know where the exit is in

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

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

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

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

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

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

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

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2 things.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MS. EISENHAUER: Alicia?

17 MS. BROADBENT: Yeah? Can you hear
18 me?

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

22 MS. BROADBENT: How about now, is that
23 --

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

MR. COOPER: Tell Donna to move from

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

3 MS. BROADBENT: You know us too well.

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

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

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

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

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

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

10 MS. BROADBENT: I would say that ...

11 MR. GREENBERG: Can't hear you.

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

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

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

20 MS. BROADBENT: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 MR. COOPER: Well, hearing none.

Thank you so much. So I think our next item on the

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2 agenda is to hear from our pediatric education
3 subcommittee.

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

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

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

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

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

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

4 One, is they --

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

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

10 MR. COOPER: A little better, thank
11 you.

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

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

DR. FEUER: Thanks, Dr. Havens. So

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

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

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

And also we are working with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 MR. COOPER: That would be great.

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

6 MS. EISENHAUER: Probably January.

7 MR. COOPER: January, okay. All
8 right. Cool. All right. So if you guys could have
9 it for us by then, maybe a month before so people
10 have a chance to review it that would be spectacular.
11 Any other questions or comments for Drs. Havens and
12 Feuer?

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

15 MR. COOPER: Sure.

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

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

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

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

16 DR. FEUER: Right?

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

21 DR. FEUER: Uh-huh.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 MR. COOPER: Isn't -- I thought I saw
24 --

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

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2 Sepsis Alliance who's going to give us a report --
MR. COOPER: Yeah.

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

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

13 MS. EISENHAUER: So --

14 MR. COOPER: A little bit later on?

15 MS. EISENHAUER: Yes.

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

18 MS. EISENHAUER: Yeah. So -

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

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

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

3

MR. COOPER: Okay. Okay, very good.

4

Thank you.

5

MS. EISENHAUER: Yeah.

6

DR. VAN DER JAGT: All right. So then

7

I can --

8

MR. COOPER: Ready?

9

DR. VAN DER JAGT: yeah, that's fine.

10

Can you hear me?

11

MR. COOPER: Yes.

12

MS. EISENHAUER: Yeah.

13

DR. VAN DER JAGT: Yeah. Okay. And

14

so I just learned from Amy that there is a very long

15

process to approve PowerPoints, like eight layers, I

16

think she said I think, and it wasn't -- or eight

17

weeks ahead of time or five weeks ahead of time. And

18

it wasn't quite ready. But I will talk from some

19

slides that I've made for this. And at some point of

20

this, we'll also look at the algorithms. The -- the

21

advant -- the collaborative protocols.

22

So this is then a report from the

23

sepsis subcommittee. If you, as you looked at the

24

minutes from the -- the April meeting, you will

25

recognize that we had -- there was a committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So this, if you could get us to where

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 DR. FEUER: No, just to --.

10 MS. CHIUMENTO: Hi.

11 DR. FEUER: Go ahead.

12 MR. COOPER: Sharon, go on.

13 DR. FEUER: Go ahead.

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

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

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2 between those two areas on that same page.

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

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

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

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

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

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

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

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

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

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2 algorithms.

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

9 DR. FEUER: Right.

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

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

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

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

13 DR. VAN DER JAGT: Right.

14 DR. FEUER: For many --

15 DR. VAN DER JAGT: Right.

16 DR. FEUER: -- for many children.

17 DR. VAN DER JAGT: Right.

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

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

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

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

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

9 DR. VAN DER JAGT: Right.

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

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

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

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

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

12 MS. EISENHAUER: We can hear you.

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

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

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

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

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2 that we have completed for the adults. And pediatric
3 data collection actually will begin in January of
4 2022. For the pediatric population, we're going to
5 be collecting severe sepsis, septic shock, also
6 COVID-19, and MIS-C cases.

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

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

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

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

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

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

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

9 And for COVID-19, it's for all COVID-
10 19 patients that are admitted to the hospital. And
11 there's no severity indicator needed for pediatric
12 collection, which does differ from our adult data
13 collection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 And so I know there was a -- a mention
7 earlier. I just wanted to let everyone know that we
8 do have data currently available. This would be from
9 the -- the prior naval ... abstraction process. That
10 data is currently available up through the end of
11 2019. And I think, you know, we -- we do have a
12 process set up where that data can be requested, and
13 we'd be happy to, you know, talk about any data that
14 we have that's available, and happy to collaborate on
15 any, I think getting any of that data that's
16 available, you know, to you through that process. So
17 happy to talk about any of the -- any of the material
18 I just went through or any other questions that --
19 that anyone has?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 MR. COOPER: Yeah.

4 MR. STATHIDIS: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MS. EISENHAUER: How about now?

17 MR. COOPER: Still can't hear.

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

20 UNIDENTIFIED MALE SPEAKER: I can
21 hear.

22 UNIDENTIFIED MALE SPEAKER: I can hear
23 okay.

24 MS. EISENHAUER: It must be on your
25 end.

UNIDENTIFIED MALE SPEAKER: I can

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2 hear.

MR. COOPER: I can hear everybody

3

else.

4

MS. EISENHAUER: Okay, how about now?

5

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

6

Thank you.

7

MS. EISENHAUER: So NEDARC and, I

8

don't want to use the word insinuated, but off the

9

top of my head that's the word I have. NEDARC has

10

insinuated that we could do our own statewide survey

11

in between years of the official N.P.R.P. So that is

12

another opportunity we may have in the future once

13

things have slowed down and staffing is better and,

14

you know, people, you know, have the time to sit down

15

and accurately report on a survey of this kind.

16

MR. COOPER: Okay, well, some good

17

news -- some -- well, some good news. Let's hope

18

that we can, you know, pull some chestnuts out of the
fire here the next few months and probably not a lot

19

of say at this particular time. We'll wait for the

20

final results from NEDARC and then at least we'll

21

have a nationwide data to -- to look at.

22

And Amy, and you and I and Ryan will

23

continue our discussion with how we can go forward

24

from here. Any questions about that? Hearing none.

25

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

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

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

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

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

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

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

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

22 MS. EISENHAUER: Thank you, Sharon.

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

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

4 MS. EISENHAUER: May --

5 MR. COOPER: Okay.

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

8 MR. COOPER: Of course.

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

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

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

20 MS. CHIUMENTO: Great.

21 MR. COOPER: Great. Thanks guys.

22 MS. CHIUMENTO: Thank you.

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

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

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

7 MR. COOPER: Sure.

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

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

14 MS. EISENHAUER: Oh.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 MR. COOPER: Sure.

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

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

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

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

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

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

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

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

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

25 You know, when we look around in the

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

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

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

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

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

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

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

20 DR. CONWAY: This is Ed.

21 MR. COOPER: I know you --

22 DR. CONWAY: This -- this --

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

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

MR. GREENBERG: It is not a mandate

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2 right now in New York State.

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

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

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

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

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

25 MR. COOPER: Others?

DR. ALBERT: This is Kevin Albert.

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2 I'm on a --

MR. COOPER: Go ahead, Kevin.

3

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

13

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

19

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

26

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

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

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

7 MR. COOPER: Yeah.

8 MR. GREENBERG: And it is not --

9 MR. COOPER: ...

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

12 MR. COOPER: Mark, go ahead. Sure.

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

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

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

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

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

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

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

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

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

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2 interested in finding out more.

3 But those that were a little
4 apprehensive before they did respond to our survey
5 and say that a lot of them did decide to get
6 vaccinated, which was great. And I'll put that --

7 MS. EISENHAUER: Thank you.

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

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

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

25 MS. EISENHAUER: State your name.

MR. GREENBERG: Sorry, it's Ryan.

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

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

MR. COOPER: Well, does anybody -- go

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2 ahead ...

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

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

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

13 MR. COOPER: That people what?

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

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

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

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

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

MR. GREENBERG: And that's the other

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

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

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

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

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

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

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

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

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2 a motion?

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

10 DR. VAN DER JAGT: I agree with --

11 MR. COOPER: Is that a motion?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 MS. EISENHAUER: Doc -- Dr. Cooper?

12 MR. COOPER: Yes.

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

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

22 MS. EISENHAUER: Yes.

23 MR. COOPER: Well, I'll try. Okay.

24 The -- resolve that the E.M.S., the Children
25 Committee recommends that the state of New York
through its Department of Health and executive

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

6 DR. VAN DER JAGT: One thing I would -
7 -

8 MR. COOPER: ...

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

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

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

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

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

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

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

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

5 DR. ALBERT: There you go.

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

8 MR. COOPER: Seconded by Dr. Prince.

9 MS. EISENHAUER: Second by Dr. Prince.

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

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

16 MR. COOPER: Yes.

17 MS. EISENHAUER: Dr. van der Jagt?

18 DR. VAN DER JAGT: Yes.

19 MS. EISENHAUER: Dr. Albert?
20 DR. ALBERT: I vote yes.

21 MS. EISENHAUER: Bruce Barry?

22 MR. BARRY: Yes.

23 MS. EISENHAUER: Sharon Chiumento?

24 MS. CHIUMENTO: Yes.

25 MS. EISENHAUER: Dr. Conway?
DR. CONWAY: Yes.

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

3 MS. EISENHAUER: Dr. Prince?

4 DR. PRINCE: Yes.

5 MS. EISENHAUER: And Rita Molloy?

6 MS. MOLLOY: I vote yes.

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

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

17 MS. EISENHAUER: Okay.

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

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

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2 - and friends from the larger outside world. We'll
begin with -- with a -- a brief statement from Drs.

3 Brooke Lerner or Peter Dayan regarding Pediatric
4 Emergency Care Applied Research Network.

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

9 MR. COOPER: Okay. Right.

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

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

16 MS. EISENHAUER: Yes.

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

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

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

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

25 Amy, do you have anything to add to

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2 that?

MS. EISENHAUER: I do not.

3

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

7

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

11

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

14

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

16

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

17

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

25

And so a New York State pediatric

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

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

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

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

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

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

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

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

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

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

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

15 MR. PRINCE: Yup.

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

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

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

25 MS. JAGARESKI: Hi. Can you hear me?

MR. COOPER: We can.

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

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

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

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

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2 We've been working with the Governor Traffic Safety
3 Committee, the New York State Chiefs of Police

4 Association and the Sheriffs Association, and as well
5 as their law enforcement liaisons.

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

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

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

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

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

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

Along with all of that, we have a

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

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

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

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

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

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

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

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

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

6 Dominic Murray died in October 5th of
7 2009. He suffered a sud -- sudden cardiac arrest and
8 collapsed on the basketball court just weeks into his
9 freshman year at Farmingdale State College.

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

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

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

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

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

7 MR. COOPER: Thank you.

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

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

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

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

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

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

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

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2 still with us? Well, I don't hear Drew Fried. And -
3 - no, he -- and I don't think I'm aware at this point
4 -- no, I don't see him on the list, but he must have
5 --

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

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

14 MS. EISENHAUER: Dr. Cooper?

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

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

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

22 MS. EISENHAUER: Oh, no Problem.

23 MR. COOPER: Go ahead.

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

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

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

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

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

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

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

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

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

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2 to a number of different areas.

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

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

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

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

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

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

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

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

18 MS. EISENHAUER: I will work with
19 them.

20 MR. COOPER: Thanks so much.

21 MS. EISENHAUER: Okay.

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

MR. COOPER: No problem. No problem.

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

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

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

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

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

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

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

17 MR. PRINCE: Jose Prince, motion to
18 conclude.

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

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

23 DR. CONWAY: Yes.

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

ALL: Yes.

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

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

8 MR. COOPER: Thank you.

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

10 (The proceeding concluded.)

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2 STATE OF NEW YORK

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

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

11 JANET WALLRAVIN
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