

5-2-2023 - EMS for Children Meeting May 2023
STATE OF NEW YORK
E.M.S. FOR CHILDREN ADVISORY
COMMITTEE MEETING MAY 2023

Tuesday, May 2, 2023
1:03 p.m. until 3:38 p.m.
WebEx

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Committee via Zoom. Amy, can you please take
attendance?

MS. EISENHAUER: Yes. When I call
your name, please state your name and say yes, so
that the court reporter can record it. Dr. Cooper?

MR. COOPER: Here.

MR. CLAYTON: Amy, before you start --

MR. COOPER: Dr. Cooper here.

MR. CLAYTON: Hit record.

MS. EISENHAUER: I did hit record.

MR. CLAYTON: Okay. Thank you.

MS. EISENHAUER: Yeah.

MR. COOPER: Dr. Cooper is here.

MS. EISENHAUER: Excellent. Dr.

VanderJagt? Dr. Albert?

MR. ALBERT: Present.

MS. EISENHAUER: Bruce Barry?

MR. BARRY: Bruce Barry is here.

MS. EISENHAUER: Sharon Chiumento?

MS. CHIUMENTO: Sharon Chiumento is

here.

MS. EISENHAUER: Dr. Conway?

MR. Conway: Ed Conway. I'm here.

MS. EISENHAUER: Dr. Pamela Feuer?

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2 (On the record 1:03 p.m.)
3 **MR. COOPER:** Hi, Amy. Can you hear
4 me?
5 **MS. EISENHAUER:** I can hear you, Dr.
6 Cooper.
7 **MR. COOPER:** Okay. I can only see Ed
8 Conway, you and me on the screen.
9 **MS. EISENHAUER:** I think people --
10 some people are sharing and some people are not.
11 **MR. COOPER:** I see. Okay.
12 **MS. EISENHAUER:** Alright. I just want
13 to make sure. Alright, you are not seeing what --
14 hang on one second. The multiple monitors always
15 mixes up all the things. Alright. So if you want to
16 start Dr. Cooper?
17 **MR. COOPER:** Sure. Do we have a -- do
18 we have a quorum? Do you need to take that?
19 **MS. EISENHAUER:** You have a quorum? I
20 can take attendance, yes. Let me do that.
21 **MR. COOPER:** Let's do that.
22 **MS. EISENHAUER:** Alright.
23 **MR. COOPER:** Okay. Let's welcome
24 everybody to the meeting today, Tuesday, May 2,
25 Emergency Medical Services for Children Advisory

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MR. FEUER: Present.

MS. EISENHAUER: Dr. Vincent Coyle?

He did e-mail me that he was going to have a
conference and might not be able to attend.

Douglas Hexel?

MR. CLAYTON: Dr. Cooper, can you go

on mute please if you're not talking.

MR. HEXEL: Douglas Hexel, I'm here.

MS. EISENHAUER: Thank you. Nickol

O'Toole? Dr. Bombard?

MR. BOMBARD: Dr. Bombard here, sorry.

MS. EISENHAUER: That's okay. Thank

you. Dr. Harris?

MR. HARRIS: Dr. Harris, I'm here.

MS. EISENHAUER: Excellent. Chief

Patakay?

MR. PATAKY: Joe Patakay here.

MS. EISENHAUER: Thank you. Jason

Haag?

MR. HAAG: Jason Haag is here.

MS. EISENHAUER: Excellent. Ben

Kasper?

MR. KASPER: Ben Kasper here.

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 2 **MS. EISENHAUER:** Great. So that is
 3 the attendance. We do have a quorum. I did want to
 4 note that Dr. Haggins sent in her resignation. She
 5 got a promotion and would not be able to meet all the
 6 requirements. We are in the process. She suggested
 7 Dr. Vera Feuer, which many of you are familiar with,
 8 as she has helped us and has also done some work with
 9 the E.I.I.C. at the federal level. So she is -- we
 10 have started the vetting process and then also Dr.
 11 Prince is going to take a step back. And Dr. Kim
 12 Wallenstein is going to be vetted as his replacement
 13 as she's done extensive work with the Ped Sub-
 14 Committee at STAC and worked with us on a variety of
 15 projects. So they are both entering the vetting
 16 process. And I'll turn it back over to you, Dr.
 17 Cooper.

18 **MR. COOPER:** Thank you so much. So
 19 welcome again, and we have a full agenda. We're
 20 going to hear from Ryan Greenberg, from Amy
 21 Eisenhauer. And then, as you can see, we have all
 22 business to cover regarding pediatric agitation, the
 23 PET program, pediatric triage recommendations, and
 24 the length-based measuring tape issue. And then of
 25 course, we're going to hear from our other things on

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 2 system committee. And so hopefully we'll keep you
 3 all busy for the next two hours. Ryan, would you
 4 lead it off, please?

5 **MR. GREENBERG:** I have to get off
 6 mute. I'm going to try and make it fairly brief
 7 today; in case it works. And then obviously have you
 8 take any comments or questions. So, a lot going on
 9 the Bureau most notably is that I've actually been
 10 hiring a number of new staff members, so we're
 11 excited to see that one in a number of different
 12 categories. In relation to E.M.S for children,
 13 operations continued down in all of our field
 14 operations and doing investigations and full-service
 15 inspections. One of the things that we are looking
 16 at is a revamp of our full-service inspections. And
 17 one of the things, my peak consideration is more
 18 focused also on our pediatrics. We know that they're
 19 both regulatory changes that are in the process right
 20 now for updated equipment standards as well as
 21 educational standards.

22 Educational standards don't change
 23 much related to pediatrics; however, the equipment
 24 standards do. And that will, open the door for our
 25 field investigators to be looking for more of the

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 2 pediatric things as well as to make sure that people
 3 know how to use the pediatric equipment that's out
 4 there and make sure that they are well treated and
 5 have the equipment that they need in order to kind of
 6 move things forward. Our program agencies and our
 7 REMSCO continue to execute their contracts and
 8 perform their regional responsibilities. Our
 9 education unit has had some changes in it. The
 10 branch chief operations, Mike Bagozzi is now the
 11 acting educational branch chief. And he is working
 12 with the unit chiefs within the education department
 13 to keep things moving over on that side of things.

14 We're also moving to a new way of
 15 testing for our E.M.T.s on the skills that they have
 16 and the skills that they learn. And we're moving
 17 from a specific skill-based exam to a scenario based
 18 exam that we take a series of scenarios and have to
 19 treat the patient from the time that they walk in
 20 until till the end and transferring care to
 21 essentially you're treating the patient in the
 22 ambulance. We say this on our paramedic exams right
 23 now, but it's now from -- side. So we are working on
 24 having more of that real life scenario moving
 25 forward. So we're very excited about that one,

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 2 seeing that come forward. We've had our second beta
 3 run of that and we're just tweaking what that process
 4 will be, but that most likely will be north of twelve
 5 to eighteen months out before you actually see that
 6 implemented. Our data and informatics unit is
 7 remaining busy.

8 We continue to collect data. That's a
 9 big thing, particularly for E.M.S. for children is
 10 our biospatial agreements and being able to collect
 11 data and put it into an analytical form for our
 12 agencies. Some of those data points that we'll be
 13 looking at is directly related to pediatrics. The
 14 top part that comes for some of our smaller agencies,
 15 which we have a thousand agencies, many of them have
 16 a fairly small subset of patient population or
 17 incidents in a given year. And so when they start to
 18 look at pediatric patients, regardless of, if you
 19 consider that's under the age of eighteen, or under
 20 the age of fourteen, there are many of our agencies
 21 that just don't have a large pediatric population
 22 that they treat. And so then looking at
 23 statistically how they're doing on certain things
 24 become a little bit more challenging. So that's one
 25 of the things that we've noticed in trying to collect

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 2 some of the data and looking for ways that we'll be
 3 addressing that one. And as for children, obviously,
 4 now that Amy talk about all her key points as well as
 5 her growth in the team, and but I'm going put a shout
 6 out the congratulations on the extension of the
 7 contract for several more years. I'm very excited
 8 about that one. And absolutely do the hard work and
 9 commitment of all of you here, as well as, -- going
 10 to come back on the camera for that one. But your
 11 work here as well is but everything that Amy's doing
 12 behind the scenes and in front to make things happen,
 13 Vital Signs next year is October 17 to 22. Again, I
 14 bring that up as we finalize the schedule for things,
 15 we are making sure that we have a focus on our
 16 pediatric components and pediatric courses.
 17 Everybody taught there. Our annual memorial, our
 18 E.M.S. memorial is May 23. That's right around the
 19 corner at the State Plaza, our next council
 20 operations, our next council meeting, our SEMSCO and
 21 C.A.C. meeting are and actually STAC is also next
 22 week. So Tuesday, Wednesday, Thursday is all of
 23 those meetings. So Art will be spending the entire
 24 week up in the Albany area. Thanks. And we are
 25 trying to align these meetings to happen in the

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 2 future, right before or very close to, in order to
 3 bring any information forward. So just keeping in
 4 mind of what that future looks like. But some of
 5 those, and you wonder why we're on certain dates.
 6 It's normally to align with those.
 7 We spoke about the regulations. They
 8 are moving through. We were hoping to have them out
 9 by public -- for public comment, by the SEMSCO
 10 meetings. You don't see that happening, but they are
 11 moving through the process upwards as we go, so I'm
 12 hoping in the next probably four to the six weeks,
 13 maybe eight weeks, we'll see those out. And we'd
 14 encourage everybody here to provide some public
 15 comments, including positive public comments. So
 16 it's always something that some people kind of
 17 sometimes stay quiet on, but positive feedback on
 18 regulations is also a good thing. So when you see
 19 the pediatric standards and things coming out, if you
 20 are supportive of those putting a public comment in
 21 related to that is always a wonderful thing to hear
 22 as well.
 23 Executive orders, safe mapping ... is
 24 still in place at this moment. The Rural Health Task
 25 Force has their next meeting tomorrow. And just a

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 2 reminder to everybody here, we have moved the bulk of
 3 our forms and things, including the PET program,
 4 which truly has been since the beginning, all the one
 5 page on our homepage, which is the forms page, and
 6 it's a dropdown. So if you do need any forms or any
 7 -- or agencies need any forms we've made almost
 8 everything electronic. A few things are still
 9 P.D.F., but they're still submitted electronically.
 10 We do not accept mail for the most part. And
 11 actually, you've even gotten to the point of certain
 12 things. We will start to return the mail to you
 13 until you submit it electronically, just to make sure
 14 that people are following that process.
 15 It helps us process things faster, it
 16 helps make sure nothing gets lost and really is a
 17 positive thing and moving forward. Last but not
 18 least, really have some great collaboration amongst
 19 different councils. We know this council works with
 20 our SEMSCO Council on a very regular basis, but we're
 21 also now working with the council on a pretty regular
 22 basis, in particular related to offload times. And
 23 so just seeing that synergy and working through
 24 allows us really to put a positive step forward and
 25 some great things especially as we start moving

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 2 forward on some of the new federal expectations for
 3 E.M.S. for children grant and now moving into
 4 hospitals even more, so I think this partnership and
 5 working with other councils will become more and more
 6 apparent is something we're going to need to even
 7 further stand.
 8 So outside of that, the last thing,
 9 the biggest thing's probably been going on the past
 10 couple of months is, is the budget, there's a
 11 proposal in the budget for E.M.S. and to advance
 12 different things in E.M.S. and different
 13 opportunities to help lead the E.M.S. sustainability
 14 study. The E.M.S. sustainability study, E.M.S.
 15 agenda for the future was released back in January if
 16 you haven't seen it. If you just Google New York
 17 State E.M.S. agenda for the future, E.M.S.
 18 sustainability should be one of the top Google that
 19 pops up there. And if not, you can go to our webpage
 20 and find it there. But very excited about that, that
 21 was a year and a half in the making with ... who
 22 really led that team, they came up with twenty-five
 23 recommendations in order to create E.M.S.
 24 sustainability around the state.
 25

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 2 Nineteen of those twenty-five
 3 recommendations were, have solutions to them either
 4 in full or in part in this year's submission with the
 5 Part F proposal that this is a budget. We're still
 6 waiting for the final side of where the budget kind
 7 of does fall and what's included or not included with
 8 that one. But very excited to see things move
 9 forward on every front in E.M.S., including our
 10 pediatric patients, and making sure that we do our
 11 best as we can, that's all that I got. Happy to take
 12 any comments, questions, or concerns?
 13 **MR. COOPER:** Thank you so much, Ryan
 14 Greenberg. Do we have any questions for Ryan or
 15 issues regarding the report that he's given us?
 16 Well, hearing none. Ryan, it sounds like it's all
 17 good, so what could be better than that? So at this
 18 point, we are aware that Jeremy Cushman is unable to
 19 be with us after two o'clock. So I'm hoping that
 20 Jeremy is able at this point to deal with the
 21 protocol updates, which are currently listed under
 22 the new business. Jeremy, does that work for you?
 23 **MR. CUSHMAN:** It does Dr. Cooper.
 24 **MS. EISENHAUER:** Give me one second
 25 just to get on the screen.

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 2 **MR. COOPER:** What? Did you say it
 3 does? Thank you.
 4 **MR. CUSHMAN:** Yep. Can you hear me
 5 okay?
 6 **MR. COOPER:** Yeah, maybe a little
 7 closer to microphone if you can.
 8 **MR. CUSHMAN:** [Crosstalk] -- getting
 9 the right one up.
 10 **MS. EISENHAUER:** I will get the
 11 seizure one up first.
 12 **MR. CUSHMAN:** Okay. Let me take a
 13 quick second to kind of summarize those if you will
 14 the substantive changes to the seizure revisions. On
 15 the PEDs end of things it is primarily to clarify and
 16 address the dosing regimen to reflect zero point two
 17 milligrams per kilo I.M. or intranasal to a max dose
 18 of ten milligrams.
 19 And then if I.V., the zero point one
 20 milligrams per kilo I.V. to be consistent with most
 21 practices, as well as the National Model E.M.S.
 22 guidelines. The remainder of the protocol itself is
 23 pretty much unchanged. So Amy, if you just scroll
 24 down to the PED section so the group can see those
 25

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 2 recommended changes. Any questions, concerns related
 3 to that recommendation for change?
 4 **MR. COOPER:** Amy, perhaps we could
 5 slide down just a bit more so we can see the
 6 paramedic level as well. Thank you.
 7 **MR. CUSHMAN:** There you go. So,
 8 again, at the C.C. level they're only giving it I.M.
 9 or intranasal at the paramedic level, they do have
 10 the option for I.V., and again, consistent with the
 11 National Model EMS guidelines having the zero point
 12 two mg/kg I.M. or intranasal and then the zero point
 13 one mg/kg if an I.V. is established.
 14 As always, best practice remains. The
 15 first line is really intramuscular administration for
 16 your first round, and not to delay obtaining vascular
 17 access, particularly in a child who is typically a
 18 little bit more challenging for most of our
 19 practitioners. And then again, the remainder of the
 20 protocol remains pretty much unchanged.
 21 **MR. COOPER:** Any questions for Jeremy
 22 about this? Okay, next protocol, then. Thank you,
 23 Jeremy.
 24 **MR. CUSHMAN:** Alright. So the next
 25 protocol looks like, so this is a pain management

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 2 protocol, looks like, holy cow, there's a lot of red.
 3 Hopefully, we won't have that one. But what we did
 4 in pediatric is frankly cleaned up a lot of stuff
 5 because a lot of things has been injected in many of
 6 the revisions during that time.
 7 What we also did was really try to
 8 simplify some of the -- not the dosing regimens, but
 9 simplify the language on it, so the protocol frankly,
 10 was not as busy. So to that end, really when we look
 11 at -- at it we are clarifying the concentration.
 12 We're making sure that the -- if equipped and trained
 13 asterisks are in the right location and then
 14 providing some standardization as you -- so again,
 15 these are the same dosing tables that you had before,
 16 but before there was a whole another column within
 17 the concentration. And so we just move that
 18 concentration to where it says acetaminophen and so
 19 forth.
 20 Amy, just scroll down to the C.C.
 21 level in terms of pain management, again, this is all
 22 aligning things with the adult in terms of how we're
 23 organizing things in terms of may choose one of these
 24 two, your dosing regimens have not changed at all.
 25 And then as you get into pediatrics, again it is

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 2 simply clarifying and simplifying the language
 3 between the adult and pediatric protocols.
 4 Amy, if you can scroll down into the
 5 paramedic section. Again, your dosing regimens are
 6 unchanged. It is just cleaning up the language to
 7 prevent confusion. The last part is in the key
 8 points and considerations. If you look at these sets
 9 of ... compared to the previous, we just simply
 10 reorganized all of the key points so that it is far
 11 more standard and is related to the class of
 12 medications that are being administered. Before it
 13 was so many bullet points, you had difficulty in
 14 reading it and figuring out what bullet point was
 15 applying to the medication that you were
 16 administering. We simply clean that up accordingly.
 17 So those are really the changes, so no
 18 new additions to this. Something that I would like
 19 E.M.S.C. not necessarily at this time, but to
 20 consider in the future is what are our options for
 21 two things? Number one, ketorolac were E.M.S.C.
 22 feels strongly that ketorolac should not be included
 23 in any way within the pediatric pain management
 24 protocol and secondly, acetaminophen in the I.V.
 25 route.

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 2 So acetaminophen is being added --
 3 recommended for addition into the adult formulary.
 4 And ultimately something for E.M.S.C., perhaps at a
 5 future meeting is to have that discussion when you're
 6 prepared to again, specifically speak to ketorolac
 7 and whether or not you would want it included in here
 8 as a non-narcotic analgesic, as well as
 9 acetaminophen. Happy to take any questions.
 10 **MR. COOPER:** All right. Amy let's if
 11 we can plan on putting those two issues on the agenda
 12 for next time. But in the meantime, let's you and I
 13 get together and we'll form a small working group to
 14 focus on these issues, review the literature and so
 15 on, have a conference call in the interim to make
 16 sure that E.M.S.C. is up to date with this. I see
 17 Ryan Greenberg has his hand up. Ryan, of course,
 18 you're always invited to speak on anything at any
 19 time.
 20 **MR. GREENBERG:** I just want to say, I
 21 have a question. I think you mentioned you were
 22 going to bring it up before, but while we had Jeremy
 23 here, before he goes out. Any of these changes when
 24 we talk about Broselow tape or other things align or
 25

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 2 differ anything with that sizes when you were looking
 3 at these or I just haven't done comparison.
 4 **MR. CUSHMAN:** Yeah. The only -- one
 5 of the reasons that this came up is, is what we
 6 discussed at med standards, and I believe you've been
 7 seen that as well, right, which was that to the best
 8 of our knowledge reviewing the Broselow tape
 9 specifically the only conflict lied in the dosing of
 10 Diazepam at zero point two milligrams, the Broselow
 11 tape does not include dosing for Midazolam.
 12 But that has caused confusion in a
 13 fair amount of consternation amongst providers
 14 because of that. By making at least this change
 15 regarding your first dose, because in the Broselow
 16 tape, it actually does not specify the route, it just
 17 simply specifies the dose. And given that our first
 18 dose would be preferably I.M., this will allow the
 19 alignment of our protocols with the Broselow tape.
 20 For the Handtevy project, which Amy is
 21 probably going to talk about a little bit later on,
 22 it's obviously moot because for the Handtevy, we
 23 program in it what the protocols are, and then it
 24 calculates the volume for us.
 25

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 2 But we did check all of the other
 3 things that are within our scope. Obviously there's
 4 a bunch of things in on a Broselow that we don't do.
 5 But there are no other conflicts with the New York
 6 State of Department.
 7 **MR. CONWAY:** So by way I have one
 8 question just concerning the oral dosing that the
 9 table lists both pounds and kilos from a patient's
 10 safety issue all the other medications are listed per
 11 kilo. I just bring it up because we still continue
 12 to see med errors as most electronic systems getting
 13 rid of the pounds and kilos. So I just bring that
 14 up.
 15 **MR. CUSHMAN:** Yeah, to speak to that,
 16 I think that's a phenomenal point. In the area of
 17 struggle that I and some of -- kind of -- the
 18 protocol working group has, is that because we have
 19 not yet quite normalized this information, that it is
 20 more likely that a parent is going to say, oh, well,
 21 yeah, they're fifteen pounds. And so what we did not
 22 want to have is the provider then have to try to
 23 figure out what the conversion from fifteen pounds is
 24 to kilos, and then look at this table to do that.
 25

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 2 And so, I agree, and I think we could
 3 go either way, but just -- you know the thought
 4 process was that more often than not, parents or
 5 caregivers are going to give pounds. And if they're
 6 using the protocol as a reference tool, then instead
 7 of having them reference two different things,
 8 meaning a conversion table and then a medication
 9 administration table, we would keep it all in the
 10 same spot. But you are absolutely spot on, and I
 11 don't know how to reconcile it.

12 **MR. COOPER:** Any thoughts about that?
 13 You know, Ed is entirely right that we've moved
 14 toward all drug dosing per kilogram, but Jeremy and
 15 the protocol group have made a very good point that
 16 parents are still thinking in terms of pounds. Ed,
 17 since you brought the issue up, do you have response
 18 to that?

19 **MR. CONWAY:** I don't have a simple
 20 answer. My concern is more, I don't worry as much
 21 making a mistake perhaps with this as with morphine
 22 or fentanyl, somebody making a miscalculation, my kid
 23 is fifteen pounds, and then somebody doses that. I
 24 mean, perhaps this is helpful just as a reminder that
 25 people would look at it or do we put some sort of a

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 2 memo up there, or like a bullet point or a red point,
 3 like please ensure that dosing is in -- or something
 4 like that. I don't know.

5 So many of us have electronic records
 6 now that kind of prevent this, but I can see this
 7 mistake, kids seizing, the parents think the kid's
 8 dying in front of their eyes, mistakes get made.
 9 They happen in the hospital unit. I've seen kids
 10 that overdosed inadvertently.

11 **MR. CUSHMAN:** Yeah. And obviously, we
 12 don't have the luxury of being able to weigh our
 13 patients in the field. And actually I know what I
 14 will do is, I got to go back to our management of
 15 pediatric patients section of the protocols. I
 16 believe that we speak of utilizing the length-based
 17 tape which is, and I think we just need to reinforce,
 18 because ultimately that's in the field, our safest
 19 option to get an estimated weight based upon their
 20 ideal body weight, i.e. their length.

21 **MS. EISENHAUER:** I'd also mention to
 22 reiterate everybody's comments. One of the main
 23 components of the future performance measures, which
 24 I'll get into in a few minutes for this grant cycle,
 25 for E.R.s, one of the requirements is that all

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 2 patients be weighed in kilograms. They did not
 3 mention that with E.M.S., but I would imagine that
 4 they would hope that that's also the case, but I
 5 understand the limitations of working in the field.

6 **MR. HEXEL:** So speaking from the field
 7 provider perspective here.

8 **MR. COOPER:** Any other comments?

9 **MR. HEXEL:** Yeah, Dr. Cooper, Doug
 10 Hexel. Just speaking as a field provider, if I flip
 11 to that or in reality, I'm opening my phone and going
 12 to the app and looking and that table pops up, if the
 13 weight in pounds is red or highlighted or bold or
 14 something, I'm going to look at that again. And why
 15 is that different than the red? Oh, okay, because
 16 that's the pounds, I'm converting to kilos and this
 17 is my dose. So I think we do need to adjust that
 18 table somehow.

19 **MS. FEUER:** Hello, this is Pamela
 20 Feuer. I actually agree. I was going to say
 21 something about the visual that if we have to keep
 22 pounds in there that it needs to be something that
 23 makes the eye not look at the same color table,
 24 something that highlights it to be there. But -- and
 25 also I think it is a little risky that the next line

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 2 says something, milligrams per kilo, and right above
 3 you can easily look and look at one column weight and
 4 pounds and think that was the kilo weight. I don't
 5 know.

6 **MR. CUSHMAN:** Yeah, honestly, the more
 7 that this conversation is going, the more that I
 8 think we just need to remove that column period. You
 9 know, we -- we state already within -- within the --
 10 the protocols under the pediatric definition of
 11 discussion. Protocols requiring weight-based dosing
 12 guidelines, pediatric dosing is calculated on a per
 13 kilogram basis and strongly recommended length-based
 14 resuscitation tapes. So what I -- I'm, yeah, even
 15 now I'm starting to change my opinion on this based
 16 on this conversation. I -- I -- yeah, let me, I'm not
 17 sure that I'm going to be able to make anything look
 18 different in a meaningful enough way to be able to
 19 even assuage my concerns now that you've made them.
 20 So I -- I hear that. Let me see if I can change
 21 something. If not it -- it may -- it may be safer to
 22 remove it, sorry. Remove pounds entirely and -- and
 23 continue to force the issue of -- of weight-based
 24 dosing utilizing a length-based tape. So, which will
 25 be in kilos by definition.

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 2 **MR. CONWAY:** So just one more. So if
 3 push absolutely comes to shove and you decide and has
 4 to stay in there, I would just sort of like the
 5 highlight the kilograms, the middle column. Because
 6 the eye is going to go to where that color is.
 7 Somebody will say, oh yeah, we can, because again,
 8 when you, the next line is morphine point one mgs per
 9 kg. So at least get people thinking in the right
 10 way. I understand the limitation because we're going
 11 to get into the discussion. I mean, I work at an
 12 institution where the E.D. doesn't believe in length-
 13 based tapes for a myriad of reasons. And I love
 14 them. I mean, I walk around, I'm on service with ...
 15 in my pocket, because no one can remember that amount
 16 of material when you're in -- crisis.
 17 **MR. VANDERJAGT:** I'm sorry, and this
 18 is Elise VanderJagt. I'm sorry, I -- I had a hard
 19 time coming on wrong -- wrong password. And maybe
 20 you discussed this already. I agree with what has
 21 just been said about making your eyes go to the
 22 weight and kilograms. I'm also wondering if you
 23 eliminate the pound column if you could put up there
 24 at least that, you know one kilogram is two point two
 25

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 2 pounds, you know, so you'd have at least some
 3 guidance. Hey, it's a matter of time to come.
 4 **MR. HARRIS:** Please. I wonder if this
 5 is meant to be more an educational point and forgive
 6 me, I can't see the entire document, but is there a
 7 portion at the bottom, sort of like the way we have
 8 art in New York City protocols of key points where we
 9 put the strike down below, right? So it's not in the
 10 middle of the protocol. People aren't going to jump
 11 to those weights and use the pounds for kilo flows,
 12 but if there is a parent who reports that their kid
 13 weighs, you know, thirty pounds, then there's a
 14 conversion table on the bottom as an educational
 15 point because almost no one is going to break out of
 16 just practically speaking. So I wonder if using that
 17 just as a reference in a key point section might be
 18 more worthwhile.
 19 **MR. COOPER:** Yeah. From my point of
 20 view — this is Art Cooper, from my point of view, I
 21 think the point that parents are frankly and not
 22 something I had really thought of at -- at great
 23 lengths prior to this conversation, I think the fact
 24 that parents are thinking in terms of pounds is a --
 25 is really a point that we really need to you know,

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 2 really spend some time thinking about. So that we
 3 have some way of you know, reconciling pounds, this
 4 is kilograms. I totally agree with the approach Matt
 5 is suggesting. I think the -- the data is going be
 6 in the details in terms of coming up with the right
 7 wording and coming up with a -- with a table that,
 8 you know, that looks you know that guides the field
 9 provider more in -- in the -- in the direction of
 10 kilograms rather than pounds, but allowing the pounds
 11 piece to be part of it, if that makes sense. Thank
 12 you. Any other comments? Matt, are you -- Matt
 13 Harris, are you still, did you have another comment
 14 or is your hand up? Elise, do you have another
 15 comment?
 16 **MR. VANDERJAGT:** I do actually on --
 17 on that table. And I don't -- I don't know what --
 18 **MS. EISENHAUER:** -- interrupt for just
 19 one moment. I have a question from the court
 20 reporter, who is the calling user, starting 607-732?
 21 **MS. O'TOOLE:** Amy, I think that's me,
 22 Nickol O'Toole.
 23 **MS. EISENHAUER:** Okay. Thanks,
 24 Nicole.
 25

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 2 **MS. O'TOOLE:** 6694. Yep, you're
 3 welcome. Sorry --
 4 **MS. EISENHAUER:** Oh, that's okay. I
 5 don't have the end. Annette, that's Nickol O'Toole.
 6 I'm sorry.
 7 **MR. CUSHMAN:** Elise. Yeah, please go
 8 ahead. You had a comment.
 9 **MR. VANDERJAGT:** Yeah, and I -- and
 10 I'm sorry that I had been late and I don't know what
 11 you have all discussed with this protocol here. I,
 12 first of all, I -- I do agree with Dr. Cooper that
 13 parents will say pounds, you know, for sure. And --
 14 and some of the -- the things that have been said are
 15 correct, I think, and I do think it might be helpful
 16 to have maybe the table lower down as an educational
 17 thing. The other question I had about this, and I
 18 don't know if you've discussed the medications
 19 already, could I just ask that, have you just started
 20 discussing that? Or was it all about weight?
 21 **MR. COOPER:** Mostly about weight, but
 22 what's your concern?
 23 **MR. VANDERJAGT:** My concern is that we
 24 don't use Motrin -- ibuprofen not to brand, but
 25 ibuprofen for kids that are less than six months of

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 2 age. And there's no, there's nothing about that in
 3 this protocol. That's number one. And then the
 4 second thing relates more to fentanyl. I'm concerned
 5 about the one point five microgram per kilogram I.V.
 6 is a starting dose. You give that to a small kid,
 7 especially, I -- I'm concerned that that's something
 8 that's too high of a dose.
 9 **MR. CUSHMAN:** Just to be clear, all of
 10 the dosing is already existing and have been
 11 previously approved by both this group and CMAP. So
 12 any dosing changes are going to go back on what has
 13 already been approved. I -- I'm indifferent. I just
 14 want to be clear that I didn't change any of the
 15 dosing. I just cleaned up the protocol to reflect
 16 things for consistency.
 17 **MR. VANDERJAGT:** Yeah, I do understand
 18 that Jeremy, I just think that however we have an
 19 opportunity to look at this again, right? So, I
 20 think there is that part of it that I just wanted to
 21 -- to say, because fentanyl is like a hundred to
 22 hundred and fifty times as powerful, as potent as
 23 morphine. And in this case it's one point five is
 24 more than that.
 25

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 2 **MR. HARRIS:** May -- may I ask a
 3 question, just a data question to Amy?
 4 **MS. EISENHAUER:** Sure.
 5 **MR. HARRIS:** And -- and this -- this
 6 could be something we can come back to at the end.
 7 Amy narcotics, as I'm aware, we have to report to the
 8 state, all narcotic administrations. Is there a way,
 9 maybe Ryan knows this, if I -- I would think that
 10 intravenous to Lisa's point, intravenous fentanyl is
 11 probably never given to kids in New York state, I'm
 12 going to say they're either -- either not getting
 13 treated, you're getting, I.M. morphine, you're
 14 getting intranasal, fentanyl. So just, but just in
 15 general, the bigger -- the bigger question is, if we
 16 do want to reapproach dosing at some point down the
 17 line perhaps the data driven approach would be to
 18 look at the state registry and see how often these
 19 different narcotic options and routes of delivery are
 20 actually being used in a given calendar year. So I
 21 wasn't sure what access we have as an advisory
 22 committee to that data.
 23 **MS. EISENHAUER:** You give me a data
 24 request and I request it from the data informatics
 25 unit. So if you give me the specifics of what you

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 2 are looking for, so what medications, what routes of
 3 administration I can submit that to the data
 4 informatics unit and request the information. They
 5 may have some questions just so that they pull the
 6 correct information. But we can obtain that from.
 7 **MR. HARRIS:** Okay, I'll reach out to
 8 you off -- I'll reach out to you. I have a couple
 9 questions about that, but I don't want to take up
 10 your committee's time. I'll reach out to you after
 11 this.
 12 **MS. EISENHAUER:** But I -- I do like
 13 your points.
 14 **MR. HARRIS:** Great.
 15 **MR. COOPER:** Yeah, Matt, I think
 16 that's a great, just a great idea. So Amy, let's
 17 follow up on that. I think Ryan Greenberg had a --
 18 had his hand up a little while ago, but Ryan, do you
 19 still have a -- a word to say here?
 20 **MR. GREENBERG:** Yeah, so Jeremy, I
 21 don't know, it's just taking a look at the
 22 collaborative, interestingly enough, there's a lot of
 23 resources and stuff in the back of the collaborative,
 24 but there's actually nothing for convergence, for
 25 weight convergence. So count six kilograms, this

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 2 might be the perfect -- if someone else said it, I
 3 apologize, but I'm just like.
 4 **MR. CUSHMAN:** No, I said it, and then
 5 I started scrolling through and I'm like, wait a
 6 second. It isn't there. It was in a previous
 7 version, and I don't think ever made it into these
 8 updated versions. You're absolutely right, Ryan. So
 9 we'll -- we'll bring that back to the group and
 10 figure out where it's best to live --
 11 **MR. GREENBERG:** But I think something,
 12 you know, in that resource area and just, you know,
 13 weight, kilograms depend, like, I think that's a
 14 quick, you know -- tap on it, bring it down and like
 15 you did. Look, most of us are probably going to open
 16 up some electronic device and work on that, but if
 17 it's not available and this is what's in the truck,
 18 it's, you know, a big one to have.
 19 **MR. COOPER:** Thank you, Ryan, and
 20 Jeremy, thank you very much for your willingness to
 21 reconsider that that issue and the location in the --
 22 in the document is where it will most likely or most
 23 appropriately set. I think Sharon Chiumento has her
 24 hand up as well.
 25

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 2 **MS. CHIUMENTO:** Just one other
 3 potential option, and if you remove that pound column
 4 and instead in the kilogram column, put in
 5 parenthesis afterwards what the pound conversion
 6 would be. So maybe parenthesis is equal six pounds
 7 or whatever -- whatever it might be. So this way the
 8 kilograms is going to be the first thing they're
 9 going to see. That's what they're going to base
 10 their weight on to their diagnosis on, but they got
 11 the conversion right there for themselves without
 12 giving an extra column, which I think is very
 13 confusing.

14 **MR. COOPER:** That's -- that's helpful.
 15 Jeremy, I guess we'll leave it in your hands and your
 16 -- and the protocol group to it again, figure out how
 17 best to handle this issue and we'll hear from you
 18 next time.

19 **MR. CUSHMAN:** Yeah, honestly, I -- I,
 20 right now temporarily I'm kind of utilizing Matt's
 21 idea, I think it was mess. And I just removed it
 22 from those, the pounds from the -- from the table.
 23 It looks much clearer, simpler, and then right now
 24 it's still within the protocol, but under the -- the
 25 key points as a reference. And then we got to make

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 2 sure we know how all of these different apps are
 3 utilizing and referencing these because if you can't
 4 move quickly from -- from one protocol to another
 5 then that's going to disincentivize utilizing a table
 6 that is elsewhere within the protocols. So we'll
 7 take care of it, but great feedback. I appreciate
 8 it.

9 **MR. COOPER:** Thank you, Jeremy. Any
 10 other comments on this particular protocol? Okay,
 11 can we have another -- oh, Elise, I'm sorry, go
 12 ahead.

13 **MR. VANDERJAGT:** No, that's okay. I
 14 think Kevin Albert had His hand up as well, but I do
 15 have some comments But Kevin, you go first.

16 **MR. ALBERT:** No, you can you can go
 17 first, Elise, it's fine.

18 **MR. VANDERJAGT:** So, again, this, I
 19 know these things were already approved, it sounds
 20 like Jeremy -- but the question I had was this
 21 cardiac monitor, is it understood that that's a
 22 cardio respiratory monitor because they really, the
 23 issues here with these narcotics is respiratory, and
 24 I don't take pulse oximetry in there. So I just
 25 wondered the emphasis on cardiac, cardiac is not the

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 2 issue with these kinds of drugs. And so what are we
 3 doing with that?

4 **MR. CUSHMAN:** Again, that's historical
 5 language that has been included in consistent
 6 throughout the entire protocols. So if it needs to
 7 be revisited, it needs to be revisited everywhere.
 8 We do not have established as a requirement, the
 9 administration -- sorry, the utilization of
 10 capnography for individuals that are receiving a
 11 narcotic analgesic that would arguably be the -- the
 12 best practice. I think we would probably both agree
 13 that, that pulse oximetry is insufficient as a -- as
 14 a respiratory monitor. And so that I think would
 15 need to be a much larger discussion because there are
 16 significant implications in terms of any type of
 17 requirement for capnography as part of any type of
 18 analgesic administration and in some cases, quite
 19 frankly reduce the ability to properly manage folks
 20 experiencing acute pain. When I think the question
 21 earlier was, you know, we really need to see what the
 22 data is and do we really have a massive problem here
 23 or not?

24 **MR. HARRIS:** Yeah, and practicality, I
 25 think you pointed out its Matt, Jeremy, that our

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 2 practicality no one who's using in title one
 3 pediatrics for. I mean, unless --

4 **MR. CUSHMAN:** I'd be careful about no
 5 one. There -- there are medical directors and
 6 systems that make it an expectation. So --

7 **MR. VANDERJAGT:** Yeah, I -- I would
 8 say, yeah, I would say that I'd say, but I would say,
 9 -- that's probably, I would, I would argue for what
 10 it's worth that you're probably in a minority. I'm -
 11 - I have not screen services.

12 **MR. CUSHMAN:** But not -- but not a bad
 13 practice. And kudos too, don't know how many people
 14 are doing there.

15 **MR. VANDERJAGT:** Yeah, I was not. I
 16 would just put the chat box. I did not recommend a
 17 capnography for the reasons you mentioned. I was
 18 concerned about that. It says cardiac and there's
 19 nothing about respiratory, anything respiratory,
 20 including oximetry and certain is a delay with
 21 oximetry. I do understand that.

22 **MR. CUSHMAN:** So, so Elise, very
 23 specific. What's your recommendation there? What's
 24 your --
 25

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 2 **MR. VANDERJAGT:** There needs to be
 3 something in there. I think maybe it's the educational
 4 piece of it or a bullet point at the top is that it's
 5 the respiratory aspects of this that I'm most concerned
 6 about. Cardiorespiratory monitor. We have gone away
 7 certainly from that with the same cardiac monitor,
 8 because if the respiratory issues are very significant.
 9 Then you gave morphine to a three-month-old, that is a
 10 problem. So that's all, I don't know, -- I would say
 11 cardiorespiratory monitor, but that's a bigger
 12 discussion as you said. Oximetry, I don't know if
 13 that's something that could be at least used, but
 14 somewhere in there that, to indicate that the side
 15 effects of these are predominantly respiratory. And
 16 this doesn't seem to imply that.
 17 **MR. COOPER:** Amy, in the interest of
 18 time let's add this particular issue to the group of
 19 considerations that our protocol task force is going
 20 to be focusing on during our upcoming conference call.
 21 I think Elise raised a good point, but at the same
 22 time, we all understand that the -- that the gold
 23 standard in terms of respiratory monitoring is
 24 entitled. But of course, we also understand that
 25 relatively few services are using that particularly in

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 2 kids. Is a certain level of you know, of deterioration
 3 in oxygen saturation. Something that should be
 4 considered as part of, a cardiorespiratory monitoring.
 5 I think that's a -- that's a very good point for
 6 discussion is Jeremy's indicated. So why don't we add
 7 that to the list of things that the protocol task force
 8 is going to be looking at. Kevin Albert, you've got
 9 a, you've got your hand up.
 10 **MR. ALBERT:** Yes. Thank you. I am
 11 referring back to the Tylenol Dosing Chart. I was just
 12 wondering if the term APAP and the top of the right-
 13 hand column would be something that confused field
 14 providers as an abbreviation for acetaminophen, or if
 15 that was commonly known to them. That was it.
 16 **MR. CUSHMAN:** I think that's a very
 17 important point.
 18 **MR. VANDERJAGT:** It is --
 19 **MR. ALBERT:** I can add the parenthetical
 20 reference or take it out entirely.
 21 **MR. HARRIS:** I'd take it out.
 22 **MR. COOPER:** -- just spell out, I see
 23 in a minute. But of course, either way.
 24 **MR. CUSHMAN:** Again, no problem. I'm
 25 glad that we're catching these. That is exactly how

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 2 it's been written for the last five to seven years. So
 3 we'll change it, but that's how it's been and we'll
 4 adjust it and move on.
 5 **MR. COOPER:** Understood, Jeremy, this
 6 is no hit on you protocol group. It's just that, that
 7 people are catching stuff and that's good for kids.
 8 Anything else? Okay. Amy, do we have another protocol
 9 to consider?
 10 **MS. EISENHAUER:** No, that was both of
 11 them.
 12 **MR. COOPER:** Okay. Jeremy, thank you
 13 so much. I know you have to leave at 2:00. I deeply
 14 appreciate your work and that of the protocol group on
 15 these issues. And we'll all stay tuned. Okay. Thank
 16 you so much. Okay. Amy, I think it's you're up.
 17 **MS. EISENHAUER:** All right. So since
 18 Dr. Cushman has to leave in nine minutes and he did
 19 mention the ... hands heavy project I will let him give
 20 a quick update at the top of my report and then I'll
 21 take care of the rest.
 22 **MR. CUSHMAN:** Great. Moving along
 23 working there's just a few final tweaks to the report
 24 from Data Informatics and allowing us to access it at
 25 the regional level, including one medication that was

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 2 left out that we're just we're waiting on, from that
 3 team, so that we can monitor any hopeful progress, in
 4 our dosing. The entire training has been developed
 5 and the trainers start this week. Related to that,
 6 we're utilizing a -- the trainer model. The app
 7 configuration is all complete. Amy was kind enough to
 8 spend hours painfully reviewing all of that and how we
 9 were configuring things to make sure that they reflect
 10 protocol and so forth. So a lot of it was actually
 11 more, more backend preparatory work than I think we
 12 had bargained for.
 13 But it is set and agencies will actually
 14 start participating in that as early as mid-month that
 15 are being trained up on that. And we'll track its
 16 progress. And more importantly, we've identified
 17 processes for addressing any medication concentration
 18 changes, which seem like they happen every day. And
 19 making sure that we don't have errors related to that.
 20 So hopefully the next time this group meets will have
 21 how many folks have downloaded and utilized the app as
 22 well as what our initial experiences are with it. And
 23 with any luck, even a little bit of data.
 24 **MR. COOPER:** That'd be great. Amy,
 25 anything to add?

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 2 **MS. EISENHAUER:** Not to this, but I do
 3 have some other things to discuss.
 4 **MR. COOPER:** Sure. Any comments on
 5 Jeremy's recent brief remarks? Okay. Well, again,
 6 Jeremy, thank you so, so much for your time today and
 7 we'll look forward to ongoing conversations with you
 8 in the Protocol group. Thank you again, Amy. Go ahead.
 9 **MS. EISENHAUER:** Thanks Dr. Cushman,
 10 and thank you, Dr. Cooper. So back to the rest of my
 11 report. So the E.M.S. grant award, as Ryan had
 12 mentioned, was renewed V.A. So the end of March, they
 13 gave us the notice of awards sadly across the board,
 14 not just New York but across the board they were not
 15 able to award the full amount, but it is more than it
 16 used to be. So we were awarded one hundred and ninety
 17 thousand dollars for this year. And currently for the
 18 subsequent three years, each year is one hundred
 19 seventy five dollars. So there will be some budgetary
 20 review to see you know, obviously what has to go and
 21 what can stay, because thirty thousand dollars is not
 22 a small amount of money. So that work is ongoing.
 23 Hopefully soon they will be sending out the performance
 24 measures that we will be measured against.
 25

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 2 I know that E.M.S.C. Federal is hard at
 3 work at finishing those up. And I will share those
 4 with you, as soon as I get them. I know that in the
 5 notice of funding opportunity much of the work, some
 6 of it is the same. So we're keeping the pediatric
 7 emergency care coordinators for both E.D.s and E.M.S.
 8 Pediatric recognition programs for both emergency
 9 departments and E.M.S. Disaster management is a key
 10 component and happily Kate Butler as a party and Matt
 11 Wiley from our office were able to help us include some
 12 pediatric specifics within some of their work. And I
 13 hope that Kate will talk about that during her report.
 14 So great stuff happening moving forward. And I'm going
 15 to talk more about the E.D. type program and E.D.
 16 recognition program during old business. So I won't
 17 get into that now in the effort of saving a little
 18 time. Let's see.
 19 So the all grantee meeting for E.M.S.
 20 for Children is in September. It is sadly the same
 21 week as SEMAC and SEMSCO. So it is going to be Jacob
 22 and I going and we will bringing back information from
 23 that during the December meeting. Some of the things
 24 that they're featuring are pediatric recognition
 25 programs, how to engage hospitals, how to engage other

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 2 stakeholders to participate. So I am looking forward
 3 to that because as I mentioned, that's part of our
 4 expectations over the next four years. So it'll be
 5 great to see what other states are doing outside of
 6 the Northeast. I know that Maine, New Jersey,
 7 Pennsylvania, and New Hampshire have similar programs
 8 to ours. And they were great, helps with references,
 9 and things, but it'll be great to see what other states
 10 are doing as well, especially the larger states similar
 11 to ours like Florida, Texas and California.
 12 So Ryan also mentioned Vital Signs
 13 Conference. I know that -- that was in the process of
 14 finalizing everything, but some of the topics that we
 15 were able to have are pediatric disaster. I know that
 16 there was also a class on penetrating injuries that is
 17 related to PED's and adults. So we were able to fit
 18 that in elsewhere in the conference, which is great.
 19 We are going to have Sarah Gruber part of our group do
 20 her de-escalation talk for, it's for everyone, but
 21 highlighting PEDs. And then also oldies, but goodies
 22 pediatric assessment which is always important. And
 23 one other medical talk, I believe PEDs respiratory, so
 24 important things that need to be reviewed and reminded
 25

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 2 of because that's the bread and butter of pediatrics.
 3 But then also some new topics that are up and coming.
 4 Also I believe I announced at last
 5 meeting that the PAT document had been updated. Thank
 6 you, Dr. VanderJagt and Sharon Chiumento for working
 7 on that. It was in printing; I believe last time we
 8 talked but I now have the documents on my hand where
 9 you can access it on our resource page. So that's
 10 available. The badge buddies are available and the
 11 E.D. or the E.M.S. tech application all of those we
 12 have forms for. And you can order those documents that
 13 way, or you can apply to be that way. And if you have
 14 any questions on that, obviously you can always contact
 15 me or Jacob and we'll get you to the right place.
 16 Just want to make sure that I did not
 17 forget anything. There is an initiative on pediatric
 18 readiness for emergency departments at the federal
 19 level. They've been doing webinars on it. We'd love
 20 to have many, many hospitals participate. Really EMSC
 21 Federal does a lot of the work in guiding the
 22 initiatives, putting things together. So yes, there
 23 will be some work on the hospital side to do the work
 24 at their facility. But it is really supported by
 25 E.M.S.C. and E.I.I.C. So if you're interested in that,

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 2 I'll be happy to share that information as well. Next
 3 meetings. So the next E.M.S.C. and E.I.I.C. meetings
 4 will be in person at the Troy Hilton Garden Inn in
 5 Troy, New York. And those will be on September 5th
 6 and December 4th.

7 As Ryan mentioned, trying to keep them
 8 in line before CMAC and ... so that if we have anything
 9 that needs to be suggested or processed through those
 10 meetings. We can have our meeting and then it doesn't
 11 have to wait another three or four months till the next
 12 set of meetings which was very important in deciding
 13 some of these dates. So the meeting will still be from
 14 1:00 p.m. to 4:00 p.m. And they will be in-person in
 15 the effort to start transitioning back to seeing people
 16 in-person. And actually, many of us include myself
 17 who are new getting to see each other. I didn't realize
 18 that I had never met Dr. VanderJagt in-person until a
 19 few months ago when I was out in Rochester. And it
 20 felt like I had known him in-person, but then I was
 21 like, man, I've never really met you in-person before.

22 So I think it'll be great to meet
 23 everyone in-person, for all of us to meet each other
 24 because we did have a lot of new members join. And
 25 for all the other providers that attend the meeting to

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 2 join us and get to be in the room where it happens, as
 3 it were. So, I will be sending out more information
 4 on that, how to make reservations, all the details on
 5 all of that soon. Also, if you don't have an ID number,
 6 I know I've been working with Tara to get them, or if
 7 you don't know it please email me and we'll work with
 8 Tara to make sure you're squared away for the meetings.
 9 Let's see.

10 **MR. COOPER:** Okay. Any questions for
 11 Amy?

12 **MS. EISENHAUER:** I have one more thing.
 13 Sure. Okay. But actually maybe this is better. I'll
 14 do the safe transport of pediatric patients update
 15 after anybody has any questions on these topics.

16 **MR COOPER:** Hearing none. Go ahead,
 17 Amy.

18 **MS. EISENHAUER:** Alright. So at the
 19 last ... meetings Dr. Daly had asked me to bring some
 20 of the safe transport pediatric patients, the newer
 21 devices related to newly born patients. So being
 22 able to safely secure patients that are just born,
 23 whether it was in the house or in your ambulance, how
 24 do we really secure our newest patients with mom and
 25 safely get everybody to the hospital. So he asked me

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 2 to bring some of those devices and my trustee ... at
 3 Birmingham to the meeting to demonstrate some of
 4 those items. And Ryan was kind enough to assist me
 5 in my demonstration and really got a lot of great
 6 questions and interests. And Dr. Cooper had asked me
 7 to give an update on our work with safe transfer of
 8 pediatric patients that have really been started with
 9 my predecessor, Mark Bohlke. And I know that she had
 10 done training programs for child passenger safety
 11 technicians, who were also first responders,
 12 paramedics, E.M.T.s, who worked on the ambulance. I
 13 believe it's the University of Indiana and I want to
 14 say 2010 or 2011, had put together a program
 15 detailing using car seats in ambulances, using the
 16 devices that had been developed at that time of which
 17 there was only a handful that were designed for
 18 ambulances when it's appropriate, how to do that et
 19 cetera. And I know that there have been several
 20 classes here in New York related to those who would
 21 train the trainer. Since then, a multitude of
 22 devices have been developed. I know that A.C.R.
 23 four, the new emergency pediatric restraint, which is
 24 the new A.C.R. four, the P.D.M.A., now has a P.D.M.A.
 25 Plus, which is a larger version. Ferno has invented

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 2 the KangooFix, which is one of the newly born patient
 3 devices, AEGIS' maternity safety belt has come out,
 4 which originally was developed for O.P. units and
 5 hospitals, but they did some crash testing and
 6 adapted some things. And it's also good for use in
 7 newly born patient situations in ambulances. And
 8 those are just a few of the devices. NASEMSO has an
 9 entire list on their website under the Safe Transport
 10 of Pediatric Patients header. And if you need that
 11 as a reference and you can't find it, again please
 12 email me, I'm happy to help and get that information
 13 to you. In light of these new advances and learning
 14 more about car seats and the cells being updated over
 15 the last thirteen or so years, there are new
 16 developments in using pediatric restraint devices. I
 17 know that we had discussed that as part of the
 18 updates for ambulances. So I know that as Ryan
 19 mentioned in his report, that there is some public
 20 comments coming up. So we'll learn more then.
 21 However, as far as training, I know that Linda
 22 Efferen just jumped off too. She is on the way to
 23 the Child Passenger Safety Technician Conference as
 24 well as I will be after this meeting. Many people on
 25 this call are either there or going there and are

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 2 going to teach there. So several of the injury
 3 prevention coordinators and a variety of the
 4 pediatric and trauma centers, who also are C.P.S.T.s
 5 and paramedics and have been trained how to use
 6 devices in the ambulance under that initial program
 7 kind of have gotten together to develop an update for
 8 New York State. And I know that's been underway and
 9 I need to follow up with that group. But it looked
 10 like promising work on including some of the new
 11 devices and how to use or not newer safety seats in
 12 the ambulance. Related to newly born patients, I've
 13 been doing education across the state on how to use
 14 the newly born patient devices and sharing that
 15 information and bringing devices to different
 16 educational opportunities and discussing right best
 17 medical practices and how that needs to be considered
 18 as more considering transport and how we transport.
 19 And in that vein, I will be talking tomorrow at the
 20 Child Passenger Safety Technician Conference on that
 21 issue. So those are some of the updates. There is
 22 some movement as far as the education to keep
 23 providers up to date. I did see some great pictures
 24 on Instagram from, I believe Ryan Beckfire, who has
 25 some very proactive pediatric emergency care

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 2 coordinators. They did some training with real
 3 children, not mine, creepy mannequins from Amazon,
 4 but real children of different sizes over the
 5 weekend. So from the photos, it looked like a really
 6 successful event and that everybody had enjoyed it.
 7 And any education that I go to where we do the hands-
 8 on skills component everybody loves it. They're
 9 always, you know, oh, this is so much easier than I
 10 thought. So I think just the contraption of the
 11 devices, which is a necessity, concerns people or
 12 makes them feel uncomfortable. But after they see
 13 them used, I think it makes providers feel much more
 14 comfortable using that for patients. Any comments on
 15 the safe transport of pediatric patients' portion?
 16 **MR. COOPER:** No, this is really a
 17 tremendous amount of work in the evening and really
 18 look forward to more on this particularly after the
 19 conference that you're attending right after this
 20 meeting. It is a very hot topic for us all and has
 21 been for some years. And it's gratifying to, seems
 22 that it lasts on progress -- in cases in this area.
 23 That seems to be a little worthwhile. So because
 24 it's really been a difficult, today unsolved problem,
 25 and we really appreciate all your work on this and of

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 2 course markets before you. Any other questions for
 3 Amy? Okay. Well, I guess, we're up to old business.
 4 Let's speak about the pediatric education protocol
 5 and check the educational component. Amy, do you have
 6 any information on that for us?
 7 **MS. EISENHAUER:** So I had several
 8 training classes forwarded to me. I know Chief
 9 Pataky sent me some of their information from We
 10 Heard. Sara Gruver sent me her de-escalation work.
 11 Also, the E.M.S. E.I.I.C. has some information and
 12 documents, reminder documents. So the collection of
 13 items has occurred. And I know that we need to
 14 schedule another meeting to review them and discuss
 15 them and see how to move forward.
 16 **MR. COOPER:** Yeah. And then ideally,
 17 we want to do that sooner rather than later, but to
 18 show some of the videos and so on, it might not be so
 19 easy to do it online. If it must need -- we could
 20 consider, hey, put it off this long, but we could
 21 consider doing it as a pre-meeting prior to our
 22 September meeting. But I'd like to see if we can't
 23 get something done before then if we can.
 24 **MS. EISENHAUER:** Okay.
 25

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 2 **MR. COOPER:** Do we have a way through
 3 the system of doing videos online that's reliable? I
 4 know sometimes over the Internet the videos can be
 5 difficult.
 6 **MS. EISENHAUER:** I will check the
 7 content. I think they're PowerPoint. So it might
 8 not be -- we might not have the video issue.
 9 **MR. COOPER:** Yeah, I think -- I think
 10 the E.I.I.C. at least has some videos on their
 11 website or dot com.
 12 **MS. EISENHAUER:** Okay. I will do some
 13 research and see how we can make that happen without
 14 having to wait till September.
 15 **MR. COOPER:** Thank you. Anything else
 16 on the -- station protocol? It's gratifying that
 17 we've collected a number of items to review, but now
 18 we just have to get the pedal of the metal and get
 19 that done. Got it. Okay. So the PET program.
 20 **MS. EISENHAUER:** Okay. That is me.
 21 Okay. I need your guys' presentation. Okay. So, as
 22 I mentioned earlier during my report, this is going
 23 to be a combination pediatric recognition program for
 24 emergency departments and a PET program within that
 25 pediatric recognition program. So in many of the

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 2 other Northeastern states, it's called Always Ready
 3 for Children. We kept -- we kept that vein because
 4 we do want to be always ready for children. And
 5 that's a huge initiative of E.M.S. at large. Let me
 6 see what you guys can see. I have two screens and
 7 I'm trying to see which screen is actually doing
 8 things. So why have a pediatric recognition program
 9 or a PET coordinator at all? Sorry for my technical
 10 issues. So it's been demonstrated through a variety
 11 of research championed by Dr. Gausche-Hill, so
 12 National Assessment of Pediatric Readiness of
 13 Emergency Departments and that was in JAMA PEDs in
 14 2015, Emergency Department Pediatric Readiness and
 15 Mortality, and critically ill children, which is --
 16 which was in pediatric patients in 2019. And then Dr.
 17 Remick in 2019, also Pediatric Emergency Department
 18 Readiness among U.S. Trauma hospitals and that was in
 19 the Journal of Trauma and Acute Care Surgery. So
 20 these research found that the presence of a pediatric
 21 care coordinator within an E.M.S. agency, E.D. or
 22 hospital, is one of the strongest drivers of improved
 23 quality of emergency care for children. And the
 24 results from the 2003 and 2013 National Pediatric
 25 Readiness Assessments also indicate that the presence

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 2 of PET is strongly correlated with enhanced pediatric
 3 readiness. So having the right pediatric supplies,
 4 having policies already be written, having processes
 5 and procedures in place, all of those things
 6 associated with readiness is one of the driving
 7 factors of excellent care for children. So benefits
 8 of having a pediatric emergency care coordinator, and
 9 you all may have heard this before, is an improved
 10 pediatric readiness score on that National Pediatric
 11 Readiness Assessment. Increased staff awareness and
 12 competencies in pediatric best practices, right? So
 13 making sure that many hospitals the PEDs is your
 14 thing, if trauma is your thing, you may have more
 15 exposure to pediatrics. But for hospitals and E.M.S.
 16 agencies at large, we don't always see a lot of
 17 pediatric patients. And I want to say for E.M.S. in
 18 2021, five percent of all of our calls were for
 19 pediatric patients. So some people that have lower
 20 call volumes may not see a pediatric patient all
 21 year. Benefits of having impact is safer, better
 22 equipped emergency department for pediatric
 23 emergencies, so they will have the right equipment on
 24 hand, and easily reached. And sustainable pediatric
 25 education and improvement program that ensures kids

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 2 always present to a safe E.R. receiving the best
 3 care, which I think all of us agree is why we're here
 4 doing this work. So what is an emergency department
 5 PED, a pediatric champion can be a physician who's a
 6 specialist in emergency medicine or pediatric
 7 emergency medicine, can be a registered nurse with an
 8 interest or training in emergency care of children.
 9 And this could be a full-time role if you are blessed
 10 like that at your hospital or it could be in addition
 11 to other responsibilities as many of us do. And
 12 these suggestions come from E.M.S.C. federal and
 13 E.I.I.C. related to pediatric readiness in the
 14 emergency department, which was a joint policy
 15 statement from ACEP, E.N.A. and A.A.P. And then the
 16 institute -- the Institute of Medicine's report
 17 growing pains from 2006. So some of those
 18 responsibilities for the PET would be to promote and
 19 verify adequate skill and knowledge of E.D.
 20 physicians, E.D. healthcare providers, and other
 21 staff. And obviously taught by similar provider
 22 level, right? So physicians would be training
 23 physicians, nurses would be training the nurses.
 24 Other ancillary staff would be trained as appropriate
 25 by leader, participating in E.D., pediatric

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 2 Q.I./P.I., patient safety, injury and illness
 3 prevention and clinical care activities. And some of
 4 these -- I know that many hospitals do this because
 5 they do this. It's part of their work, especially
 6 the education hospitals. But for the smaller
 7 facilities, E.M.S.C. Federal does a variety of Q.I.
 8 projects. Currently, there is a suicide program in
 9 the E.R. or suicide of pediatric patients for
 10 emergency department's Q.I. program going on. And I
 11 know that they have another one for pediatric
 12 readiness upcoming, I believe it's in the fall. So
 13 also assist with development and review of E.D.
 14 policies and procedures, standards for meds, much
 15 like we just did, making sure that all the equipment
 16 is up to date, and supplies are accessible for
 17 pediatric patients. And ensure pediatric needs are
 18 addressed in hospital disaster and emergency
 19 preparedness plans. I know that that is a huge work
 20 to make sure that the hospital is prepared for a
 21 variety of disasters, whether natural or manmade.
 22 And we just want to make sure that children have
 23 enough supplies, appropriate meds, any specific
 24 things that they need. And I know in discussions
 25 with a variety of people, pediatric reunification

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 2 with many of the disasters and school incidents going
 3 on across the country. Reunification is a huge deal.
 4 So, our plan; Always Ready For Children, there are
 5 three different levels. So, pediatric engaged means
 6 you want to do something, but maybe you haven't
 7 before, you don't have a lot of experience, you don't
 8 see a lot of kids. So you would complete the
 9 National Pediatric Readiness Assessment, which is the
 10 interim tool that E.M.S. for Children has put out for
 11 the years in between the N.P.R.P., which is the
 12 actual survey. And I want to say we did the survey
 13 in 2021. The next one I believe is 2024, 2025. So
 14 in between, it's the same thing. You just do it on
 15 your own. So doing the NPRA, so you have a score and
 16 you see where you're at, at this moment in your E.R.
 17 And you can do this every three months, every six
 18 months, every year, depending on your goals and
 19 initiatives. It's up to the individual emergency
 20 department. So have that readiness score. So you do
 21 get a report after you complete the N.P.R.A. and you
 22 definitely get a report, a gap report after the
 23 N.P.R.P. So what is your readiness score? So that
 24 we know that you did it. And then we can suggest any
 25 recommendations, resources. The hope is after the

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 2 program is fully rolled out, that we can do some
 3 mentoring between hospitals. You know, hey, we've
 4 done this before, you're looking to do this, can we
 5 help each other? And then identify an E.D. pediatric
 6 emergency care coordinator. So who's going to be the
 7 person or persons, because it doesn't have to be just
 8 one, it could be multiple, depending again, on -- on
 9 your hospital's goals. Identify somebody that we can
 10 reach to talk to and who will be responsible for the
 11 work, essentially. And then the next level is
 12 pediatric ready. Right? So many of the same -- many
 13 of the same things except your score on the N.P.R.A.,
 14 or N.P.R.P. be seventy or above. So maybe you've
 15 already done some of this work and your assessment
 16 has shown, hey, it's working, it's great, you want to
 17 do better. And then for Pediatric Innovator and I'm
 18 sure that New York State -- and I know that all of
 19 you are a component of many of these systems. Your
 20 score would be eighty or above. You would have a
 21 pack -- four packs and then also be willing to share
 22 your best practices and resources. So what projects
 23 did you do? What worked? What didn't work? And I
 24 know when talking to people, sometimes what didn't
 25 work for you is a better help than what did work.

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 2 Especially because New York has a -- a large range of
 3 differences in communities across the state. But
 4 saying, hey, we did this and it was an absolute
 5 disaster for these reasons. Okay, right? My -- my
 6 region, my area, my hospital has similar features.
 7 Maybe we don't do that. Maybe we plan something
 8 else. So be willing to share those best practices
 9 and your resources. And as I mentioned, my hope is
 10 in the future years once we get everything kind of
 11 settled and off the ground is to do some professional
 12 development or do maybe a quick learning day. I know
 13 that I would also like to do that for E.M.S., but
 14 more education development for E.M.S. And for
 15 hospitals as we find out what hospitals need to
 16 develop those days for them. So how to participate?
 17 Ensure your facility has an emergency department
 18 path. I know that many of the hospitals that have
 19 reached out that are interested also because this is
 20 going to be a requirement for A.C.S. for trauma
 21 verification and re-verification in September of this
 22 year so many people already have somebody that
 23 functions in this role. I know the injury prevention
 24 managers; I've talked to work with a team. So I
 25 don't think that this will be as much of a reach for

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 2 hospitals as maybe it is for E.M.S., because a lot of
 3 the hospitals, particularly the trauma centers,
 4 pediatric hospitals, have somebody that does all of
 5 this already, which is great. We're just putting a
 6 name on it. So also complete N.P.R.P. And again
 7 it's at dot org. If you can't find it again, I'm
 8 always happy to help. Submit your application with a
 9 commitment letter to us. And as we have many forms
 10 for many things, we'll have forms for this. Jacob --
 11 Jacob didn't know until now, but that's going to be
 12 one of his projects in the next couple weeks as we
 13 move this forward. And then of course, start
 14 advancing patient care even more than you already
 15 are. So some of that guidance and tools, right?
 16 You're not doing this by yourself, myself and Jacob,
 17 and anybody else in our State Partnership Program are
 18 always a resource for anything, E.M.S.C. There is
 19 the E.M.S.C. E.I.I.C. site that has a wealth of tool
 20 kits research, educational information, a lot of the
 21 Q.I. initiatives are listed on this website past --
 22 past Q.I. and upcoming Q.I. So always keep an eye
 23 out there if you're interested in projects. And then
 24 of course, the N.P.R.P. assessment which will be
 25 coming back up, I want to say in 2024, but it might

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 2 be 2025. It's either one. And then of course, The
 3 American Academy of Pediatrics, ENA, ACEP, they do a
 4 lot of the heavy lifting at the larger level for
 5 research. Certainly Dr. Gausche and Dr. Kate Remick
 6 are prolific and do a lot of work surrounding
 7 pediatrics and pediatric preparedness. So next steps
 8 after -- after I speak with all of you, I will be
 9 speaking with staff next week. And kind of what
 10 we're looking for. I checked with the Division of
 11 Legal Affairs, we don't need a vote or a motion, but
 12 just kind of a yes, we support this statement is what
 13 they said was necessary to move this forward. Jacob
 14 and I will work with Public Affairs Group on updating
 15 our PAC webpage and resources. So as soon as this is
 16 approved and I can move forward, my hope is to have
 17 that done. ... is wonderful and super helpful. So I
 18 will reach out to him as soon as everything is
 19 approved to get that rolling so that it's up there
 20 and everybody can sign up. We will start the program
 21 rollout to hospitals. And I -- definitely I, but
 22 maybe Jacob will join me on some of the local ones.
 23 We'll be attending the RTEC meetings over the summer
 24 and the fall to talk about this with the regional
 25 trauma advisory councils as this is an A.C.S.

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 2 initiative. And I will be working with Patty and Dan
 3 to make sure that all of the trauma centers have this
 4 information so that they can get on board, and they
 5 are enrolled and there is no issues. So that is the
 6 next steps for this program. And this is how you can
 7 find me. But you all knew that. Does anybody have
 8 any questions about the program? I know this is kind
 9 of a high-level overview. Our hope was not to make
 10 it so, so specific that different levels of hospitals
 11 or different regions with different capabilities or
 12 initiatives couldn't participate. We wanted to make
 13 it all inclusive.
 14 **MR. COOPER:** Any questions for Amy?
 15 Hey, this is a boatload of work. We really thank you
 16 for all you're putting into it. Obviously, we
 17 recognize that this is a key element of -- of
 18 E.M.S.C. and well within your charge, but
 19 nevertheless you're doing a phenomenal job with us
 20 and they appreciate us. Any other comments or more
 21 questions for Amy? Okay, so let's move back to the
 22 next agenda item, then. You'll repost that agenda
 23 for us Amy?
 24 **MS. EISENHAEUER:** Yes, let's see.
 25

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 2 **MR. COOPER:** Okay. So Peter, your
 3 triage recommendation is the next item on the agenda,
 4 Amy?
 5 **MS. EISENHAEUER:** Alright. So give me
 6 one second and I will post that. I think I found it.
 7 I just want to make sure that you were seeing the
 8 correct document. It's a little crazy. Okay. So
 9 you should be seeing -- seeing our pediatric trauma
 10 triage destinations graph. Since you edited this,
 11 Dr. Cooper, do you want to discuss it?
 12 **MR. COOPER:** I certainly can. So this
 13 builds off a document that was created in 2014 by a -
 14 - a group composed of members of E.M.S.C. as well as
 15 members of the staff. And at that time, it was
 16 determined that all pediatric trauma patients must be
 17 transported to it from the level one or level two
 18 pediatric trauma center if they meet current American
 19 College of Surgeons Committee on Trauma field triage
 20 guidelines and are able to arrive within fifty
 21 minutes. The circumstances have arisen over the past
 22 ten years or so. Where -- whereby some exceptions to
 23 that absolute requirement seem to be appropriate.
 24 Not to say that we don't want patients to go to level
 25 one and level two pediatric trauma center, okay? But

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 2 there are circumstances in which that simply isn't
 3 feasible, perhaps due to lack of time and transport
 4 capabilities among -- among others. So in -- in
 5 editing this it seemed to make sense to put a strong
 6 should as opposed to an absolute must, as the part of
 7 this -- part of this document. So, that's -- that's
 8 bullet point number one. Can we slide down, please
 9 Amy, a little bit? And of course, same -- same for -
 10 - for the second bullet point. Clearly if the -- if
 11 the patient still meets field triage criteria upon
 12 arrival, you know, at a -- at an adult trauma center
 13 or non-trauma center, they should be transferred if,
 14 again -- if it's feasible. I can imagine that there
 15 are circumstances where, again, if it might not be
 16 feasible, might not even be safe. So -- so again,
 17 this would be providing some level of flexibility,
 18 but with a very strong admonition that that patients
 19 should be taken to pediatric trauma center --
 20 designated pediatric trauma center. And the decision
 21 to transfer the patient who wants do primary survey,
 22 with potential surveys are initiated, ideally within
 23 thirty minutes. That's the decision, ideally within
 24 thirty minutes. Okay? Initiation of the transfer
 25 process should take place as soon as possible

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 2 thereafter, ideally within fifteen minutes. So
 3 that'll be a total of forty-five minutes into the --
 4 into the resuscitation. And then ideally, transfer
 5 should occur as soon as possible. Thereafter,
 6 hopefully within two hours. But again that's
 7 depending upon transport resources. So -- so this is
 8 the you know -- the -- the whole thrust of the
 9 potential suggested revisions are that we want to
 10 provide some level of -- some level of flexibility
 11 while still maintaining, the -- the -- the fact that
 12 pediatric patients belong in pediatric trauma center.
 13 And accordance to do that all pediatric trauma
 14 transfers needs to be reviewed in a timely manner.
 15 So that's basically it. And I invite any -- any
 16 questions or comments at this point.

17 **MR. HARRIS:** Alright. It's, Matt, may
 18 I just ask a point of clarification?

19 **MR. COOPER:** Sure.

20 **MR. HARRIS:** Thank you. So this is,
 21 as you know, has come up a couple of times in the New
 22 York City RE/MAX discussions. And there is, I think,
 23 a conversation to be had about how a pediatric
 24 patient is defined and not by the college. I think
 25 that's really well out there. But there seems to be

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 2 discrepancy between how a pediatric patient is
 3 defined for treatment and how a pediatric patient is
 4 defined for disposition in terms of transport
 5 disposition. Just to be clear, are you exclusively
 6 referring to pediatrics in this context, is those
 7 under the age of fifteen?

8 **MR. COOPER:** Matt I can't quite hear
 9 you. Can you -- can you please up that last little
 10 bit? Please.

11 **MR. HARRIS:** Sorry, forgive me. I was
 12 just looking for a clarification on are we
 13 exclusively referring to pediatric patients as those
 14 under fifteen for the purposes of destination
 15 determination?

16 **MR. COOPER:** Well, that's -- that is -
 17 - that is you know open for discussion. If can Amy,
 18 can you slide back up to the top? And if you can see
 19 --

20 **MR. HARRIS:** The reason -- sorry, I
 21 was just going to give some -- some context for a
 22 moment. I'm driving, so forgive me, I can't see
 23 anything. I ...

24 **MR. COOPER:** -- if you can see, the
 25 last line of the introductory paragraph speaks about

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 2 patients that have not yet reached their fifteenth
 3 birthday, it doesn't speak about patients over
 4 fifteen or more.

5 **MR. CONWAY:** Right. So I guess the
 6 reason I bring this back up for the group's
 7 discussion are -- and forgive certainly differ for
 8 person to you as a subject matter expert in this.
 9 When you look at different regions in New York in
 10 different protocols, and I -- I haven't reviewed the
 11 collaboratives recently, so please forgive my
 12 annotate here. But Pete, a seventeen-year-old with
 13 asthma may end up in either an adult emergency
 14 department or pediatric emergency department, and
 15 they are going to be treated under pediatric
 16 protocols, even though they're getting in adult
 17 medications and probably based on their age and
 18 weight. We've been having a big struggle about -- in
 19 our -- in our little cohort here at Cohen's about
 20 these patients who are fifteen in a day to seventeen
 21 and three hundred and sixty four days, where we in
 22 the last two years, just some revising context, we
 23 received two hundred adolescents, fifteen to
 24 seventeen, three sixty four for transfer from adult
 25 trauma centers, fifty percent of whom required

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 2 admission. So these would fall under that cohort of
 3 kids that granted not discussed in this document
 4 because you have your age limitations, but in the
 5 bucket you described, if kids who show up in an
 6 outside institution because A.C.S. allows them to go
 7 there because they're over fifteen, but then it
 8 doesn't seem like a lot of these adult trauma centers
 9 are admitting this cohort of adolescent patients. So
 10 they're showing up to an E.C.S. accredited trauma
 11 center for adults, I'm sure being totally
 12 appropriately managed, but then not being admitted
 13 there for whatever reason. Maybe don't have
 14 pediatric expertise, -- et cetera. But do we feel
 15 that it's something we need to address in this
 16 document? Because I feel like that group gets lost.
 17 They are not quite adults, they are not treated as
 18 kids, and it's in, I still somewhat ambiguous, I
 19 think, what should happen and where they should go if
 20 -- at least in our -- in our small cohort here in
 21 Queens and Nassau County, you know, we're getting a
 22 hundred transfers a year for admission. Well, you're
 23 raising a very, very timely issue. You know, I think
 24 many institutions are grappling with the same issue
 25 as the present time. You know, I mean, it may be as

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 2 simple in some cases as the adult trauma centers may
 3 not have a robust pediatric inpatient service, you
 4 know, and certainly may not have a pediatric I.C.U.
 5 in their facilities. And certainly, for patients
 6 requiring that level of care, that would obviously be
 7 an issue that would necessitate transfer to a
 8 pediatric trauma center, which of course by
 9 definition does have to have pediatric handling
 10 capabilities. But this document didn't -- didn't
 11 initially get into the issue of, you know,
 12 separating, you know, if you will levels of response,
 13 i.e., level one, level two, trauma consult, that sort
 14 of thing. And I think in a sense what you're saying,
 15 Matt, correct me if I'm wrong, is that you concerned
 16 that there are significant members of adolescent
 17 patients between their fifteenth birthday and their
 18 eighteenth birthday who perhaps don't meet level one
 19 or level two criteria who are -- who are just getting
 20 transferred to the adult center or sorry to the
 21 pediatric center just because, you know, it's trauma
 22 and adult service at the center hospital for whatever
 23 reason, may not feel comfortable dealing with those
 24 kids. Am I hearing your point correctly?
 25

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 2 **MR. HARRIS:** Well, I think there's
 3 sort of two groups. There's the groups sort of
 4 essence sort of minimal trauma that are -- are not
 5 cancer evaluating at adult institution because
 6 they're not comfortable or fill in the blank. But I
 7 think perhaps even more impressively, there's fifty
 8 percent of these kids is adolescents who get
 9 transferred to us get admitted, right? So one of us
 10 who get admitted.
 11 **MR. CONWAY:** Right.
 12 **MR. HARRIS:** So you can make -- you
 13 can make the argument that in a geographically
 14 appropriate area, had they just gone to the
 15 children's hospital, there would be no need for
 16 secondary transfer. I guess that's kind of the point
 17 I wanted to bring up is that I wonder we seem to be
 18 giving pretty clear guidance that if you're under the
 19 age of fifteen and you can't quite get to a pediatric
 20 trauma center, go to the adult place and we'll
 21 transfer and that's fine. I guess do we want to
 22 offer similar guidance for that fifteen to eighteen
 23 group because it seems like that's what's happening
 24 either way, or do we want to make the same sort of
 25 soft recommendation that actually should be fifteen

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 2 to eighteen year olds or fifteen to seventeen, three
 3 sixty four. Should we actually go to the pediatric
 4 trauma center? I guess, I'm not, I defer to you as
 5 the trauma surgeon here to help answer that question
 6 where they should be taken primarily.
 7 **MR. COOPER:** Well, Kim Wallenstein is
 8 also on this call, and she's our also trauma expert.
 9 And I think you framed the question very well, but
 10 I'm first going to turn to Conway because I've seen
 11 his hand up. Ed?
 12 **MR. CONWAY:** Yeah, a quick question. I
 13 know, we're using various ages as cutoffs, but a lot
 14 of the institutions go up to age twenty one. So I
 15 know we're talking less than fifteen now. We're
 16 cutting it off at eighteen. But I think probably the
 17 majority of pediatric institutions, now I don't know
 18 what you guys put -- but we do go up to twenty one
 19 here. I'm just putting that in the mix.
 20 **MR. HARRIS:** Trauma.
 21 **MR. COOPER:** Excuse me. Your adult
 22 trauma surgeons just sort of the pediatric group and
 23 since eighteen to twenty one.
 24 **MR. CONWAY:** So we just got our level
 25 two designation, so we'll -- we'll take everything up

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 2 to twenty one. There are certain rules that they
 3 will go to the adult surgical I.C.U. if it's a bullet
 4 to the chest, a headshot, they think they need to go
 5 back to the O.R. But we -- we co-manage both ages.
 6 Under fifteen, we have PED surgeons that are involved
 7 and then up to twenty one are trauma surgeons take
 8 care of them.
 9 **MR. COOPER:** The PED surgeons are
 10 involved for the fifteen to seventeen, right, or no?
 11 **MR. CONWAY:** No, the adults will do
 12 everything over eight -- seven or eight. They have
 13 an agreement. I think it's age eight.
 14 **MR. HARRIS:** Okay, I think right, Ed,
 15 yeah.
 16 **MR. CONWAY:** Sorry, go ahead Matt.
 17 Yeah.
 18 **MS. HARRIS:** I was just going to say,
 19 to answer Ed's question, I think that in the -- in
 20 the five boroughs, I would say that it's most common
 21 that adult emergency, I'm sorry, pediatric emergency
 22 departments are up to eighteen, a few to twenty one,
 23 N.Y.U., I think it's a twenty five. But I think --
 24 but I think that currently the fire department and
 25 the ordinance department, we enact each drugs, take

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 2 people under the age of eighteen, not for trauma, but
 3 for medical to a pediatric emergency department if
 4 they meet PED's GED criteria. So Ed's point is well
 5 taken.
 6 **MR. COOPER:** Yeah. Kim Wallenstein, do
 7 you have any thoughts about this?
 8 **MS. WALLENSTEIN:** Yeah, hi. It's Kim
 9 Wallenstein. It's -- it's a great point. I actually
 10 hadn't thought of this issue before with the -- the
 11 transfer being done to adult trauma centers and then
 12 transferring to pediatric places. I think -- I
 13 would, I don't know how I feel about putting language
 14 in about transferring a fifteen to seventeen year old
 15 perhaps to pediatric trauma centers, because you're
 16 going to get a whole range of different places.
 17 Like, for example, as people were saying, like where
 18 I am at upstate, we're a separate level one pediatric
 19 and a level one adult trauma center. And as
 20 pediatrics we -- for trauma, it's under fifteen. So
 21 you can say, oh, transfer those sixteen year old
 22 trauma patient to the pediatric trauma center, which
 23 would be us, but it would be the adult trauma team
 24 taking care of them. So it's -- you don't get the
 25 same thing that you think you're getting,

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 2 transferring them to a pediatric center. So it makes
 3 covering -- which is a little more tricky.
 4 **MR. COOPER:** I think Kim is right. I
 5 think that there's a tremendous disparity statewide
 6 between how different facilities handle the
 7 adolescent group. I think it's probably more common
 8 for the --the above fifteen age group to be handled
 9 by the adult trauma surgeons at least initially. And
 10 bringing the pediatric surgeons in as you know as
 11 needed. But again, that's totally institution
 12 specific. I'm going to recognize Ed Conway and Ed,
 13 please add your thoughts to the discussion at this
 14 point. Ed?
 15 **MR. CONWAY:** Sorry, I just, I left my
 16 line in for too long. I just took it down.
 17 **MR. COOPER:** Okay.
 18 **MR. CONWAY:** One is enough.
 19 **MR. COOPER:** I see that there's a
 20 couple of comments in the chat. And they by and
 21 large tend to confirm what's been said already that
 22 there's quite a bit of disparity. I think that Lisa
 23 has pointed out that in Rochester, the adult trauma
 24 surgeons take care of those patients, but they're
 25 admitted in the pediatric I.C.U. But that would

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 2 still necessitate a transfer to a pediatric facility
 3 that has a pediatric I.C.U. And then I guess it
 4 would be to that facility to decide which group of
 5 surgeons was -- was involved in -- in the care of
 6 those patients. I think this is a pretty complicated
 7 issue. Perhaps what we should do is to set up a -- a
 8 conference call, Amy and discussion with physician a
 9 little bit more detail and then bring us back to the
 10 next meeting. Does that make sense to everyone?
 11 **MR. HARRIS:** I'd like to participate
 12 in that conversation --
 13 **MR. COOPER:** I am sorry.
 14 **MR. HARRIS:** I was just saying, yeah,
 15 I was just saying I would love to participate in that
 16 conversation. Thank you.
 17 **MR. COOPER:** Oh, sure. Of course. I
 18 think that Mr. Douglas mentioned this to me privately
 19 that in areas outside they're pretty good.
 20 Therefore, there are very few places that can
 21 actually be looking at trauma centers within fifty
 22 minutes, which is part of the reason for being a
 23 little bit less, if you will hard and fast about --
 24 about the "muscular" was in place prior to this. I
 25 guess I still think that it's probably worth a longer

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 2 the discussion that we have time for during this
 3 meeting that a small group that has a specific
 4 interest in this area probably should get together
 5 and discuss it and we'll bring it up at the -- at the
 6 next meeting. I don't think there's any rush in
 7 getting this off but there we are. So does anybody
 8 disagree with that approach? Okay, Amy, so let's --
 9 let's set up a working group. Anybody that wants to
 10 be part of that, please let Amy know. I certainly
 11 will that -- that Aaron has said he wants to be part
 12 of that. Anybody else that's able to participate,
 13 please let Amy know and we'll get this thing set up.
 14 And I think your perspective would be very useful
 15 from Jacobi if you take kids way up to the age of
 16 twenty one. So that would probably be -- be very
 17 helpful.
 18 **MR. CONWAY:** I'd be glad to
 19 participate.
 20 **MR. COOPER:** I see that Brooke Lerner
 21 wants to be part of it and certainly Kim Wallenstein,
 22 so that's great. Okay. So -- so let's do that and
 23 I'll give her some -- some homework. We did discuss,
 24 I think, the length based discuss resuscitation tape
 25 a little bit earlier. Is there anything more we need

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 2 to discuss about that Amy or do we cover everything
 3 pretty much? I think we did that really.
 4 **MS. EISENHAUER:** I just have a short
 5 update. So Megan Williams, her paramedic class was
 6 reviewing the protocols and how the pediatric
 7 protocols and how -- how the dosages are written
 8 versus the -- on the light base meditate. So she
 9 emailed me this morning and said she was not able to
 10 make today but also mentioned that her class has done
 11 a bulk of the work and that they are putting together
 12 a document with their findings. So I anticipate that
 13 being ready for the next meeting. And we'll probably
 14 have an interim subgroup meeting. Just a little
 15 break. Yes. And then we'll present the findings at
 16 the next meeting in September.
 17 **MR. COOPER:** Yes, please. But make
 18 sure we have -- current meeting. I know that Elise
 19 VanderJagt and Nickol O'Toole have both said they
 20 want to participate in the -- in the work group. So
 21 we will do that for trauma.
 22 **MS. EISENHAUER:** Next.
 23 **MR. COOPER:** Tell me. New business
 24 we've already covered that. So I think we are up to.
 25

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 2 **MS. EISENHAUER:** I think -- I think we
 3 have one -- one item brought up at the meeting. I
 4 know Dr. Winslow, are you able to unmute?
 5 **MR. WINSLOW:** Yeah. Yeah, thanks,
 6 Amy. How are you?
 7 **MS. EISENHAUER:** Good, how are you?
 8 **MR. WINSLOW:** It kind of ties in with
 9 this whole trauma discussion, but one thing that's
 10 come up in our region, and we've discussed ... heart
 11 attack is the current new red criteria as approach is
 12 pediatric trauma patients, as -- as its red criteria
 13 for ages zero to nine, systolic blood pressure less
 14 than seventy plus two times even in years. And many
 15 of the E.M.S. providers do not take pediatric blood
 16 pressures, especially on very small children, ages
 17 zero, one and two, and three for a couple of reasons.
 18 Not to mention the fact that it's difficult on a --
 19 on a very small child who's injury may be not
 20 cooperative to get an accurate reading anyway. So
 21 our concern was that if that's the criteria,
 22 shouldn't there be an alternate such as or the
 23 pediatric assessment triangle. That's what we teach
 24 in ... it allows for the pediatric patient to be
 25 assessed without documenting a blood pressure reading

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 2 and gives you valuable information and also a
 3 systolic level blood pressure that low is obviously a
 4 very late sign of shock.
 5 **MR. COOPER:** These are good points.
 6 The -- the only issue that I've seen with -- with --
 7 with what you suggested is the fact that there --
 8 there was strong pediatric representation on the
 9 national work group that put together the changes in
 10 the ... triage guidelines. And secondarily I'd be
 11 very surprised if SACC isn't going to -- isn't going
 12 to endorse the national guidelines, you know, for
 13 youth in New York State at its upcoming meeting. I
 14 could be -- I could be wrong, but I'm guessing that
 15 is what will happen. But I certainly, you know,
 16 think the points that you're making are -- are -- are
 17 strong ones. I think we all are familiar with the
 18 difficulty of trying to get blood pressures on -- on
 19 small children. You know, and I think -- I think
 20 that this is something that perhaps the workers is
 21 looking at trauma triage could actually, you know,
 22 secondarily take a look at the -- the groups tend be
 23 getting together with the triage anyway. Is that --
 24 is that -- is that an approach that would work for
 25 you, Jason?

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 2 **MR. WINSLOW:** Well, we already started
 3 on an educational piece from ... it's really an
 4 educational piece. I don't mean to change a protocol
 5 but just realize that if that is your one criteria
 6 for red, you're missing a lot of sick children. So
 7 what we're doing as an educational piece is that
 8 there are other indicators of pediatric serious
 9 injuries.
 10 **MR. COOPER:** Sure.
 11 **MR. WINSLOW:** Such as skin colored
 12 temperature and condition, and increased work of
 13 breathing, generalized look of the patient. So we're
 14 look working at it with our two pediatric trauma
 15 centers working in concert to put out an educational
 16 piece for our providers. But it's something that I -
 17 - we kind of plan to continue to work on. I'm
 18 curious to see if there's other regions that would be
 19 similar educational material. I don't need a
 20 protocol to be changed. I'm just advising that --
 21 that although is a parameter that can be followed is
 22 probably not the best one.
 23 **MR. COOPER:** Well, you know, once
 24 again, I'm not sure that we're going to have a whole
 25 lot of success in changing that national protocol,

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 2 but your educational piece I think would be very
 3 helpful, you know, to this discussion. And I would
 4 like to invite you, if you don't mind, to -- to join
 5 you know, the pediatric trauma triage group and as an
 6 additional item of business for that group, perhaps
 7 you could present your -- the work that you've been
 8 doing and your region. Does that work?

9 **MR. WINSLOW:** Sure. Yes, I happen to
 10 work at --

11 **MR. COOPER:** Great.

12 **MR. WINSLOW:** -- pediatric trauma
 13 center for the last fifteen years of my practice at
 14 Good Samaritan. We see adults and children. But one
 15 thing I can tell you is -- is that blood pressure is
 16 often not even done in the trauma room as the first
 17 order of business.

18 **MR. COOPER:** Yeah, you're absolutely
 19 right. I think most of us who work in trauma centers
 20 would -- would you know, share their experience.

21 **MR. WINSLOW:** Amy, if you want to
 22 include me, I'd appreciate it.

23 **MR. COOPER:** Yes, that would be great.

24 **MS. EISENHAEUER:** On the list.
 25

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 2 **MR. COOPER:** You are hereby included,
 3 sir.

4 **MR. WINSLOW:** Thanks.

5 **MR. COOPER:** Right. Okay. And Amy
 6 anything else before we move on to update to our
 7 partners?

8 **MS. EISENHAEUER:** I guess not. Did you
 9 want to discuss pediatric strokes Dr. Winslow?

10 **MR. WINSLOW:** Yeah. Yeah, sorry to
 11 get both of my agenda items off in one scoop, but I
 12 will tell you, it has come up in our region as we
 13 look at regionalization of stroke care because we
 14 have three pediatric, sorry, we have three regional
 15 stroke centers and ten primary stroke centers. That
 16 there's no such thing as a New York State designation
 17 for pediatric stroke, and yet when you read them, the
 18 collaborative protocol that we all use, it groups
 19 adult in pediatric stroke together and states take
 20 patients to a pediatric stroke center. I'm sorry it
 21 says take suspected stroke patients to a stroke
 22 center. So I just bring it up for discussion. I
 23 don't want to create a new protocol, but just realize
 24 that some stroke centers may not be able to or should
 25 be taking care of pediatric stroke patients, which

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 2 are very rare entities and are a little different
 3 animal than the adult. And I just wanted to show
 4 have the group look at the fact that currently
 5 pediatrics are included in the adult stroke protocol,
 6 which is written for adults.

7 **MR. HARRIS:** Hey, Arth, can I add with
 8 a quick response.

9 **MR. COOPER:** Sure. I think you've
 10 identified an important gap. Was that Matt who
 11 wanted to -- who wanted to respond?

12 **MR. HARRIS:** Yeah. I think Earth,
 13 correct me if I'm wrong, I think in the city, I don't
 14 believe Nassau, but I think in the city when this
 15 discussion came up to Jason's point I think we
 16 changed the recommendation and the language to say
 17 that pediatric sepsis stroke should go to a PEDs
 18 critical or City Center, recognizing that most
 19 pediatric strokes are not ischemic and usually
 20 require more pediatric expertise than necessarily out
 21 of all the O.O.H.s Adult Comprehensive Stroke
 22 Center, that increasingly brings up an important
 23 point that you know, I think the, the destination of
 24 being a pediatric critical facility or pediatric
 25 capable facility with an I.C.U. is probably a more

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 2 appropriate destination than the closest to Adult
 3 Stroke Center.

4 **MR. COOPER:** Other comments?

5 **MR. VANDERJAGT:** Hi. This is Elise
 6 VanderJagt, I just totally agree.

7 **MR. COOPER:** Please ... go ahead.

8 **MR. WINSLOW:** Yeah. I totally agree
 9 with what's been said. I think I like the last
 10 comment that these patients with pediatric strokes
 11 need to go to a pediatric critical care center
 12 because the etiologies are very variable. And that's
 13 probably the better place to go than a standard adult
 14 stroke center because they're quite different in
 15 etiology and potentially management. So -- but there
 16 is nothing, I believe again in our protocols that
 17 would suggest that, and maybe that should be an area
 18 to be recognized. All of our own institutions, we
 19 have developed a pediatric stroke protocol. We do
 20 have that. So I suspect other pediatric critical
 21 care or pediatric children's hospitals with those
 22 kinds of facilities will probably also have similar
 23 protocols and then that's where they're located
 24 rather than the standard adult stroke center.

25 **MR. COOPER:** Yeah. I will--

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 2 **MR. COOPER:** I'm sorry.
 3 **MR. WINSLOW:** I'll share with the
 4 group that I brought this up with the collaborative
 5 protocol discussion meeting about a week-and-a-half
 6 ago. And the consensus among the collaborative
 7 working group was that because there's no separate
 8 guidance for pediatrics that they're better off in an
 9 adult stroke center than no stroke center at all.
 10 However, I kind of disagree with that. I do think
 11 that they were better served in a pediatric capable
 12 center, and so it's just a point of discussion. I
 13 also think it may be wise, and this was my
 14 recommendation, was to simply delete the word
 15 pediatric from the stroke protocol and having the
 16 vagueness of a pediatric patient that presents with
 17 stroke be that it's a rare entity that requires
 18 either medical control to be involved for a transport
 19 decision or just to flag it into something different.
 20 But leaving in pediatrics with adults now makes you
 21 take pediatric stroke patients to adult stroke
 22 hospital by protocol, and that was my whole point.
 23 **MR. VANDERJAGT:** This is Elise --
 24 **MR. COOPER:** Okay.
 25 **MR. VANDERJAGT:** Sorry.

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 2 **MR. COOPER:** Go ahead Elise.
 3 **MR. VANDERJAGT:** Yeah. I'm not sure
 4 that I'd eliminate -- I'm not sure that I would
 5 eliminate it because there is such a thing as where
 6 the trauma can occur and hemorrhagic stroke that can
 7 occur. So I'm not sure what I would -- how I would
 8 think about it entirely, but I am a little bit
 9 concerned about eliminating it unless you are
 10 interested in looking at a separate protocol
 11 completely.
 12 **MR. WINSLOW:** You know, that would be
 13 the way the other protocols have been written. It's
 14 interesting that this one grouped them. When you
 15 look at the remainder of the protocols, they all have
 16 adult and pediatric separated, and this is one
 17 vestige of a previous generation of protocols that is
 18 currently being reviewed. We are new to the
 19 collaborative working group here in Suffolk. We just
 20 went live with the protocols this January, and we're
 21 still finding these issues. It's my opinion is to
 22 write a separate pediatric stroke protocol and
 23 instead of taking them to an adult stroke center, you
 24 could say taking preferentially to a pediatric
 25

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 2 capable center, because there is no such state thing
 3 as a New York State designation for pediatric stroke.
 4 **MR. VANDERJAGT:** But I do think it
 5 might be helpful, like you said, Jason, is to, maybe
 6 there should be that separation of pediatric stroke
 7 versus adults stroke, like they separated out
 8 seizures, like they separated out pain rather than
 9 inclusive, including it, but there needs to be done a
 10 separate protocol, and I think that's not an
 11 unreasonable thing.
 12 **MR. COOPER:** Okay.
 13 **MR. WINSLOW:** I'll be--
 14 **MR. COOPER:** Yeah. Let's -- there's
 15 enough, you know, smoke and fire around this issue
 16 that I think we need to get together a conference
 17 call and -- and take it through. In general, I think
 18 that you know that, that the comments that have been
 19 made around the target that for the great majority of
 20 pediatric strokes, you know, the pediatric I.C.U. is
 21 the best environment. But there are, there may be
 22 occasional exceptions to the rule that Dr. ... has
 23 pointed out in terms of a hemorrhagic stroke, for
 24 example. Such a child might do better in a stroke
 25 center or a designated stroke center. But I do think

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 2 we need to come up with some specific recommendations
 3 if we think that the, a pediatric stroke protocol
 4 ought to be separated out from the current protocol.
 5 So let's plan on Amy getting together about the work
 6 group, I can see --rolling your eyes with the thought
 7 of -- of a not yet another group, but -- but I think
 8 this is, and we thank you, Jason, for bringing this
 9 up because it is an important enough issue that we
 10 should probably have a specific position on it.
 11 Jason, did you have anything else? Did you have
 12 anything else? Jason?
 13 **MR. WINSLOW:** Sorry. No, I was just
 14 saying thank you. Please include me in the group.
 15 **MR. COOPER:** Sure.
 16 **MR. WINSLOW:** Or maybe also we could -
 17 - maybe also we could discuss it when we're in state
 18 council next week.
 19 **MR. COOPER:** Of course.
 20 **MR. WINSLOW:** Thank you.
 21 **MR. COOPER:** You will clearly be
 22 included, and again Elise you would be part of that,
 23 kind of where you pay your employer, you're both
 24 pediatric intensive units. I don't know if you want
 25 to be part of it or not, I'll leave it to you. But

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 2 certainly your comments would be, you know, very
 3 helpful, and if the other folks want to be part of
 4 this discussion?
 5 **MR. HARRIS:** It's Matt, I would.
 6 **MS. EISENHAUER:** And I got you,
 7 Nickol.
 8 **MR. COOPER:** Okay. Okay, wonderful.
 9 Thank you. Okay. There we are. So is there any
 10 other new business that didn't quite make it to the
 11 agenda? Well, hearing none at the moment let's move
 12 on to update from our -- from our sister advisory
 13 committees the D.O.H. Partners. Brooke and Peter, I
 14 don't know if Peter's on. I know Brooke is on.
 15 **MS. LERNER:** Yeah, I didn't see Peter.
 16 I can tell you -- just recomplete, so hopefully Peter
 17 and I will still be with you in September, but we
 18 won't know until the results of the recomplete come
 19 in. The seizure study that you all approved has been
 20 running in Buffalo. We've enrolled twenty six
 21 children. It's going well. That's using the
 22 emergency exception from informed consent and looking
 23 at age-based dosing compared to weight-based dosing.
 24 Well, last time I was here, I talked to you about our
 25 TRAC study, which is looking at bundles care and a

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 2 checklist for respiratory distress. We're going to
 3 be -- we're finishing our notification and community
 4 consultation plan, and so we'll be starting to share
 5 with the Buffalo community that, that study could be
 6 done here and getting acceptance for that. And I
 7 think that is all that PECARN is doing, but it's all
 8 very exciting.
 9 **MR. COOPER:** Brooke, thank you so much
 10 for your report. And for those of you who may not
 11 know Brooke as well as I've had the pleasure and
 12 honor of knowing Brooke over the -- these many years.
 13 Brooke is amazing. She's made so many incredibly
 14 important major contributions to E.M.S. care. It's -
 15 - the list is almost endless. And we're just very,
 16 very lucky that that she's with us here in New York
 17 State, and you know -- and you know, of course you
 18 see this every time she speaks because she comes with
 19 data, you know, and -- and proposals for data on
 20 which the base decisions that are made. She's a
 21 really -- really a model of an academic scientist.
 22 So, Brooke, thank you for all your contributions
 23 there, so important to the world in which we
 24 function.
 25

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 2 **MS. LERNER:** Thank you for your kind
 3 words, and I am ecstatic to be back in New York, so
 4 I'm happy to be where I grew up.
 5 **MR. COOPER:** Great, great. You know,
 6 I grew up in Western New York, Brooke, so, you know,
 7 we both love the cell. So I'm informed that Amy
 8 Jagareski from the -- from the Bureau of Occupational
 9 Health and Injury Prevention, you know,
 10 affectionately named BOHIP is not with us today. And
 11 unfortunately, a successor has not been named. So
 12 we'll have to wait until September to hear from
 13 BOHIP. I don't know if anyone's up from Family
 14 Health, Marilyn Kacica are you with us today?
 15 **MS. KACICA:** I am here and I've been
 16 listening.
 17 **MR. COOPER:** Oh, great.
 18 **MS. KACICA:** No updates.
 19 **MR. COOPER:** Great. I'm sorry, I
 20 can't see with, with the agenda up. I can't see
 21 everybody on the screen. So --
 22 **MS. KACICA:** No problem.
 23 **MR. COOPER:** -- you kind of were here.
 24 So tell us -- tell us what you've been doing?
 25

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 2 **MS. KACICA:** We -- you know -- we
 3 haven't been so much involved in the pediatric
 4 framework lately. It's been a lot of women's health
 5 and abortion work. So that's kind of been keeping us
 6 busy.
 7 **MR. COOPER:** I'm sure. Okay. Well,
 8 we're -- we're grateful for your participation
 9 because you certainly have been busy with us in the
 10 past. So we hope that, that the future issues arrive
 11 that need your outstanding input. We'll be -- we'll
 12 be able to, you know hear from you at that time.
 13 Thank you.
 14 **MS. KACICA:** Yeah.
 15 **DR. COOPER:** Okay. Kate Butler, as a
 16 party from Health Emergency Preparedness Central
 17 Office. Katie, are you with us? I think I saw your
 18 name.
 19 **MS. BUTLER-AZZOPARDI:** I am here.
 20 Thank you, Dr. Cooper.
 21 **MR. COOPER:** Great. Can you say a
 22 little --
 23 **MS. BUTLER-AZZOPARDI:** I just have
 24 great things that are germane for this group today.
 25 As many of you know, we have some federal

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 2 requirements to work on specific surge annexes for
 3 the State of New York. And we will be starting the
 4 process from the chem surge plan and, and response
 5 annex shortly. So I did want to actually disclose to
 6 this group if there's anyone who would like to sit on
 7 the expert into the group for as we're, when we're
 8 cracking that for the state, and then additional
 9 guidance for the regional level. Please reach out to
 10 me or reach out to me through Amy. There's anyone
 11 who has any interest or if you have any suggestions
 12 that would be greatly appreciated.

13 **MR. COOPER:** Dr. Kate, can you say a
 14 little bit more about, about what, what has entailed
 15 in this project? So we'll have a better sense of who
 16 might be able to help you?

17 **MS. BUTLER-AZZOPARDI:** Yeah. So what
 18 we -- so over the course of our five year cooperative
 19 agreement, we have had a requirement to do five
 20 separate specialty surge annexes. So this year we're
 21 just wrapping up the radiological surge. We get to
 22 have PEDs very early on in our cooperative agreement
 23 infectious disease. And so what we have been doing
 24 is the approach we take as far as we do for cracking
 25 some of the larger documentation that we bring

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 2 together, you know, the best of the best across the
 3 state to help inform that document. So what we're
 4 doing is, so usually is two to three meetings that
 5 are hybrid and or with a virtual option to really
 6 kind of go through some of the things that would go
 7 into that. It's not truly an operational document
 8 because it's really a rollup of everything that's
 9 happening within the state. But the roll-up of the
 10 actions for New York State Department of Health, so
 11 in that same vein we are working to do that, that
 12 chem -- chemical surge response annex. And usually
 13 we do kind of a -- an overarching one meeting that's
 14 kind of broader strokes, and then kind of tease it
 15 down to really inform that document as we prepare to
 16 submit it to our federal partners and have it
 17 available for our regions to use for their use. Does
 18 that helps?

19 **MR. COOPER:** Yeah. That the focus for
 20 the -- so that's great, so the focus for this
 21 particular time is on the chemical surge, correct?

22 **MS. BUTLER-AZZOPARDI:** Correct. Yes.

23 **MR. COOPER:** Okay. Alright. And if
 24 there's anyone with a particular expertise in that
 25 area please get in touch with Amy and, you know, and

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 2 Amy and I will work to identify someone who can
 3 fulfill that role for you, okay.

4 **MS. BUTLER-AZZOPARDI:** Yeah, it's
 5 really interest only if, if there's someone who has
 6 any interest, we -- but we, I did want to because
 7 this was a really great venue to, to float that for
 8 some of the minds on this call, so I do appreciate
 9 that.

10 **MR. COOPER:** Sure. Anything else?

11 **MS. BUTLER-AZZOPARDI:** I just had the
 12 last thing, Amy did mention when she was going over
 13 some of the Always Ready for Children Initiatives is
 14 that, so we have the, the luxury that we get to
 15 directly fund one hundred thirty six of the hospitals
 16 outside of the New York City region through our
 17 hospital preparedness program. We've been working
 18 over the last couple months to try to crack a
 19 deliverable for our next grand year that involves the
 20 hospitals doing the National Pediatric Readiness
 21 Assessment. We essentially can offer them a carrot
 22 to go in and do the survey. So hopefully as we, and
 23 we have had to have designated this as a required
 24 activity for them, so we should have a one, it'll
 25 give a nice little boost for the folks that are

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 2 looking towards that always ready program. And we'll
 3 have that as some of that additional data and the
 4 facilities will have that, that progress report that
 5 you get back from the system. So we were able to
 6 build that into their contracts for next year. I'm
 7 actually really excited. I think it's going to be
 8 really helpful across our two grand programs, not
 9 even as far as what we're trying to do, but also very
 10 important for some of our work that we're doing
 11 across the state.

12 **MR. COOPER:** Yeah.

13 **MS. BUTLER-AZZOPARDI:** So I'm glad
 14 that that got through, and it was -- I'm really
 15 looking forward to kind of this, this cross activity
 16 between our two grand programs, because I don't know
 17 that that's happening in other parts of the nation.

18 **MR. COOPER:** Got it. Okay. Thank you
 19 so much. Anything else from -- from -- from you,
 20 Kate?

21 **MS. BUTLER-AZZOPARDI:** Yeah. Okay.
 22 That's all I have for now unless anyone has
 23 questions.
 24
 25

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 2 **MR. COOPER:** Anyone have questions for
 3 Kate? Okay, then Drew Fried from Long Island, Health
 4 Emergency Preparedness. Are you with us today?
 5 **MS. EISENHAUER:** I do not see Drew our
 6 list of participants.
 7 **MR. COOPER:** Okay. We'll move on to
 8 the Quality & Patient Safety/Sepsis Initiative. Alda
 9 or Linda or Kate or George, are you one or more of
 10 you on the line?
 11 **MR. STATHIDIS:** Yeah. Hi, good
 12 afternoon, Dr. Cooper. Yeah. This is George
 13 Stathidis with the Office of Quality and Patient
 14 Safety.
 15 **MR. COOPER:** Hey, George.
 16 **MR. STATHIDIS:** How are you? I'm
 17 going to share my screen. I have a slide deck to
 18 share with you here. I will actually give a quick
 19 update, and then I have my colleague with me Stephen
 20 Goins going to give an update on the slides here.
 21 I'll walk through that. So before we jump into the
 22 slides, just a brief update for the substance
 23 program. Since we last met for here at the E.M.S.C.
 24 meeting, we actually released our 2019 report. That
 25 report was sometime in the making, of course, it got

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 2 interrupted by the COVID pandemic. However, we were
 3 able to get all of secure all our approvals and
 4 release that report. And that is what we're actually
 5 going to go over here today. That was an interesting
 6 report that we actually did some risk adjustment for
 7 the pediatric population, which was the first time
 8 that we were able to do that. And Stephen will go
 9 through that in a couple moments. But that's what
 10 we're going to talk about today. In addition, we are
 11 still working on our 2021 Annual Report that we have
 12 all that data in-house right now. We're going
 13 through our research team, I should say, going
 14 through extensive validation and discussions on how
 15 we'll present that data and will be a new format. So
 16 it's not quite ready yet for live for prime time.
 17 But of course, our process is usually that we'll
 18 bring any initial results to our pediatric sepsis
 19 advisory group, which I know Dr. Cooper and Dr. ... I
 20 know you're both on that. So you -- we will probably
 21 see some preview of some data in the coming months.
 22 I'm not sure exactly when we'll have that available,
 23 but we are working on it quite seriously here. And
 24 then in addition, we just wrapped up data collection
 25 last week for 2022 data for adults and for pediatric

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 2 population. So we have quite a bit of data in-house
 3 that we're working on right now. I would almost
 4 venture to say that we're buried in data, but we are
 5 working on that and we're working on again putting
 6 the reports together. So I want to turn it over to
 7 Stephen Goins from our office. He's a Research
 8 Scientist and introduce yourself and then we can go
 9 through a slides here.
 10 **MR. GOINS:** Yes. Thank you, George.
 11 You can hear me, okay?
 12 **MR. COOPER:** Yes.
 13 **MR. GOINS:** Alright. Great. Thanks.
 14 Yeah. So I would agree with George. We are buried
 15 in data. I'll back him up on that. But yeah, so
 16 good afternoon, everyone. I'm -- yeah, as George
 17 mentioned my name is Stephen Goins. I'm the Director
 18 of the Bureau of Vital and Health Statistics in
 19 Q.P.S. And one of the roles of bureau is to provide
 20 analytic support for the New York State Sepsis
 21 Initiative using the data collected through the
 22 initiative. And that includes more recently, as
 23 George mentioned, the development of risk adjusted
 24 mortality model for the pediatric severe sepsis
 25 population that I'll be presenting today and that was

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 2 included in our 2019 report. George, if you don't
 3 mind, go ahead, please. And one more thank you.
 4 Okay. So I'll just start with a brief overview of
 5 some high level characteristics of the pediatric
 6 severe sepsis population in 2019. So the table on
 7 this slide shows the volume, distribution and
 8 population incidence rates of pediatric severe sepsis
 9 for age, group, sex, and race ethnicity. There were
 10 a total of six hundred and twenty-four severe sepsis
 11 cases in patients' age less than eighteen years old
 12 in New York State in 2019. And while incidence is
 13 thankfully much, much lower than what we observed in
 14 the adult population within the pediatric population,
 15 incidence is highest among the youngest patients. As
 16 you can see here, that's patients' age less than one
 17 year old and then second highest among patients age
 18 one to two years old. There is a slightly higher
 19 incidence among males versus females in 2019, though,
 20 not that much of a difference in race. And then in
 21 terms of race and ethnicity again, not huge
 22 differences in race but we did see incidence was
 23 highest among the black non-Hispanic population and
 24 lowest among the Native American Pacific Islander and
 25 multiracial population. So I will note that the

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 2 sample size is quite small for that group with only
 3 thirteen cases before me. Next slide, please.
 4 Thank you. So next here, I just want
 5 to give an idea of our approach to developing the
 6 model. So we decided to build a multi-variable mixed
 7 effects logistic progression model. The primary
 8 feature of this model is to account for outcomes
 9 clustering by hospital, which we did detect in this
 10 population. So that's why we went in that direction.
 11 The outcome we chose to represent mortality was
 12 thirty-day all cause mortality, post presentation of
 13 severe sepsis. So we did consider a ninety-day
 14 outcome, but ultimately decided that that approach
 15 could capture additional deaths that were unrelated
 16 to sepsis. And so we stuck with the third-day. Also
 17 note that the intent of this model was to assess
 18 trends in risk adjusted mortality over time in this
 19 population. It's a little bit different from what we
 20 do on the adult side where we intend our model to
 21 facilitate comparisons of hospital performance. But
 22 really, we like the sample size to take this approach
 23 for pediatrics. And I won't go through all the
 24 exclusions here, but I just do want to note that we
 25 did exclude newborns. That is patients who were born

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 2 in the hospital and developed with severe sepsis or
 3 septic shock before they were discharged. And for
 4 patients who had more than one hospitalization for
 5 severe sepsis, we only included a single hospital for
 6 ... patients.
 7 And calling all those exclusions
 8 ultimately, we ended up with one thousand four
 9 hundred and seventy-four eligible cases from 2017
 10 through 2019 model.
 11 **MR. COOPER:** Steve, can you just
 12 comment on the unmatched SPARCS Group? That seems
 13 like a pretty big group.
 14 **MR. GOINS:** Yeah. Yeah, certainly.
 15 So we added that exclusion because we actually use
 16 our SPARCS data in order to facilitate our match to
 17 BS. So to determine our thirty-day all cause
 18 mortality outcome. We use vital statistics but we
 19 don't directly match vital statistics to our sepsis
 20 data. We actually go through our match to SPARCS in
 21 order to determine that outcome. So that's why
 22 that's added here as an exclusion is because yeah,
 23 obviously without the SPARCS match, we can't detect a
 24 vital statistics outcome. So yeah, and I will.
 25

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 2 **MR. COOPER:** Sorry. What is SPARCS?
 3 I'm sorry for those ...
 4 **MR. GOINS:** I'm sorry. Yeah. So
 5 SPARCS, I'm going to make sure I get the acronym
 6 right, Statewide Planning and Research Cooperative
 7 System. It's a database that the D.O.H. has been
 8 collecting I think since 1987. But it contains all
 9 institutional hospital discharge and E.D. visit data
 10 reported by the hospitals to the D.O.H. And it's a
 11 pre-adjudicated administrative data. So it contains
 12 things like patient demographics, which we use the
 13 link here as well as like a diagnosis and procedural
 14 information as well.
 15 **MR. COOPER:** The reason I ask the
 16 question is simply we often find -- and the -- in
 17 reviewing the trauma data, from the trauma registry,
 18 we often find that when we measure the SPARCS that,
 19 that, that either one or the other has resulted in a
 20 miscode of some kind, and it may not be a real trauma
 21 case. I just wondered if there was some sense that
 22 the mismatch is here indicated that these patients
 23 might not have been septic or in fact, they are
 24 septic, but for some reason SPARCS didn't include
 25 them. Any sense of that at all? I think this -- to

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 2 get my understanding as to whether we could be
 3 missing something here if, but there's a skew here
 4 somehow that is contaminated your data set. That's
 5 all.
 6 **MR. GOINS:** Yeah. No, certainly.
 7 Yeah. Well, the first thing I do want to know is
 8 typically our -- there are a fair number of cases
 9 excluded here, but the match rate to SPARCS that we
 10 normally get is pretty good. Ninety plus percent,
 11 obviously we wish it was better. And actually, I
 12 think we're improving our process for future years to
 13 kind of boost that match up. But yeah, we have -- we
 14 do typically make comparisons between severe sepsis
 15 diagnostic criteria that we see in SPARCS versus what
 16 we have collected in our sepsis database. And I
 17 don't remember the exact numbers off the top of my
 18 head, but it tends to be pretty good. I would say in
 19 general, we tend to see more cases classified or
 20 reported to us rather, I should say, as severe
 21 sepsis. In the sepsis initiative data than we do
 22 compared to SPARCS, but we usually defer to our data
 23 collected through the initiative at least in this
 24 case, in this historical data here because the
 25 definition of severe sepsis was based off of clinical

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 2 medical record abstraction, right, whether or not it
 3 resulted in a diagnosis. And we've usually --
 4 **MR. COOPER:** Let me ask the question.
 5 Yeah. Let me ask that question in another way. If
 6 you were to have included those cases as opposed to
 7 excluded them, would it have changed the outcome in
 8 any way?
 9 **MR. GOINS:** So the reason we did not
 10 include them is because they're at least the way our
 11 outcome was defined, it would've depressed our
 12 mortality outcome, right? Because necessarily
 13 because we didn't have them match the SPARCS, we
 14 could not detect a mortality outcome for them in
 15 vital statistics. So that was really the intent
 16 behind excluding them as far as if we had used in-
 17 hospital mortality, for instance, which we would've
 18 for all those cases and we would've included them, it
 19 may have changed the results here. But we usually do
 20 an evaluation of in-hospital mortality in addition to
 21 our thirty-day and at least in those true
 22 comparisons, there wasn't a significant impact on the
 23 -- at least the crude trends that we saw when we did
 24 that.
 25 **MR. COOPER:** Okay. Thank you.

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 2 **MR. GOINS:** Yeah. No, great
 3 questions. Hopefully, I answered that directly
 4 enough, but --
 5 **MR. COOPER:** Close enough.
 6 **MR. GOINS:** Alright. Great. Thanks.
 7 Thanks, George. Okay. So I know in the previous
 8 slide, we called this the -- or we -- I called this
 9 the 2019 risk adjusted mortality model, but we did
 10 actually use three years of data seventeen through
 11 nineteen to build the model. This is done primarily
 12 to increase the sample size for this analysis, but
 13 also, obviously having three years of data allows us
 14 to examine trends and mortality over time. And the
 15 way we chose to evaluate that was by trending the
 16 standardized mortality ratio or S.M.R. by quarter
 17 across the three years in our analysis. So the
 18 S.M.R., if you're not familiar, represents the ratio
 19 of observed mortality outcomes to the number expected
 20 based on the risk factors in the model. So an S.M.R.
 21 greater than one indicates worse mortality than
 22 unexpected, while an S.M.R. less than one indicates
 23 better mortality than I expected. This is sort of
 24 the simplified standard in interpretation when
 25 evaluating results from a standard logistic

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 2 progression model. But the interpretation does hold
 3 even for when using a mixed model as we did here.
 4 Next slide. George, thank you. Okay.
 5 So moving into the results here. So the chart on
 6 this slide is showing trends in the statewide S.M.R.
 7 including ninety five percent confidence intervals by
 8 core. So on the X-axis here, you can see the quarter
 9 of discharge from 2017 quarter one through 2019
 10 quarter four. Well, S.M.R. is plotted here on the Y-
 11 axis. The dot, of course, represents the S.M.R.
 12 estimated for that quarter. And then those lines
 13 extending vertically there are the confidence
 14 interval. And then the lines here, we have colored
 15 to represent whether or not the S.M.R. is -- the
 16 quarterly S.M.R. is statistically higher or lower
 17 than expected in the quarter. And then just lastly
 18 here at the bottom of the chart, we have the number
 19 of hospitals contributing cases to the S.M.R. in each
 20 quarter.
 21 So as you can see, there's a fair
 22 amount of variability in the S.M.R. for -- from
 23 quarter-to-quarter, it hops around and we have pretty
 24 wide competence intervals. In fact, we only have two
 25 instances where the observed outcomes are

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 2 statistically different from expected. So yes,
 3 seeing 2018 Q4 there, we have mortality significantly
 4 lower than expected and then in 2019 Q4 where
 5 mortality is significantly higher than expected. So
 6 I would say, in general, we don't really observe any
 7 peer trend in the pediatric risk adjusted mortality
 8 in this field.
 9 **MR. COOPER:** Have you looked at
 10 anything beyond fourth quarter in 2019 yet?
 11 **MR. GOINS:** No, not to this point. So
 12 yes, we have a pretty consistent data source from
 13 2017 to 2019. But you know, we've sort of changed
 14 our data collection since then. So we haven't looked
 15 at anything.
 16 **MR. COOPER:** I only asked because you
 17 know, the fourth quarter 2019, you know, performance
 18 was good compared to the rest of the experience. And
 19 I wondered if we were -- we're just beginning to
 20 catch the first little bit of COVID there. I don't
 21 know, we're not recognizing just a thought. That's
 22 all.
 23 **MR. GOINS:** Yes. No, no, no. I'm
 24 still. Sorry. I was just stewing on that. Yeah,
 25 yeah, yeah. I mean, possibly. But yeah, I mean --

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 2 you're right, right, right. Yeah. And so certainly
 3 that's the outlier, right? And it is statistically
 4 significant. I was just looking here, right? We do
 5 see the bump in Q4 in 2017, and then of course, in
 6 2018, it's statistically lower.
 7 **MR. COOPER:** Yeah.
 8 **MR. GOINS:** So yeah, it's kind of --
 9 okay, so next slide. Next, chart. Okay, so this next
 10 chart is a similar view, but add the element of case
 11 volume in here. So again, quarter along the X-axis,
 12 but now we have case volume in addition to the SMR on
 13 the Y-axis. So that colored line on the chart
 14 represents the same SMR data points as in the
 15 previous chart. And then the bars here represent
 16 case volume. So the dark green representing patients
 17 who died within thirty days of a severe sepsis
 18 presentation. And then the light green representing
 19 patients who survived at least thirty days following
 20 presentation.
 21 And I think the point I just kind of
 22 want to emphasize on this chart here is just kind of
 23 the remaining influence of small sample size on these
 24 trends. So even though, we have a -- we would seem
 25 at least have enough cases in each quarter overall in

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 2 order to produce stable estimates here. The number
 3 of outcomes in each quarter is relatively small,
 4 right. So ultimately, that means that our SMR is
 5 very sensitive to swing in just a handful of
 6 mortality events. And this likely contributes to
 7 some of the -- that wide variability that we see.
 8 **MR. COOPER:** Right?
 9 **MR. GOINS:** Yeah. Like, again, yeah,
 10 that big swing 2019 Q3 to Q4. I mean, it's almost a
 11 doubling of mortality events, but it's still only
 12 seven deaths.
 13 **MR. COOPER:** Right, right.
 14 **MR. GOINS:** Alright, George, last
 15 slide. Okay, so just a way of summary, so as I
 16 mentioned, we didn't really observe any clear trends
 17 in risk adjusted mortality in the pediatric
 18 population for the years that we studied here.
 19 However, we do really recognize their limitations to
 20 our data collection and modeling that that might
 21 obscure any trend that we could observe. I mentioned
 22 it before, small sample size really limits the
 23 statistical power in this analysis.
 24 And I'll also note that the data
 25 collected through the sepsis initiative used here was

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 2 designed and constructive more specifically for the
 3 adult severe sepsis population and to facilitate risk
 4 adjustment in the adult population. So maybe data
 5 that is more tuned to the pediatric population with
 6 regards to risk factors would likely improve the
 7 performance of the model here.
 8 And then just lastly and kind of
 9 related to that point, there's often additional
 10 complexity in the diagnosis and treatment of severe
 11 sepsis in the pediatric population, somewhere you're
 12 aware, that's something that we are often from the --
 13 our pediatric sepsis advisory group. But that also
 14 makes risk adjustment for this population more
 15 challenging.
 16 So I suppose in a way of closing, I
 17 would say, well, our ability to model pediatric
 18 sepsis mortality may currently be limited. We are
 19 intending to continue to work with the data, the
 20 pediatric data that we have available to develop
 21 appropriate outcome measures for this population.
 22 **MR. COOPER:** Okay. Well, as always,
 23 the presentations for your group is -- the
 24 presentations are very thought-provoking. We
 25 appreciate your time in presenting this data, George,

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 2 and certainly even more important your time in
 3 putting it together. That obviously for us, our main
 4 concern continues to be early recognition, and early
 5 treatment measures that are likely to potentially
 6 limit the unsure effects of severe sepsis. And as
 7 you pointed out, the data probably is not quite
 8 robust enough yet in terms of volume being more than
 9 anything else. Get us an opportunity to look at
 10 those minor points.
 11 But we go not, and hopefully, as we
 12 look at the next group of data, which I'm hoping you
 13 might be able to have for us by September, maybe,
 14 maybe not, I don't know. But I certainly hope so.
 15 Maybe, we'll see you know, a bit more of a trend
 16 toward improvement. But that will await your
 17 analysis. So thank you very much. Does anybody else
 18 have any questions for George or Steve? Okay, well,
 19 thank you so much. Mike McEvoy, are you with us?
 20 **MS. EISENHAUER:** Mike had emailed me
 21 that he might have a conflict and I do not see him on
 22 our list.
 23 **MR. COOPER:** Okay. Well, ... And
 24 finally STAC & Pediatric Trauma Subcommittee, we have
 25 not met in quite some time, Kim Wallenstein, do you

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 2 have anything for us? I don't know that we have that
 3 since the last meeting of EMSC, so I don't know we
 4 have anything new to bring some stuff of these
 5 trauma. There may have been --
 6 **MS. WALLENSTEIN:** Yeah, very brief --
 7 **MR. COOPER:** Go ahead. Wallenstein.
 8 **MS. WALLENSTEIN:** Nothing really --
 9 nothing really new. The last staff meeting, because
 10 we know was not held, so we did have a brief interim
 11 meeting in March and we talked about it, a few issues
 12 with our TEQIP collaborative data as well as our --
 13 the new standards of mental health screening that are
 14 going to be with our verification. But we will
 15 hopefully be able to meet again before our next
 16 E.M.S.C. meeting, if we're not going to have a
 17 pediatric subcommittee meeting at the next staff
 18 that's coming up within the next couple weeks,
 19 because it conflicts with the American Pediatric
 20 Surgical Association Annual Meeting where most of us
 21 are going to be. So I don't think we would have a
 22 good forum there. So we are not going to hold that,
 23 but we will try to get an interim meeting in place to
 24 talk about some more initiatives.
 25

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 2 **MR. COOPER:** Great. Thank you. Okay.
 3 Well that we had a lot of ground covered today. I
 4 anticipated that this meeting would probably extend
 5 until four-thirty, but I'm fortunately wrong and I
 6 see Amy as smiling as well. So I know she's pleased
 7 that we're done a little bit early, but I see that
 8 Sharon Chiumento has her hand up and has something to
 9 share with us. You're muted, Sharon.
 10 **MS. CHIUMENTO:** I just wondered if
 11 we've had any progress on the pediatric education
 12 materials that we were working on trying to develop
 13 educational materials and things like that. Has
 14 there been any progress on that at all?
 15 **MR. COOPER:** On the education stuff?
 16 **MS. CHIUMENTO:** Right.
 17 **MR. COOPER:** We did speak about that.
 18 We did speak about that earlier in the meeting. Amy
 19 has collected a whole slew of --
 20 **MS. CHIUMENTO:** I remember -- senior
 21 moment.
 22 **MR. COOPER:** That's okay. That's
 23 okay. We all have those -- even those who are
 24 younger than seniors, so there we are. Thank you,
 25 Sharon. Anything else?

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 2 **MS. CHIUMENTO:** No.
 3 **MR. COOPER:** Well, in that case, wow,
 4 we are finishing twenty-five minutes ahead of
 5 schedule. I'm sure that that will allow everyone to
 6 run to the nearest coffee yard to recharge. And our
 7 next meeting, Amy, will be when September --
 8 **MS. EISENHAUER:** September 5th in
 9 Troy, New York at the Hilton Garden Inn from 1:00
 10 p.m. to 4:00 p.m.
 11 **MR. COOPER:** That is before or after
 12 Labor Day, that sounds like it's after Labor Day; is
 13 that right?
 14 **MS. EISENHAUER:** It's after.
 15 **MR. COOPER:** Pardon?
 16 **MS. EISENHAUER:** It's after Labor Day.
 17 **MR. COOPER:** After Labor Day. So
 18 that's Thursday after Labor Day then, correct?
 19 **MS. EISENHAUER:** Yes.
 20 **MR. HARRIS:** Can you share the
 21 location one more time, Amy?
 22 **MS. EISENHAUER:** Hilton Garden Inn in
 23 Troy. And I will be sending out more information to
 24 everybody as we get. Just a little bit closer
 25 probably June to make sure everybody has the

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 2 information they need. But I want to make sure that
 3 you guys have the date so you can mark it off. It is
 4 an in-person meeting. It is in the Capital region.
 5 So I will help with the travel stuff, but I wanted to
 6 let you guys know, because I know that everybody has
 7 crazy schedules and we need to make plan up here.
 8 The train is not far from the city. So if you like
 9 Amtrak, the train is near the hotel, not too far, if
 10 you didn't want to drive, so some options.
 11 **MR. COOPER:** Thank you, Amy. So this
 12 --
 13 **MR. HARRIS:** I've only train like
 14 twenty minutes, is that cool? Okay. ... few seconds.
 15 I'm sorry. Alright.
 16 **MS. COOPER:** Matt, I'm sorry, I didn't
 17 quite hear you. Matt? Okay. So I just wanted to
 18 remind everyone that our custom in the past have been
 19 to meet at 875 Central Avenue, where the Bureau of
 20 E.M.S. offices are located. We are not meeting
 21 there. We are meeting in Troy. So for those of you
 22 who will be coming up the morning of the meeting,
 23 please don't go to the wrong place.
 24 And Amy I know you'll count -- I can
 25 count on you to remind me because, I've spent so many

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 2 years going to 875 Central Avenue, right? Good, well
 3 end up in the wrong place. So again, Hilton -- hired
 4 in for everybody and we will see you in September,
 5 okay? Take care everybody. Have a great summer and
 6 we'll look forward to a whole bunch of conference
 7 calls, mostly in July, because I know people are
 8 largely going to be away in August, okay? Thank you.
 9 Take care everybody.

10 **MS. EISENHAUER:** Thanks. Hi everyone.

11 **MR. COOPER:** Thank you for a great
 12 meeting.

13 (Off the record)
 14 (The meeting concluded at 3:38 p.m.)
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 2 I, ANNETTE LAINSON, do hereby certify that the foregoing
 3 was reported by me, in the cause, at the time and place,
 4 as stated in the caption hereto, at Page 1 hereof; that
 5 the foregoing typewritten transcription consisting of
 6 pages 1 through 117, is a true record of all proceedings
 7 had at the hearing.

8 IN WITNESS WHEREOF, I have hereunto
 9 subscribed my name, this the 2nd day of May, 2023.

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 11
 12 ANNETTE LAINSON, Reporter
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