

2/4/2025 – E.M.S. for Children – WebEx
NEW YORK STATE
DEPARTMENT OF HEALTH
E.M.S. FOR CHILDREN
ADVISORY COMMITTEE

DATE: February 4, 2025
TIME: 1:01 p.m. to 3:21 p.m.
CHAIR: ARTHUR COOPER
VENUE: WebEx

Reported by: Danielle Christian

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Tom Bonfiglio
Vera Feuer
Vince Calleo
Vincent Quimette

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2 **APPEARANCES:**
3 Alexa Cappola
4 Allison Lynch
5 Amy Eisenhauer
6 Benjamin Kasper
7 Beth McGown
8 Brielle Phillips
9 Colby Rowe
10 Cristine Lannoti
11 Daniel Clayton
12 David Violante
13
14 Deanna Ratigan
15 Dr. Elise Van Der Jagt
16
17 Dr. Matthew Harris
18 Drew Fried
19 George Stathidis
20 Helen Fries
21 Jacob DeMay
22 James Downey
23 Jennifer Goldman
24 Jessica Falgiate
25 Kevin Albert
Kim Wallenstein
Kirsten Siegenthaler
Kris Alfonso
Lisa Hunt
Maia Dorsett
Mark Hanna
Marilyn Kacica
Meghan Williams
Merry Rudinger
Michelle Cole
Neal Cartin
Nicole O'Toole
Pamela Feuer
Peter Brodie
Ryan Greenberg
Scott Buffin
Scott Di Pino
Sharon Chiumento
Suzanne Stegch
Suzanne Swan
Tiffany Bombard

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(The meeting commenced at 1:01 p.m.)
DR. COOPER: All right. Let's see.
Let us begin. So I'd like to welcome everyone to the
February 4th, 2025, meeting of the State Emergency
Medical Services for Children Advisory Committee to
the New York State Department of Health. And our
first task as always is to confirm attendance. Amy,
you had noted that we have a quorum. Do you want to
call the roll or is that not necessary?
DR. HARRIS: Can -- can it wait
longer?
MS. EISENHAUER: No, I can do that.
MR. COOPER: Okay.
MS. EISENHAUER: Yeah. So we'll start
with Mr. Cooper.
MR. COOPER: I am here.
MS. EISENHAUER: Dr. Van der Jagt is
not able to attend today. Dr. Albert.
MR. ALBERT: I am present.
MS. EISENHAUER: Excellent --
excellent. Bruce Berry. Sharon Chiumento. Dr.
Conway is also not able to be here today. Dr. Pamela
Feuer.
MS. FEUER: Present.

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 2 MS. EISENHAUER: Excellent. Dr. Kim
 3 Wallenstein.
 4 DR. WALLENSTEIN: Present.
 5 COURT REPORTER: I'm sorry --
 6 MS. EISENHAUER: Dr. Vince Calleo.
 7 COURT REPORTER: -- there's some
 8 background noise. I don't know if it's -- because
 9 it's making it hard for me to hear when you're
 10 calling the roll. It's like an echo or something.
 11 MS. EISENHAUER: Can everybody, unless
 12 you're talking, go on mute? Dr. Vincent Calleo.
 13 DR. CALLEO: Present.
 14 MS. EISENHAUER: Douglas Hexle.
 15 MS. CHIUMENTO: Hi ya.
 16 MS. EISENHAUER: Oh, hey -- hey,
 17 Sharon.
 18 MS. CHIUMENTO: Okay.
 19 MS. EISENHAUER: Just doing the roll.
 20 MS. CHIUMENTO: Yeah, I was having
 21 trouble getting in. So -- okay, we're good.
 22 MS. EISENHAUER: Okay. We're good
 23 now. So Sharon Chiumento is present. Nicole
 24 O'Toole. I saw her.
 25 MS. O'TOOLE: I'm here. Can you hear

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 2 me?
 3 MS. EISENHAUER: There you go. Now I
 4 can hear you.
 5 MS. O'TOOLE: Okay.
 6 MS. EISENHAUER: Dr. Tiffany Bombard.
 7 Dr. Matthew Harris.
 8 DR. HARRIS: Hi. Good afternoon.
 9 MS. EISENHAUER: Hey. Chief Joseph
 10 Pataki said that he would not be able to be here.
 11 Jason Hague, he also said that the system at his
 12 agency was busy today. He may not be able to make
 13 it. Ben Kasper.
 14 MR. KASPER: Present.
 15 MS. EISENHAUER: Hey. Dr. Vera Feuer.
 16 DR. VERA: Present.
 17 MS. EISENHAUER: Thank you. Kelly-Ann
 18 McDonald. Jessica Falgiatano.
 19 MS. FALGIATANO: Present.
 20 MS. EISENHAUER: Dr. Mark Hannah.
 21 Okay. And I see, not vetted yet. Just one more --
 22 one more probably meeting because your letter is in
 23 the process. I saw that Dr. Dorsett was here.
 24 DR. DORSETT: I am.
 25 MS. EISENHAUER: Okay. So we have a

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 2 quorum.
 3 MR. COOPER: Thank you, Amy. So the
 4 next item on the agenda is approval of the minutes
 5 from our November 20 -- 2024 meetings. Those were
 6 distributed to everyone electronically. I ask now if
 7 there are any additions, deletions, or corrections to
 8 those minutes? Hearing none, I'll ask for a motion to
 9 approve.
 10 MR. KASPER: Approved.
 11 MS. CHIUMENTO: Motion made.
 12 DR. HARRIS: Second.
 13 MR. COOPER: Thank you.
 14 COURT REPORTER: I'm sorry. Can I get
 15 who --
 16 MR. COOPER: (unintelligible)
 17 COURT REPORTER: -- who made the
 18 motion and who made the second? I didn't -- I don't
 19 know who that was.
 20 MS. CHIUMENTO: Sharon Chiumento,
 21 motioned.
 22 DR. HARRIS: Matt Harris, second.
 23 MR. COOPER: Thank you. All in favor
 24 please signify by saying, aye.
 25 MS. CHIUMENTO: Aye.

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 2 MR. KASPER: Aye.
 3 DR. HARRIS: Aye.
 4 MR. ALBERT: Aye.
 5 MS. O'TOOLE: Aye.
 6 MR. COOPER: Any -- any -- any no's or
 7 abstention? Hearing none, then the minutes are
 8 approved. All right. Amy, tell us all about the
 9 E.M.S. for children grant report.
 10 VOICE ASSISTANT: This meeting is
 11 being recorded.
 12 MS. EISENHAUER: Thank you, Ryan. So
 13 for everybody else, we're recording now. So the
 14 E.M.S. for children grant report. The Always Ready
 15 for Children Pediatric Recognition Program, I
 16 believe, we are at thirty five hospitals right now.
 17 There's one that we're reviewing, everybody else
 18 should be on the website. We also sent out welcome
 19 packets. We got everything together and much thanks
 20 to Ally for doing that -- the actual putting together
 21 of the packets and making everything look really
 22 great. So that would include a certificate, the
 23 Pediatric Assessment Triangle document that Dr. Van
 24 der Jagt and Sharon have kept up-to-date and done the
 25 heavy lift on that, some badge buddies and

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2 (Pages 5 to 8)

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 2 information on where they can find more resources for
 3 pediatric preparedness in their hospital.
 4 So those went out about a month ago,
 5 maybe a little longer than that, just around
 6 Christmas. And I've heard back from several
 7 hospitals that they got it, they were very excited
 8 and we're very excited for that as well. It's our
 9 hope that once we hire somebody -- which I'll cover
 10 in a moment. Once we hire somebody that late summer,
 11 early fall depending on how things go, we'll be able
 12 to have like a one day or even a half-day symposia to
 13 introduce the pre-hospital PECs to the hospital PECs
 14 and do some PEC learning workshops. Very recently
 15 there were three PEC Modules released by the E.I.I.C.
 16 And I'm going to send out an email to everybody with
 17 all of those as soon as I make sure that they are
 18 available and on the website.
 19 As you may know, the Federal
 20 government has issued a -- a pause on some
 21 communications from healthcare -- from the healthcare
 22 groups and E.M.S., HRSA, and then E.M.S. for children
 23 was a part of that. So we're just on a pause until
 24 everything gets reviewed. So I just want to make --
 25 I, you know, commit to it because there may be a

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 2 delay in getting it out. I think that's everything
 3 that's going on with Always Ready for Children. Ever
 4 moving forward, which is awesome and wonderful. We
 5 did remove --
 6 **MR. COOPER:** Amy.
 7 **MS. EISENHAUER:** Yes.
 8 **MR. COOPER:** Amy -- Amy, may I?
 9 **MS. EISENHAUER:** Sure.
 10 **MR. COOPER:** Stop and -- stop you here
 11 for a moment and ask a question. It's my
 12 understanding that there are about -- tell me if I'm
 13 wrong. Amy and Ryan. There are about a hundred and
 14 eighty hospitals in the state. We've only heard from
 15 thirty five of them. Is that -- is that what I'm
 16 hearing from you?
 17 **MS. EISENHAUER:** I want to say it's a
 18 hundred eighty -- eighty eight hospitals, of course
 19 we --
 20 **MR. GREENBERG:** Yeah, of course.
 21 **MS. EISENHAUER:** -- we've only heard
 22 back from -- from thirty-five.
 23 **MR. COOPER:** Is there something we can
 24 do to, you know, push some of these hospitals to
 25 participate in the program? Do you think?

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 2 **MS. EISENHAUER:** Right, so --.
 3 **MR. GREENBERG:** So I think right now -
 4 - Amy, let me take this one.
 5 **MS. EISENHAUER:** Go ahead.
 6 **MR. GREENBERG:** So I think right now,
 7 you know, to be honest, the number of thirty-five is
 8 -- is pretty strong. You know, we haven't been doing
 9 this that long. We have not been pushing too hard.
 10 And I think part of what's going on right now too is
 11 also we're learning from the first adapters what's
 12 working, what's not working that -- that -- I
 13 wouldn't want to push too hard at the moment. I
 14 think this is a kind of a nice growth spurt in part
 15 because of Northwell. There's no question about that
 16 one. They are definitely champions in this, so thank
 17 you Northwell. But they have done it as a system
 18 approach, and we're really looking at that approach
 19 to see how we can take that model and bring it to
 20 other places. So I -- I think a little bit more of -
 21 - of pacing along and then we would gear it up a
 22 little bit more, would be my recommendation.
 23 **MR. COOPER:** Okay. All right. Thank
 24 you, Ryan.
 25 **MR. GREENBERG:** Amy, I don't know if -

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 2 -
 3 **MR. COOPER:** Thank you, Amy.
 4 **MR. GREENBERG:** -- you feel the same
 5 way or not, but hundred percent.
 6 **MS. EISENHAUER:** I -- well, I do.
 7 There is -- also there's been some discussion, and I
 8 think that's probably why Dr. Harris was raising his
 9 hand. There's been some discussion on promoting the
 10 program and how can we do that? And looking at
 11 different avenues. And I know Dr. Wallenstein has
 12 been a part of that conversation as well -- as well
 13 as Dr. Van der Jagt and some other members from
 14 PedsDoc. So there -- there has been discussion on --
 15 on how to move forward getting more interest. But
 16 Ryan is right, we are learning a lot by the early
 17 adopters. Our early plan of having all the trauma
 18 hospitals jump in and join first kind of naturally
 19 what happened was systems jumped in and joined first.
 20 As Ryan mentioned Northwell, their whole system is
 21 now a part of Always Ready for Children. And I know
 22 University of Rochester, Lauren Whitman over there
 23 has really kind of been reaching out to her system
 24 hospitals and getting everybody prepared and -- and
 25 signing in. So right, as we go that's great

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 2 information to know and learn and see maybe if that's
 3 a more appropriate direction.
 4 **MR. COOPER:** Okay. I just wanted to
 5 see if there's anything the committee could do to
 6 help, you know, push this out. You know, this is a
 7 really important initiative and -- for us and -- and
 8 so we will await your guidance and that of Ryan as to
 9 when the appropriate time might be to push a little
 10 bit harder.
 11 **MS. EISENHAUER:** Yeah. I would say --
 12 **MR. COOPER:** Thank you.
 13 **MS. EISENHAUER:** -- maybe one thing
 14 that would not be overreaching would be just go to
 15 your hospitals and say, hey, there's a program. And
 16 just say, you know, I'm on this committee, I work
 17 with this endeavor, how can I help you be prepared
 18 and sign up?
 19 **MR. COOPER:** Sure. Absolutely.
 20 **DR. HARRIS:** Dr. -- Dr. Cooper --.
 21 **MR. COOPER:** I -- I -- I'm sure that
 22 everyone on this -- I'm sure that everyone on this
 23 call has reached out to their own hospitals. I know,
 24 I certainly have. Matt, did you have a comment?
 25 **DR. HARRIS:** Thanks for the few

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 2 moments. I wonder to both Ryan, with everyone's
 3 point, if a good middle ground is -- you know, I
 4 think there's some opportunities that we're going to
 5 discuss later today about some of the outreach
 6 efforts we're doing and could be doing. With other
 7 work that E.M.S.C. is doing that, there's likely
 8 representation from this group at all the REMSCOs and
 9 the REMAC. So rather than go right to the hospitals,
 10 but to learn the lessons we've had from Northwell,
 11 from other places, they should just be part of our
 12 elevator pitch maybe when we have our regional
 13 representation as part of our normal work at the
 14 REMSCOS and the REMAC to remind people that this is -
 15 - and that can be done, it's not time specific.
 16 I think there was a lot of information
 17 that came out over the summer about the pre-hospital
 18 readiness program, which had a very defined end
 19 because it was still on that initial whatever. I
 20 think this would be a good opportunity for us to just
 21 say, this is an ongoing enrollment and that there's
 22 no calendar date for it. So maybe that's the middle
 23 ground and just urging all of our members here who
 24 engage in the REMAC and REMSCOs to bring it there.
 25 Just food for thought. Thanks for the time, Dr.

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 2 Cooper.
 3 **MR. COOPER:** Not a bad idea. We'll
 4 discuss that further off line. Thank you, Matt.
 5 Amy, do you want to get into the grant sponsor visit
 6 issue?
 7 **MS. EISENHAUER:** Yes. Well, not an
 8 issue at all. So representatives from HRSA came to
 9 visit us here in New York just to see kind of what
 10 we're doing, what we've been up to, projects that
 11 we've been working on, and just sharing information.
 12 I feel it was really great and productive. They had
 13 questions about our system and about the projects
 14 that we've been doing, how they've impacted --
 15 impacted E.M.S. in hospitals. Also Dr. Cooper and
 16 Dr. Van der Jagt visited with us. Nicole represented
 17 the Family Action Network. So -- so we had a bunch
 18 of different meetings covering all the -- all the
 19 E.M.S. umbrellas, and I thought it was really
 20 productive.
 21 And so we're just waiting on feedback
 22 from them. Just, you know, Hey, this is great. Hey,
 23 have you thought about this? We also had the program
 24 manager, so my role, but from Utah. They have
 25 recently upgraded their PEC program. And we talked

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 2 about different things that they've been doing and
 3 how they've been tying in their PECs with other
 4 initiatives in the state. So that was great to hear
 5 from -- from other states that may have similar --
 6 similar endeavors. So it was really great to hear
 7 other -- other thoughts, other processes, how other
 8 people are doing things. Do you have any comments on
 9 the visit, Ryan?
 10 **MR. GREENBERG:** I -- you know, I will
 11 say we -- we didn't know what to expect with this
 12 visit. So that -- that was, you know, just -- I just
 13 want to echo that one. You know, they said they were
 14 coming and just wanted to learn more about us and
 15 stuff like that. I've been here seven years and they
 16 haven't had a visit in the time that I've been here.
 17 So it was -- we didn't know fully what to expect, but
 18 it was really nice. I think we had a really nice
 19 couple of days together. We got to learn from --
 20 from some other states. We got to learn from the
 21 PEDS. We got to express some of our concerns with
 22 the program too. I think, you know, they were really
 23 good listeners too, which was nice. You know, things
 24 about funding and programs and stuff we would love to
 25 do, but just, you know, the -- the bandwidth isn't

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 2 there.
 3 And so it -- it was nice to get the
 4 FaceTime and -- and to get to have those discussions
 5 with T and, you know, the rest of the team. So --
 6 and I think, you know, we did a pretty good job of
 7 relaying and, you know, thank you to Art and some of
 8 the others who joined us on, you know, some of the
 9 different discussions to talk about the work that
 10 we're doing. And we did, you know, one of the big
 11 things I think that we emphasized for them is just
 12 the reminder of, you know, our numbers may not always
 13 be as high as we would want them to be when it comes
 14 to a percentage, but our numbers of those that
 15 participate normally exceed what most other states do
 16 by double. And so, you know, just recognizing the
 17 lift in what we can do and what we're able to do.
 18 And -- and just to give an example,
 19 you know, when we have thirty five percent of our
 20 hospitals respond to a survey, you know, that is, you
 21 know, fifty or sixty hospitals. Well, for most
 22 states, that's more hospitals than what they have.
 23 So, you know, the data that we bring in and what we
 24 provide is, you know, pretty significant even when
 25 we're not able to capture, you know, a hundred

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 2 percent of what we would like to capture of
 3 everything else. When we have, you know, two hundred
 4 and fifty PEC agencies, you know, that's significant
 5 compared to most states that don't have that many
 6 E.M.S. agencies or don't have that many PEC
 7 agencies. So I think that, you know, having that
 8 time to talk about that and discuss it was, you know,
 9 just really nice. And -- and again, and getting them
 10 out and to see some of our PECs in our hospitals, I
 11 really enjoyed it. So --
 12 **MS. EISENHAUER:** Dave.
 13 **MR. VIOLANTE:** Hey. Sorry about being
 14 offline -- off video there for a little bit. One of
 15 the -- the suggestion that came up is maybe create a
 16 one pager for some of the other hospitals. I know
 17 that you wanted to sort of temper some of the growth
 18 a little bit to be able to make sure we're doing what
 19 we're doing and -- and follow it along. But maybe
 20 that could be helpful as well, at least, for some --
 21 some ideas for them as to -- to what this is about
 22 and how it could be helpful for them.
 23 **MR. COOPER:** I think that's not -- I
 24 think that's not a bad idea. You're getting out of,
 25 you know, a very brief one pager sort of annual

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 2 report of what's been accomplished, I think would be,
 3 you know, very helpful. Thank you, David, for that
 4 suggestion. That's a really great idea. Thank you.
 5 Anything else, Amy?

MS. EISENHAUER: I think that's it for me.

MR. COOPER: Any questions for Amy?

MR. KASPER: Oh, Amy, I just have one quick question. I -- I know because we do outreach to the Veterans Hospital in Buffalo and they weren't listed. I don't know if that was the one hospital or not, but I think that they -- I know they filled out the paper copy but they were looking and they were reaching out for submission electronically. I -- I -- and I just -- I know they don't get pediatrics on a regular basis, but they've had a few instances of critically injured patients over the past eighteen months.

MS. EISENHAUER: So they did email me through the E.D.C., and they have been added to the database probably about a few weeks ago. So some of the -- in the past, we took the V.A. hospitals out because they told us they weren't seeing PEDS and that they didn't want to do the survey. So we said,

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 2 okay, we'll take you guys out because you don't see
 3 PEDS. Although apparently, sporadically that seems
 4 that that's not really the case. So they've been --
 5 your hospital has been added back in and they will be
 6 able to do the electronic version of the survey.
 7 **MR. KASPER:** Awesome. Yeah. Thank
 8 you very much. Yeah.
 9 **MS. EISENHAUER:** Yeah.
 10 **MR. KASPER:** It's just one of those --
 11 yeah, it's a kind of a reactive response after -- as
 12 soon as they say they don't get them, that's when
 13 they start getting some.
 14 **MS. EISENHAUER:** Well, we're happy to
 15 have them.
 16 **MR. KASPER:** Awesome. Thank you so
 17 much.
 18 **MS. EISENHAUER:** Yeah, thank you.
 19 **MR. GREENBERG:** And that was related
 20 to the V.A.? Is that what you said, Amy?
 21 **MS. EISENHAUER:** Yes. Yes.
 22 **MR. GREENBERG:** So for those of you
 23 who don't know, I feel like this is just a -- a fun
 24 bit of trivia for -- for this group that I think
 25 you'd find interesting. As many of you probably

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 2 know, our commissioner of health is a pediatrician by
 3 training. What some people may not know is that his
 4 role in the Navy was a pediatrician in the Navy,
 5 which most people don't think of the Navy needing
 6 many pediatricians. But as he has told me, they --
 7 there are lots of babies that are made when shoreside
 8 and so on the bases there are lots of kids. And he
 9 was a pediatrician in the Navy. And so a lot of good
 10 stories from him when I've spoken to him on that one.
 11 So not only the V.A. --
 12 **MR. COOPER:** Thank you, Ryan.
 13 **MR. GREENBERG:** -- but also on the
 14 bases.
 15 **MR. COOPER:** Thank you. Okay. There
 16 being no other questions for Amy, we can move right
 17 on to Nicole O'Toole. Please tell us about the
 18 E.M.S. for Children family act -- action network
 19 activities for the last couple of months. Nicole?
 20 **MS. O'TOOLE:** Hi, can you hear me?
 21 **MR. COOPER:** We can.
 22 **MS. O'TOOLE:** Okay, great. I don't
 23 have much of a report, unfortunately, since the fans
 24 are under a pause as well under the E.I.I.C. But
 25 they did meet in January. And there is a fan from

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 2 Colorado and they're working on a readiness program
 3 for disasters and how to help children. And then
 4 there was another fan who is trying to get E.M.S.C.
 5 advisory committee meetings happening in her state,
 6 and I believe that was Delaware. But that's about
 7 it. Unfortunately, we're just kind of on a pause.
 8 No more meetings at the time during the pause. We
 9 can make phone calls to them, but they can't put out
 10 any emails or anything like that. So we're kind of
 11 on hold.
 12 **MR. GREENBERG:** You said you can make
 13 phone calls or you can't make phone calls?
 14 **MS. O'TOOLE:** I'm sorry, Brian, can
 15 you say that again?
 16 **MR. GREENBERG:** You said you can make
 17 phone calls or you can't make phone calls?
 18 **MS. O'TOOLE:** I can make a phone call
 19 to the fans, one-on-one phone calls. But they said
 20 no general meetings until they're off of pause.
 21 **MR. COOPER:** I presume that applies to
 22 the entire E.I.I.C.; is that correct?
 23 **MS. O'TOOLE:** That is correct. Yep.
 24 **MS. EISENHAUER:** Yeah, all of our --
 25 so the -- the E.I.I.C. does write educational

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 2 webinars for program managers and other E.M.S. for
 3 children stakeholders, though some have been paused
 4 for now as well as -- for example, the E.M.S. for
 5 Children Data Center does like a thirty minute tech
 6 talk once a month. Those have been paused, any
 7 information coming out about the survey data has been
 8 paused until all of that can be reviewed.
 9 **MS. O'TOOLE:** Including social media
 10 too. There's nothing.
 11 **MS. EISENHAUER:** Yeah.
 12 **MR. COOPER:** Have we had, Amy, a
 13 formal directive from -- from Washington on -- on
 14 this? Have they told us what we can or cannot do,
 15 other than no meetings and so on?
 16 **MS. EISENHAUER:** So it's no meetings
 17 from them. They cannot have meetings.
 18 **MR. COOPER:** Yeah.
 19 **MS. EISENHAUER:** Yes. So --.
 20 **MR. COOPER:** That's all right. Yeah.
 21 **MS. EISENHAUER:** So the last directive
 22 I got was about a week ago, and they called me on the
 23 phone just to tell me that, you know, everything had
 24 been taken off our calendars and explained why and
 25 that they would know more in -- in the short future.

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 2 So no -- no real directive because I think they're
 3 still figuring it out as well.
 4 **MR. COOPER:** Okay. Well, fortunately,
 5 we have our activities in the statute, so we are
 6 obligated to continue, which is a good thing for the
 7 children of New York. So anyway, let's pray that
 8 things get sorted out in Washington and this program
 9 is back up and running as quickly as possible. Okay.
 10 Ryan, I hope you have some better news for us than
 11 Washington has for us.
 12 **MR. GREENBERG:** Well, you know, let me
 13 just start off by saying, you know, I think it's
 14 important to recognize what you just said, which is,
 15 you know, this isn't statute now. The E.M.S.
 16 Advisory Council is -- is not a federal program. The
 17 -- I'm sorry, the E.M.S. for Children Advisory
 18 Council is not a federal program. That is a state
 19 program through our statute that has support by our
 20 E.M.S. for children partners at the federal level.
 21 So you know, should something change, it would not,
 22 you know, directly change this because it is in New
 23 York State statute that this committee would convene
 24 and discuss pediatric issues and things like that.
 25 Might affect some of the other things that happen,

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 2 you know, our PEC programs and things of that nature.
 3 But you know, for this group, I think that's
 4 important to -- to understand the importance of your
 5 work and everything as well.
 6 So from our side, you know, we are --
 7 we are busy. No question about that one. You know,
 8 we continue to, you know, be out there doing our
 9 outreach, you know, from the operations investigation
 10 side. We're excited to see the equipment regulations
 11 moving forward. So we had our -- they were out for
 12 public comment, they came back. We had a response to
 13 many public comments related to new equipment
 14 standards. And then we are putting them back out for
 15 public comment again because the number of changes
 16 that were made. Why do I bring it up to this group?
 17 Because there are significant things related to
 18 pediatric equipment that will become part of -- part
 19 of the eight hundred.
 20 Now, a lot of ambulances had that
 21 anyway prior to, but this really codifies it
 22 including pediatric transport devices and things of
 23 that nature that were not required to before be
 24 carried on ambulance that post this will be required
 25 to be carried. So excited to see that happen. Yes,

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 2 thank you. So moving that forward. We also have a
 3 number of regulatory packets that are in the process
 4 including some system and agency performance
 5 standards as well as blood is in the process. So,
 6 you know, pre-hospital E.M.S., both air and ground
 7 being able to carry pre-hospital blood and what does
 8 that mean, and how does that work, and things of that
 9 nature. So a number of different things. You're
 10 going to see a lot of regulatory things come forward
 11 in -- in the future, and -- and we're excited to see
 12 that and move those things forward.
 13 The -- sorry, there's something
 14 beeping in my house and I'm not sure what it is. So
 15 the out -- outside of that, you know, some of the
 16 bigger changes just on our side. You know, we are
 17 moving from a bureau to a division or we have made
 18 the move from bureau to a division. What does that
 19 mean? It means we're going to become the division of
 20 state E.M.S. and then we'll have three bureaus
 21 underneath us, the Bureau of E.M.S. Administration,
 22 the Bureau of E.M.S. Surveillance and Compliance, and
 23 the Bureau of Emergency -- E.M.S. Emergency
 24 Management. We're excited to continue to grow as --
 25 as a division, to hire more staff, to do more things,

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 2 and hopefully, again, do more things on the pediatric
 3 side as well.
 4 And, you know, with that, we are
 5 continuing to hire. Like Amy said, we're in
 6 interview process right now still for our E.M.S. for
 7 children's position. We're hiring a number of data
 8 positions. We're hiring a number of other positions
 9 to move forward. And so, again, lots of growth going
 10 on. Excited to see that growth and, you know, more
 11 to come and more information to come at, you know,
 12 the February meeting for SEMAC and SEMSCO. And then
 13 we also did make it into the budget this year, so
 14 E.M.S. was in the budget. There's some, you know,
 15 pretty significant things that are in there,
 16 including making E.M.S. an essential service which
 17 was proposed by the governor. And some other things
 18 that will, again, align with, you know, our desires
 19 on pediatric care and -- and, you know, bringing
 20 forth, you know, some more innovation related to
 21 pediatric care throughout the state. So happy to
 22 take any comments or questions, but I think I'll
 23 leave it at that for right now. All right. You're
 24 on mute, Ryan.
 25 **MR. COOPER:** Do you think it would be

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 2 -- do think it would be possible to, you know, share
 3 with the group the sections of the budget that --
 4 that specifically, you know, address pediatrics?
 5 **MR. GREENBERG:** Absolutely.
 6 **MR. COOPER:** So -- now, but via some
 7 sort of, you know -- you know, electronic
 8 communication.
 9 **MR. GREENBERG:** Yeah. And you won't
 10 find anything in there that says the word pediatrics.
 11 It's more just as it strengthens the system, it will
 12 strengthen the pediatric care that we provide as
 13 well. But it is part R as in rain or -- or Ryan.
 14 Part R, is the part of the budget this year that is
 15 for EVAC.
 16 **MR. COOPER:** It's definitely R for --
 17 definitely R for Ryan, no question.
 18 **MR. GREENBERG:** There you go. So that
 19 is -- that's out there and yeah, we're absolutely
 20 happy to share that. There's two other sections in
 21 there too that have some smaller stuff. We'll share
 22 that with everybody just so you have the awareness
 23 for it.
 24 **MR. COOPER:** Thank you so much, Ryan.
 25 **MR. GREENBERG:** Thank you.

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 2 **MR. COOPER:** Any questions for Ryan?
 3 All right. Well, thank you so much. We are
 4 rocketing along on this agenda today and I'd note
 5 that we have probably the best attendance we've had
 6 in quite a while, and we're very grateful for that to
 7 all of you who are attending. And we will be
 8 respectful of your time. So let's move on to old
 9 business. And next up is, of course, our dear friend
 10 and business partner, Sharon Chiumento, who has an
 11 update for us on the Pediatric Agitation Protocol
 12 Education work group. I hope we will learn that
 13 there's been a little bit more video activity, but
 14 Sharon, take it away.
 15 **MS. CHIUMENTO:** Well, unfortunately,
 16 we've not been able to have a meeting. I've tried to
 17 do that a couple of times, but we're not able to get
 18 people together to -- to have a -- a meeting. But I
 19 have had some communications with Chief Pataki. The
 20 -- I -- he was not aware of any additional videos
 21 having been done. I know that he had offered to work
 22 with Vera Feuer and Matt Harris at the last meeting,
 23 but I don't know whether anything along those lines
 24 has occurred and -- and whether anything was done in
 25 that area. Amy, do we have the video that was done

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 2 to show today?
 3 **MS. EISENHAUER:** We do not. It was my
 4 understanding that we were going to wait until they
 5 were all kind of --
 6 **MS. CHIUMENTO:** Okay.
 7 **MS. EISENHAUER:** -- ready, so that we
 8 only had to put them through once.
 9 **MS. CHIUMENTO:** Okay. No problem. I
 10 just -- I just didn't -- wasn't sure what -- which
 11 way we had gone with that. The other thing I have
 12 done is I take -- took the outline that I had
 13 developed a while back and I've started to develop
 14 the PowerPoint. So as the videos are done, they are
 15 -- they will be incorporated within the PowerPoint as
 16 well as hopefully, some directly related -- maybe a
 17 slide or two directly related to the -- to each
 18 PowerPoint with points that were made in the
 19 PowerPoint or with additional concepts that should be
 20 considered. So -- so we're -- we're at least moving
 21 forward on that component, as they say. I don't have
 22 any further information about the videos reduction
 23 themselves.
 24 **MR. COOPER:** Sharon, what can we do to
 25 help you and your committee move this along? It's --

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 2 it's -- you know, we were very heartened that last
 3 time that the video was -- for the first video was
 4 completed. But as you've noted, there are two more
 5 that need to -- need to be produced and we're sort of
 6 on hold with getting approval through the E.V.C.
 7 process, you know, until all three are done. Is
 8 there anything we can do to help you with this? I
 9 don't know if Chief Pataki is online today or not.
 10 **MS. CHIUMENTO:** He's out of -- out of
 11 the country, so he's not -- he was not going to be
 12 available for today.
 13 **MR. COOPER:** Got it.
 14 **MS. CHIUMENTO:** I don't know Matt --
 15 Matt or Vera, do you have any -- any progress that
 16 you can report on?
 17 **DR. HARRIS:** No. I don't think --
 18 Vera, I can't speak for you, but I -- I haven't heard
 19 from the Chief. I think that there --
 20 **MS. VERA:** No, I haven't either.
 21 **DR. HARRIS:** -- there -- there is a
 22 studio that we have access to that can help do the
 23 physical taping and editing, and they've agreed to do
 24 that. And the turn around very -- is very, very
 25 quick on those, usually within a couple of weeks. I

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 2 think if the content's done and we have the people to
 3 do it. I think we can definitely facilitate it.
 4 **MS. CHIUMENTO:** Great. Yeah, I think
 5 --
 6 **MR. COOPER:** Sure thing.
 7 **MS. CHIUMENTO:** -- you could just, you
 8 know, maybe reach out to Chief Pataki because I think
 9 he was waiting to hear from you, so I think it might
 10 just be a communication issue here. And, of course,
 11 with the holidays and everything, it's kind of -- I
 12 am sure it slowed things down.
 13 **DR. HARRIS:** I'll reach out to him
 14 now.
 15 **MS. CHIUMENTO:** Thank you.
 16 **MR. COOPER:** Yes, thank you. Let's --
 17 let's get this back on track because we really need
 18 to get this finished up. It's been too long. Okay.
 19 Any questions for Sharon? Hearing none. Well, sadly,
 20 I learned just a few days ago that Dr. Van der Jagt
 21 was not going to be with us and just before the
 22 meeting that Dr. Conway would not be able to be with
 23 us. So we have no reports on procedural sedation
 24 work group, nor on the pediatric care standards work
 25 group. So we will have to wait until May for those.

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 2 So we are now one hour ahead of time, believe it or
 3 not. And Marilyn Kacica, are you in a position to be
 4 able to present the Title Five stuff that you wanted
 5 to bring forward?
 6 **MS. KACICA:** I think actually Dr.
 7 Siegenthaler wanted to have that opportunity.
 8 **MR. COOPER:** Okay.
 9 **MS. KACICA:** I think we had given her
 10 the time of two, but I'll message her. But may- --
 11 maybe we could like move on and then we could track
 12 back to it.
 13 **MR. COOPER:** Sure. Sure, of course.
 14 Amy, go ahead.
 15 **MS. EISENHAUER:** Dr. Cooper, so Dr.
 16 Harris had something that he wanted to discuss under
 17 new business. But this was already in process, so I
 18 told him just to bring it up under this stitch --
 19 **MR. COOPER:** That would be fine, sure.
 20 **MS. EISENHAUER:** -- and maybe we could
 21 do that. Yeah.
 22 **MR. COOPER:** That would be fine, sure.
 23 **DR. HARRIS:** Thank you, both. Thanks
 24 Dr. Cooper. Happy to be a space filler -- while we
 25 find the report that's -- that's pending. I don't

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 2 know if Ryan wants to speak to this or -- or Amy, but
 3 I think there's a couple of opportunities that are
 4 coming up with some data that's going to be presented
 5 at SEMAC that I think has some relevance. And this
 6 is very much fed by some data that was presented at
 7 the National Association of the E.M.S. physicians
 8 related to pediatric airway management, pediatric
 9 cardiac arrest. So I wanted to put a feeler out to
 10 this group on two topics, and then I will submit for
 11 our next meeting, Amy, a formal -- this document for
 12 formal review to come out of this group with the
 13 intent of making recommendations for collaborative
 14 changes to the collaborative protocols on both of
 15 these topics.
 16 So the first of which -- and -- and
 17 those who are more knowledgeable about this, please
 18 keep me honest here, is that I believe there is going
 19 to be some presentation at the upcoming SEMAC meeting
 20 on the B.L.S. i-gel program, which has been
 21 predominantly an adult i-gel program in the Hudson
 22 Valley and in Long Island and other places. Which
 23 looks -- for those who are not aware, is a
 24 supraglottic airway device in the hands of B.L.S.
 25 providers with the idea that there's a body of

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 2 evidence certainly in the adult literature and -- and
 3 also on previous pediatric literature for higher
 4 rates of first pass success rate and lower rates of
 5 complication. And again, those are who more
 6 knowledgeable than I can speak to this, but my
 7 understanding is that the B.L.S. data coming out of
 8 Hudson Valley -- Hudson region rather and from Long
 9 Island, are going to end up showing a very successful
 10 pilot program for B.L.S.
 11 I know there's been some discussion
 12 from our colleagues on the adult side to make this a
 13 proposal for statewide B.L.S. implementation of i-
 14 gels. So I wanted to -- to bring this up in the
 15 context that, you know, there are two things that I
 16 think will feed airway management guidelines in the
 17 state. And, obviously, those guidelines will feed
 18 any education that comes out of this group, and that
 19 is two things. One is for those who are not aware,
 20 there is an active enrollment in this study called
 21 P.D. part which Buffalo and others are participating
 22 in. Northwell will be participating in moving
 23 forward, as well as some other agencies in the city.
 24 P.D. part is a -- a two-phased PECARN trial which is
 25 pairing supraglottic airway devices in the hands of

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 2 A.L.S. providers against bag-valve mask ventilation
 3 in the goal of getting somewhere in the ballpark of
 4 three thousand patients in their prospective study.
 5 The winner of that outcome, meaning
 6 those with better out -- in clinical outcomes, will
 7 then be paired against a cohort of patients who are,
 8 again, whether it's i-gel, which is the likely
 9 winner, or B.V.M. versus endotracheal intubations.
 10 The goal is somewhere in the ballpark of six thousand
 11 enrolled patients over five years. My understanding
 12 is that this started in July and they already have
 13 about four hundred patients enrolled, so it does look
 14 like public demand. It is very, very likely based on
 15 prior data that i-gel will be or supraglottic devices
 16 in general i-gel will be -- be the definitive winner,
 17 if you will, for airway devices. Certainly, in the
 18 hands of A.L.S. providers and likely in the hands of
 19 B.L.S. providers for pediatric airway management.
 20 I'm going to guess for all comers, pediatric, cardiac
 21 arrest, seizure, asthma, et cetera, for kids.
 22 So on the one hand, if we want to wait
 23 five more years, I think we'll have robust data to
 24 support, you know, in -- in the largest prospective
 25 study the use of supraglottic airway devices in kids.

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 2 I think that there is sufficient data based on prior
 3 studies by weighing in others by data as presented at
 4 N.A.S.P., which I'll submit for Amy's consideration
 5 for the next meeting so people can review on their
 6 own through our formal process. That when the i-gel
 7 comes up for the collaborative protocols in New York
 8 at the next SEMAC meeting, I think it is a reasonable
 9 thing for us to advocate that it'd be extended to
 10 pediatric patients. I think with appropriate
 11 education. This is something that is a muscle memory
 12 that does not require a unique knowledge of
 13 pediatrics. It is a -- it is a -- I think well-
 14 vetted both in the pre-hospital and in the in-
 15 hospital setting. So I would just like to solicit
 16 feedback from those on this call. There's general
 17 gestalt on putting together an -- an amendment to
 18 what I know is coming on the B.L.S. i-gel side for
 19 the adult airway management program. So with that,
 20 I'll pause before diving into the next topic, but I
 21 would appreciate the feedback of those on this call.
 22 **MR. COOPER:** Matt, I think it would be
 23 helpful if you were able to circulate among the --
 24 the membership of the committee any scientific
 25 literature that's available in terms of use of

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 2 pediatric i-gel. I think as we all recognize, there
 3 are various sizes of the -- of the device that --
 4 that, you know, will need to be employed and, you
 5 know, the -- the ages for which they are available
 6 and how to size them and so on. It sounds like a
 7 simple thing but, you know, it may not be quite so
 8 simple as -- you know, as -- as we would -- we might
 9 at first think. You know, and so I think some pretty
 10 good data on that from -- you know, from various
 11 appropriate sources, most likely the Prehospital
 12 Emergency Care Journal, would be very helpful. Some
 13 of it may not be available yet in print. It may be
 14 available only in abstract form. I don't -- I -- I
 15 was unable to make the meeting this year at the last
 16 minute. So I'm not in a position to know quite as
 17 much of the latest and greatest as I'm sure you do.
 18 But I think any -- any -- any of that information
 19 that you have, I think would be very good to share
 20 with the committee. So, you know, we're in a
 21 position to offer, you know, an educated view --
 22 **DR. HARRIS:** Happy to do so.
 23 **MR. COOPER:** -- and -- and that's a
 24 response to your question.
 25 **DR. HARRIS:** Happy to do so.

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 2 **MR. COOPER:** Any other questions for
 3 Matt?
 4 **MS. DORSETT:** I just have that --?
 5 **MR. COOPER:** Is that --
 6 **MS. DORSETT:** Hi, Matt.
 7 **MR. COOPER:** -- is that -- is that
 8 Maia? Yeah, Maia, please. Yeah, go ahead.
 9 **MS. DORSETT:** I just have a comment
 10 which is I totally agree with Matt. And I think that
 11 somehow separating children out from the expanded
 12 scope of practice around i-gel continues -- sorry,
 13 got a phone call all of a sudden. Somehow separates
 14 children out from everything else. And I think that
 15 there is a lot of data to support that i-gel is
 16 easier than bag mask ventilation in particular,
 17 actually in everybody. I think that thinking about
 18 how you integrate it, the one thing that's really
 19 different for pediatrics is not the sizes because
 20 there's lots of things that are different, right?
 21 They have to size a mask in a pediatric patient.
 22 It's fixation of the i-gel with downward pressure and
 23 how to do that properly. But that's been well-
 24 developed in numerous systems who have implemented
 25 the i-gel in pediatrics in an A.L.S. system, and I

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 2 think would be easy to teach people at the B.L.S.
 3 level on how to do that. And so I would
 4 wholeheartedly support expanding the scope of
 5 practice for B.L.S. to use a pediatric i-gel because
 6 the technique of placement is not different. It's
 7 the -- or the verification, it's the securing of the
 8 device.
 9 **DR. HARRIS:** Well, I think, Maia, you
 10 did point out just as C.P.M. scans up, but you did
 11 point out an important component of the B.L.S. side
 12 of this. Is that -- there a requirement in the pilot
 13 for end-tidal CO2 which would be the same for PEDS.
 14 I think that, you know, where we'd have to just kind
 15 of terse this out. Again, I don't know this off the
 16 top of my head as whether they're same and in line
 17 end-tidal CO2 would apply for neonatal supraglottic.
 18 So I think take Art's point into Maia's expertise
 19 here, there's a little bit more digging that has to
 20 be done and I'll include some of that information.
 21 And Amy, if it's okay, I'll circulate some of the
 22 studies in one pages through you to this committee
 23 for feedback.
 24 **MS. DORSETT:** And -- and when I think
 25 about like neonatal --

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 2 **MR. COOPER:** Thank you. Go ahead,
 3 Maia.
 4 **MS. DORSETT:** -- yeah, when I think
 5 about this neonatal supraglottic issue --
 6 **MR. COOPER:** Go ahead, Maia.
 7 **MS. DORSETT:** -- it's just -- just
 8 because N.R.P. doesn't rapidly, like regularly
 9 incorporate waveform capnography does not mean that
 10 it's not the right thing to do. And thinking about
 11 how do we expand use of waveform capnography for the
 12 verification of effective ventilation for all
 13 patients, I think is a -- is a much bigger deal. One
 14 of the places where we have fallouts, one of the
 15 measures we track regionally is the use of waveform
 16 capnography with all B.L.S. ventilation. And we like
 17 preload capnography on all our bags, and one of our
 18 fallouts is pediatric patients. And I see that as
 19 pediatric patients getting less good care. And so I
 20 think around like equity and care for pediatric
 21 patients. I think expanding waveform capnography,
 22 the expectations of its use can only make care safer.
 23 **DR. HARRIS:** Great.
 24 **MS. DORSETT:** Thank you.
 25 **MR. COOPER:** Thank you, Maia. Pam?

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 2 **MS. FEUER:** Hi. Thanks, Maia. I
 3 fully support the expansion of waveform capnography.
 4 Anyone who sits with me on any E.R., I.C.U. meetings,
 5 that's kind of my number one discussion. What I
 6 wanted to ask you guys, so you've explained some of
 7 the downsides or difficulties in securing this
 8 device. I've never had my hands on it or anything.
 9 Have either of you experienced placing it? I'm
 10 looking forward to getting more information from you.
 11 So, you know, I'd like to know how you compare these
 12 devices to either if you have put in an L.M.A. or,
 13 you know, bag-valve mask. Uh-huh.
 14 **DR. HARRIS:** Yeah. I mean, I could
 15 say here our group is now -- if you're -- if you come
 16 in and cardiac arrest with a B.L.S. crew, we
 17 exclusively put in supraglottic devices. And so
 18 we've sort of gone to two or three rounds of C.P.R.
 19 here unless we have, you know, anesthesiologist at
 20 the bedside who can do endotracheal intubation
 21 without interruption to C.P.R. So that's something
 22 that Pam, we've recently adopted. I think Josh,
 23 again, our numbers are real -- thankfully very, very
 24 low.
 25 **MS. FEUER:** Yeah, they're low. Uh-

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 2 huh.
 3 **DR. HARRIS:** Well, what -- what I'll
 4 tell you is that it -- it -- you know, and I grew up
 5 as a medic using L.M.A.s and, you know, I -- I -- I
 6 interestingly, Maia, like I find that yes, the i-gel
 7 get -- has a little pop. But the L.M.A.s were just
 8 so much less reliable back in the day. And I think
 9 that the i-gels have become -- I hate using the term
 10 standard of care, but considering how ubiquitous that
 11 I feel that everyone has become much more comfortable
 12 with them, Pam. So, yeah, I mean, I think Maia's
 13 point is that with the old L.M.A.s, you'd insert
 14 them, you'd inflate them, you knew they were going to
 15 pop up. With the i-gels as they would ease and they
 16 start to get bigger, they can get displaced.
 17 I've never actually had one displaced,
 18 but again, the end of our experience is relatively
 19 low. But when you look at the greater experience in
 20 the adult population, I think, again, to Maia's
 21 point, this has been so well educated out there that
 22 whatever we put out there as a recommendation from
 23 this group and certainly into a collaborative
 24 protocol -- I'm going to hone on my colleagues Paul
 25 here. Paul -- Pam is very well. Guidelines --

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 2 guidelines must be coupled with education not be
 3 education of themselves. I think whatever review
 4 will have to come with robust education and this
 5 would be a great body for that to arise out of
 6 especially given that we have several intensivists on
 7 this call on a regular basis. So between, you know,
 8 Doug and Pam and Elise and others, I think we can
 9 really put out some robust education.
 10 **MR. COOPER:** Maia, did you have more
 11 to say? Your hand is still up.
 12 **MS. DORSETT:** Yes, I did. I was -- I
 13 was going to say that we implemented it. It's
 14 actually easy to teach. We don't have a huge end but
 15 in places and the ones that it's actually been used,
 16 it's been successful. And if we compare that even
 17 though a very small N, we have fail -- have had, when
 18 I look at the capnography waveform of failed mask
 19 ventilation in pediatric patients who had bad
 20 outcomes. And so I think that the N is not large,
 21 but the opportunity is great. As far as education,
 22 because we've implemented it across multiple agencies
 23 in our region, we have education that's available
 24 that we would be happy to share.
 25 **DR. HARRIS:** Yeah.

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 2 **MR. COOPER:** Thank you, Maia. And
 3 Matt just one -- one comment from, you know -- oh,
 4 I'm sorry. Mark, did you have a comment?
 5 **DR. HARRIS:** I -- I just want to echo
 6 everything that's being said. Different -- different
 7 E.M.S. agencies up in like the Westchester,
 8 Washington Heights area where we service, have also
 9 been migrating towards the i-gel. And the education
 10 and implementation -- and -- and it's exactly the
 11 same as everybody else. Our N is low, but we're
 12 seeing like an increased use of frequency and success
 13 rate here, just anecdotally. We're evaluating this
 14 data right now, and we hope to put it out once we
 15 reach a number that makes sense. But I -- I just
 16 want to champion this effort and say that I -- I
 17 think that for pre-hospital, out of hospital cardiac
 18 arrest, like it -- this, I think my personal opinion
 19 is that this is a viable option for airway placement.
 20 **MR. COOPER:** Thank you, Mark. I just
 21 want to also note that Ms. Bombard commented in the
 22 chat her wholehearted support for waveform techno --
 23 capnography as the appropriate technique to -- to
 24 confirm airway placement. As -- speaking as, you
 25 know, as a dinosaur here, I -- I just want to remark

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 2 that -- that while i-gel will -- will certainly
 3 improve our ability to manage pediatric airways, I
 4 think on some level it does reflect the fact that our
 5 teaching of bag-valve mask ventilation has not been
 6 perhaps as good as it could be. And, you know,
 7 that's a -- a fundamentally basic skill that -- that
 8 I have never felt as strongly enough emphasized. You
 9 know, i-gel may -- may improve the ability to
 10 ventilate, you know, a child, but certainly, you
 11 know, we need not, you know, as they say, throw the
 12 baby out with the bath water and ignore a B.V.M.
 13 ventilation entirely. So let's focus on that piece
 14 of it as well. And if -- if an educational program
 15 is developed, I would hope that it would include an
 16 emphasis on -- on B.V.M. as well as on i-gel
 17 placement and ventilation via that device. Any other
 18 comments on this? Okay. Matt, onto -- onto issue
 19 two.
 20 **MR. GREENBERG:** Sorry, Dr. Cooper,
 21 just one thing on this one. And I--
 22 **MR. COOPER:** Oh, Ryan, go ahead.
 23 Sorry.
 24 **MR. GREENBERG:** It's come up in some
 25 discussions but Maia particularly hearing from you,

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 2 you know, if it's really starting to become more and
 3 more the go-to. Probably further emphasizing that on
 4 the E.M.S. side statewide that, you know, this is an
 5 acceptable outcome. I think, you know, there's
 6 obviously a lot of E.M.S. providers, particularly at
 7 the A.L.S. level. They're not doing a lot of, you
 8 know, pre-hospital cardiac arrest, thank God. But I
 9 think the more that they can be comfortable with
 10 something and right, like it is probably more
 11 comfortable to place an i-gel something that I do,
 12 you know, on a regular. You know, something most
 13 paramedics will do on a fairly regular basis but now
 14 doing it on a smaller person on a -- on a PEDS would
 15 make it a stressful situation no matter what. A
 16 pediatric cardiac arrest pre-hospital maybe, you
 17 know, a little bit less stressful. You know, and
 18 then we know the stress that comes with intubation
 19 and things like that. So it could be an interesting
 20 conversation having a SEMAC as well of, you know, how
 21 do we express the -- the possible support for, you
 22 know, this being, you know, a -- a first step, you
 23 know, and then get things stabilized and things like
 24 that, if that's what the group feels, obviously.
 25 **MR. COOPER:** Yeah. I -- you know,

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 2 those are all good points, Ryan. Again, I -- I'm
 3 hopeful that Matt and perhaps Maia will be able to
 4 get together the -- you know, the scientific
 5 literature and support of this. That will help us a
 6 lot at the SEMAC level as well as, you know,
 7 statewide and in getting our colleagues on board with
 8 this. Okay. Any other points, questions? Was your
 9 hand up, Maia, or no? No. Okay. Any other points
 10 about -- about this issue? Okay. Matt, issue number
 11 two.
 12 **DR. HARRIS:** Well, actually, Ryan --
 13 Ryan's comment really dovetails really nicely with
 14 this. So the other big topic and, obviously, around
 15 PEDS was actually pediatric out of hospital cardiac
 16 arrest. And, you know, there was some great
 17 presentations that I actually -- are out of
 18 Washington State, and that when you talked to their
 19 A.L.S. leadership who was there, and they had a great
 20 paramedic who presented with their medical director.
 21 I think our friends who are north of the -- you know,
 22 the -- the -- the New York City Westchester region,
 23 their -- their experience is probably very -- likely
 24 very similar to this group in Seattle. That's sort
 25 of like sixty miles north of Seattle and really, you

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 2 know, does not have fifteen children's hospitals to
 3 spit into every once in a while.
 4 And so there have been some
 5 modifications that I want to -- and again, I'll
 6 submit to Amy, that are already publicly available.
 7 So in the -- in the New York City REMAC, as Art
 8 knows, we modified the guidance around pediatric out
 9 of hospital cardiac arrests, oh, I'd say about a year
 10 ago. And with some specific language actually saying
 11 that i-gels or bag-valve masks are a reasonable
 12 alternative to endotracheal intubation for first line
 13 airway management. And so that is another point of -
 14 - that I think is worth bringing to the state level
 15 now. There's, again, I think we -- we are never
 16 going to have a randomized control trial in pediatric
 17 out of hospital cardiac arrests. So see, I observe
 18 (unintelligible) your comment. Thank you.
 19 So I think that the next point is
 20 talking about making modifications, again, at the
 21 SEMAC level to guidance in the collaboratives around
 22 pediatric out of hospital cardiac arrest. There's a
 23 couple of points which, again, I'll -- I think Art,
 24 I'm going to hone you here. And I think you're going
 25 to say the same comment as before as I'll present

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 2 some of the data both from N.M.S.P. and from some
 3 recent publications in pediatric as -- as out of
 4 hospital cardiac arrest. But there's a couple of
 5 things that I'll bring to note. I don't think Susie
 6 Burnett is part of this call, but I think we're all
 7 very familiar with Susie through the CARES work that
 8 she does. She's an active paramedic, and I think
 9 like always fifteen minutes away from finishing her
 10 PhD. And -- and -- and I think, and I say this in
 11 the most complimentary way possible as sort of like
 12 the next book learner and I think she would feel very
 13 proud -- very proud to hear that.
 14 So in New York State -- so out of
 15 hospital cardiac arrest survival with meaningful
 16 neurologic outcome nationally is eight percent,
 17 right? And that's obviously well below the adult
 18 numbers. For good reason, the adult's going into
 19 ventricular arrhythmias, kids have lower rates of
 20 recognition, everything that this call -- folks on
 21 this call know. In New York State with only forty
 22 eight percent of the state participating in CARES,
 23 we're at five percent. So we are substantially below
 24 even the national data which is obviously sort of
 25 sobering to begin with. Susie and I, one of my

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 2 fellows are -- are working on some research here to
 3 better paint -- there -- there are certainly going to
 4 be some pockets of higher rates of success probably
 5 in more urbanized environments where kids are getting
 6 to care quicker. But, you know, I think the take
 7 home message in New York State, we are below the
 8 curve for pediatric out of hospital cardiac arrest
 9 management survival.

10 If you look at some of the data that
 11 was presented this year, and again, this is in -- and
 12 again, this is consistent with some of the studies
 13 out of Polk County in Florida from a couple of years
 14 ago from Pia Tevye and Paul Pepe and others. There
 15 are a couple of things that I -- I'm going to make a
 16 suggestion for modification to the SEMAC
 17 collaborative. But again, your feedback now is -- is
 18 -- is welcome and then as we present the data to you
 19 for the next meeting, I think formal feedback as we -
 20 - as we build a collaborative -- as we revise the
 21 collaborative is important. One, I think we've sort
 22 of hit home is going to be airway management. Two,
 23 is going to be a recommendation that we're safe, a
 24 formal guidance to remain on scene for fifteen to
 25 twenty minutes with medical cardiac arrest.

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 2 There is -- you know, I -- I think as
 3 close as we're going to get to overwhelming
 4 literature on the adult side and a fair amount of
 5 pediatric literature that shows better outcomes when
 6 three to five rounds of -- of high quality PALS is
 7 done on scene. And I can tell you locally and purely
 8 anecdotally with the agencies that I provide
 9 oversight to, we've had better outcomes because we're
 10 -- and we're empowering paramedics to provide the
 11 same level of PALS that we provide in the children's
 12 hospital. But it was -- and Amy certainly said this
 13 is nothing magical about the epinephrine in my ER
 14 except that they receive it. Right? So I will put
 15 forth again in our next meeting, this same set of
 16 recommendations that will mirror what we put together
 17 in New York City for early bag-valve mask versus
 18 supraglottic airway devices, a recommendation for
 19 fifteen to twenty minutes of on scene resuscitation
 20 where safe, which is going to require a ton of
 21 education, and I think emotional support for our
 22 providers who I think are often given a baby in
 23 cardiac arrest and feel the need to go.

24 And I think what's going to be very
 25 interesting and -- and -- and discussion oriented is

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 2 what the role, if any, moving forward of epinephrine
 3 will be. And there's some -- I think the new PALS
 4 guidelines are going to deemphasize. Though Pam, I
 5 certainly would appreciate your guidance here. Are
 6 going to deemphasize epinephrine and add -- and
 7 witness out of hospital cardiac arrest because
 8 there's really no data to support that's coming. But
 9 I think the early non-controversial or minimally
 10 controversial things that I think will have a very
 11 meaningful outcome will be the guidance that comes
 12 from our airway recommendations and guidance for more
 13 on -- more on scene resuscitation prior to transport.
 14 So I just want to again bring that up for the
 15 consideration of this group with the plan of
 16 providing the guidance to Amy for distribution and
 17 some wording for modifications to the SEMAC
 18 protocols. I'll stop there.
 19 **MR. COOPER:** Thank you, Matt. I --
 20 you know, I -- I think without the literature and
 21 without the support of this committee getting any
 22 change in the collaborative protocols is going to be
 23 a pretty heavy lift. Maia?
 24 **MS. DORSETT:** One of the -- I
 25 wholeheartedly support, right? Like staying on scene

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 2 and one of the things we've been working on for
 3 pediatric cardiac arrest in our region. But my
 4 question is, do we think it belongs as a protocol
 5 recommendation or as some other -- I don't know what
 6 the alternative format is because it doesn't -- I
 7 have to double check. But I don't think the adult
 8 protocols say like, you will stay on scene for twenty
 9 minutes.
 10 **MR. COOPER:** Yeah.
 11 **MS. DORSETT:** And then so I feel a
 12 little bit strange sort of protocolizing where the
 13 care is delivered. I mean, it might be like in --
 14 you know, at the end they have some suggestions and
 15 recommendations. But I agree, if I think about like
 16 the big picture of how do we get people empowered to
 17 stay on scene and provide good care for children?
 18 What is the best mechanism to do that? I'm just not
 19 sure a protocol -- recommend protocol change the way
 20 to do that --.
 21 **DR. HARRIS:** I -- I get that, yeah. I
 22 -- I think you've hit the nail on the head. Like, I
 23 think that like, you know -- and the -- the -- this
 24 is -- and, you know, you and -- I think I had this
 25 conversation of like, you know, what is going to

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 2 reach more people? And that's going to be education,
 3 right? So like, I think -- I think I'd emailed you a
 4 couple of weeks ago about this and my failure to
 5 follow-up. And I think one of the things that -- and
 6 maybe this is -- and I'll defer to Art and Amy, but I
 7 think one of the things that we can decide as a
 8 committee to move forward is that if -- if we -- if
 9 we agree on the body of evidence, which we can
 10 discuss in the next meeting after it's attributed --
 11 and even in the absence of any formal changes to
 12 guidelines, but maybe in those bullets at the bottom,
 13 I do think a -- a large scale educational effort
 14 supported by this group through webinars, through
 15 meetings at the REMCO, the REMAC, et cetera, in a
 16 purely educational fashion is warranted.
 17 I mean, we are -- you know, there are
 18 children not surviving in New York State because of
 19 bad care. And care that could be optimized and I
 20 think is ultimately not bad because of provider, but
 21 because of the discomfort around these incredibly
 22 high acuity, low frequency events and a lot of
 23 mythology around it. And so I think that whether it
 24 ends up in a protocol or to your point maybe more
 25 appropriately in those pearls at the bottom, I do

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 2 think that this might -- this should be the year of
 3 the -- the E.M.S. committee -- E.M.S. for children
 4 committee to say we recognize that we are -- we have
 5 an obligation to educate to help New York City meet
 6 the mark and we can use the CARES data or another
 7 repository to help get there. So I think your point
 8 is very well taken there.
 9 **MS. DORSETT:** And I think as far as
 10 the repository of data, I think you have to take a
 11 few different stabs at it because agencies who are
 12 enrolled in CARES are already going to be more
 13 engaged in sort of quality management around cardiac
 14 arrest. So it's a relatively biased sample. I think
 15 that there are ways, though imperfect, you can use
 16 the state data around this to actually look at the
 17 relative time from on scene to transport for
 18 pediatric cardiac arrest --
 19 **DR. HARRIS:** Agreed. Yeah.
 20 **MS. DORSETT:** -- and time
 21 determination of resuscitation. And I think that's
 22 data that would be actually relatively easy to write
 23 a state report around because it's not something that
 24 people have to put in a free text and --.
 25 **DR. HARRIS:** Yeah, agreed, yeah.

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 2 MS. DORSETT: -- times. But I think
 3 maybe -- I don't know. I don't think E.M.S.C. does
 4 position statements or clinical guidelines or
 5 something. But I think a group of people who are
 6 representing E.M.S.C. making a recommendation to stay
 7 on scene and why, I think that's actually the first
 8 step because it sort of officializes it. There's
 9 lots of things that we've done where people are like,
 10 well, nobody gave me a policy or a guideline that
 11 said that, that said it was okay. And I think people
 12 are uncomfortable with this for a multitude of
 13 reasons. But the first step is them actually not
 14 knowing. It's not just okay. It's better and now we
 15 need to empower you with the tools to actually take
 16 care of these patients and manage families on scene
 17 and the rest of it.
 18 DR. HARRIS: Yeah. And I -- I -- I'll
 19 defer to Art, but I do think -- and Art, correct me
 20 if I'm wrong. I don't -- I think there is precedence
 21 within this group but I think it's before my time for
 22 like a position statement like effort. I mean, I
 23 don't know if we for -- formally called them a
 24 position statement or we just issued guidance. But
 25 that guidance -- but I'll defer to Amy, Ryan or Art,

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 2 you know, from historical perspective about what --
 3 like what the -- we have --.
 4 MR. COOPER: And we have -- we have
 5 issued guidance in the past, few and far between. I
 6 think it's actually before Ryan's and Amy's time, so,
 7 you know. But there's no barrier to our doing that.
 8 We might want to do it in conjunction with SEMAC. We
 9 might want to do it another way. But -- but you
 10 know, I don't -- I don't think -- I don't see a
 11 barrier. This is all good stuff. We need to, you
 12 know, move deliberately based upon the available
 13 science and so on. I -- I would just caution however
 14 that, you know, we don't kind of get into panic mode
 15 because our numbers don't look so good. You know,
 16 there are -- there are -- there are innumerable
 17 reasons why -- why those numbers might not look so
 18 good. It may be that we work much harder to get
 19 patients to the hospital, okay? Whereas in other
 20 venues, people may declare on the scene and the
 21 patient never makes it to the hospital, you know.
 22 You know, there are confounding factors like that.
 23 You know, I find it hard to believe,
 24 you know, that -- that the -- you know, that the
 25 training of our -- of our -- of our pre-hospital

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 2 providers, you know, is -- is so super deficient, you
 3 know, compared to others that, you know, that -- that
 4 our numbers are -- are, you know, not -- not where we
 5 would like them to be. I'm not saying that -- that
 6 the numbers are -- are not correct, don't get me
 7 wrong. And I'm not saying that -- you know, that --
 8 that there's not vast room for improvement. And I'm
 9 also not saying that -- that the look isn't very
 10 good, the optics are not good. But, you know, it's
 11 not entirely clear to me that -- you know, that --
 12 that the issue is that our -- that our pre-hospital
 13 personnel are doing a worse job than anyone else is.
 14 What we do need to do is make sure that they're doing
 15 as good a job as this possible, you know, given that
 16 -- given the circumstances that we have. Maia?
 17 DR. HARRIS: Yeah, I think -- yeah.
 18 MS. DORSETT: Yeah, I was going to say
 19 that I -- I think that's true. So the CARES data
 20 though, right? Takes into account all the patients
 21 who have a pre-hospital cardiac arrest. So whether
 22 or not they're transported to the hospital, we have
 23 that outcome and we also know that termination of
 24 resuscitation rates in the field for pediatric
 25 patients are exceedingly low compared to other --

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 2 other populations that we take care of. I think the
 3 biggest thing is that we can look and we -- if we
 4 look sort of where we are nationally, I don't think
 5 we're bad nationally. But we know that nationally
 6 pediatric cardiac arrest care pre-hospital is
 7 extraordinarily poor compared to the care that we
 8 give adult patients, which is in part because people
 9 are sort of more nervous and so it's complicated.
 10 But there are systems that have --
 11 it's actually not that much more complicated other
 12 than that, right? Like we've made it more complicated
 13 but there's ways to simplify it. But I think also
 14 because we have not -- we sort of somehow said that
 15 children are special and different in some way when
 16 they're not, act like if we just treated them like we
 17 treated our adult patients. We do have good examples
 18 of systems that have been able to turn this around.
 19 So there's systems in Florida that went from saying,
 20 we transport all kids and had two percent survival to
 21 saying we're going to stay on scene and resuscitate
 22 children and having like twenty to thirty percent
 23 survival, which is similar to what they reproduce for
 24 adults.
 25 So and these types of changes in

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 2 E.M.S. systems across the country have reproducibly
 3 led to improved cardiac arrest outcomes for children
 4 across most of the systems that have implemented
 5 them, which I think gives us guidance because there
 6 are people who've gone through the -- the trials and
 7 the failures of how do you implement staying on scene
 8 for pediatric cardiac arrest. And it's a
 9 reproducible way to improve outcomes because
 10 nationally we're at like less than -- you know, we're
 11 like five percent. But we know that you can be
 12 thirty, just like we know that for adult cardiac
 13 arrest if we do what Seattle can do, then we can get
 14 to sixty.

15 **MR. GREENBERG:** Actually in the -- the
 16 collaborative protocols, it kind of does indicate
 17 that, you know, it's -- it's counterintuitive to --
 18 to transport. And it says that, you know,
 19 compressions and moving ambulances pose a significant
 20 danger to providers are less effective and should be
 21 avoided. So I think that the -- the verbiage is
 22 already there, it just might be up to kind of
 23 empowering the -- the paramedics on the scene to
 24 effectively resuscitate before making that decision.
 25 And I think that, like -- just to come down to like

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 2 being comfortable with the situation at hand and
 3 whenever there is a pediatric arrest. I know that
 4 I've, you know, worked quite a few of them and the --
 5 the tension is quite high.

6 And -- and that's why it's -- it's a
 7 very difficult thing to do to terminate resuscitative
 8 efforts in the field when you have family right there
 9 especially with an untimely death. So I don't know
 10 if we're going to necessarily avoid that easily, just
 11 be -- I -- for the pre-hospital people on -- on the
 12 phone or on the -- the call now like that's a --
 13 that's a difficult thing to do. But I've worked them
 14 both while en route and on scene, and working on
 15 scene obviously, you're going to provide better care.
 16 So I think that the -- the verbiage is already there,
 17 just to further instill in the -- in the protocols.

18 **DR. HARRIS:** Just an intre --
 19 interesting historical note. And then, Amy, if I can
 20 share my screen for one second to show a slide, and
 21 you can tell me if that's allowed or not. Okay. I
 22 will send it to you and you can send it out. But the
 23 -- if you -- if you go the -- the study that Maia's
 24 talking about is the Polk County study, and I'm just
 25 going to read since I can't share it. That when they

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 2 looked at their -- it was a before and after study in
 3 2014, where all they did -- they didn't change any
 4 PALS. They just said you should stay on scene for a
 5 minimum of fifteen minutes or three to five rounds of
 6 C.P.R. So in 2012 and 2013, they had P -- 38
 7 pediatric cardiac arrests. Scene time was variable.
 8 They tend -- I think they -- they left within nine
 9 minutes on average. And they had two ROSCs and no
 10 survivors.

11 In 2014 when they implemented their
 12 change, which again, only said fifteen minutes when
 13 safe. They had fifty six cardiac arrests, seventeen
 14 ROSCs and thirteen survivors. So it is not a subtle
 15 or small difference in doing this. And I guess one
 16 other educational po -- points -- two other quick
 17 educational points. What's interesting and Maia can
 18 definitely speak to this more than -- than I can --
 19 than I can, but one of the very interesting things to
 20 come out of the adult termination of resuscitation
 21 guidelines and implementation, and I think this was
 22 shown at the study in Yale from Dave Cohen, is that
 23 when they implemented their termination of
 24 resuscitation guidelines, which by the way just says
 25 you have to be on scene for fifteen minutes before

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 2 you terminate with all the other, you know, caveats,
 3 their ROSCs rates went up, right?

4 So like, it just showed that if you
 5 permit people to stay on scene, whether it's to get
 6 to a termination or because of good care, your ROSC
 7 rates go up. So and Maia, your point is so well
 8 taken that the most dangerous thing we've ever done
 9 in pediatric education is when we -- is when we said
 10 to our providers, children are not little adults
 11 because so much of what they do in resuscitative
 12 science is the muscle memory of this. And I'll --
 13 I'll get off my stool now and I will -- I will submit
 14 this information to Amy for distribution. And I
 15 appreciate the time.

16 **MR. COOPER:** Tiff Bombard had a point
 17 a minute ago, she had her hand raised, but I -- I
 18 know she's still on the call. Tiff, are you -- you -
 19 - you -- you had -- you had a -- a point you wanted
 20 to make.

21 **MS. BOMBARD:** It was made for me, so I
 22 took my hand right back down. All good. Thank you.

23 **MR. COOPER:** Okay. All right. All
 24 right. Well, a lot of food for thought here. You
 25 know, I don't want to at this exact minute to get

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 2 into the issue of, you know, when cardiac arrest
 3 actually occurs. We all -- we all know that the kids
 4 generally get there from respiratory deterioration
 5 rather than cardiac deterioration, you know, and
 6 spending more time on scene with, you know, with good
 7 ventilation and CPR. But for that reason, you know,
 8 may -- may provide a -- you know, a -- a -- a leg up
 9 in terms of the resuscitation. But let's get that
 10 literature shared with everybody and -- and we'll
 11 have a more robust discussion about this next time.
 12 Perhaps, you know, Amy maybe we could organize a --
 13 you know, a -- a call to look at that literature
 14 before the next meeting? I would imagine that -- that
 15 Matt and Maia and Tiff would be particularly
 16 interested in being involved with this. Pam Feuer,
 17 perhaps you too. I don't know if you have time. But
 18 let's -- let's get a look at this literature so we
 19 can -- can have a -- have a robust discussion about
 20 this at the next meeting. Okay. Matt, is that it
 21 for you at the moment?
 22 **DR. HARRIS:** Yeah, I think I've used
 23 my time. Thanks, Art.
 24 **MR. COOPER:** Okay. Okay. All right,
 25 no problem. So I -- I note at this point that Dr.

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 2 Siegenthaler has joined us and Marilyn Kacica had
 3 indicated that Kirsten would be doing the -- would --
 4 would be doing the -- the presentation on the Title
 5 Five stuff. So please take it away.
 6 **MS. SIEGENTHALER:** Good afternoon and
 7 thank you for inviting us to join. My name's Kirsten
 8 Siegenthaler. I am with the New York State
 9 Department of Health and our Office of Public Health,
 10 and I'm the director of the Division of Family
 11 Health. And I'm joined today -- I just want to give
 12 a moment for them to say hello, by Dr. Marilyn Kacica
 13 if she wants to say hello.
 14 **MS. KACICA:** Hi everybody.
 15 **MR. COOPER:** Hi Marilyn.
 16 **MS. SIEGENTHALER:** And Suzanne Swan.
 17 Sue Swan is our director for our Bureau of Child
 18 Health. Sue, do you want to say hello?
 19 **MS. SWAN:** I'm trying to.
 20 **MS. SIEGENTHALER:** Okay. We heard
 21 you.
 22 **MS. SWAN:** Hello.
 23 **MS. SIEGENTHALER:** So we appreciate
 24 you giving us a few moments of your time. It'll be a
 25 -- a little bit of a turn from your prior discussion

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 2 which was, you know, fascinating to listen to. So
 3 appreciate the opportunity to talk more about some of
 4 the public health side of the maternal and child
 5 health work that the Department of Health does. And
 6 I am going to -- oh, thank you, Amy. I'm going to
 7 attempt to share. Are you able to see my PowerPoint
 8 and can you verbally tell --
 9 **MR. COOPER:** We can.
 10 **MS. SIEGENTHALER:** -- because I can't
 11 -- okay.
 12 **MR. COOPER:** Yes.
 13 **MS. SIEGENTHALER:** I can't see -- I
 14 can't see now that I have the PowerPoint on. So
 15 please just sort of ask questions. I'll try to pause
 16 as I go through this. But I just wanted to take this
 17 opportunity to share broadly a little bit more about
 18 what the Department of Health does to support what we
 19 really think of as birth through reproductive age
 20 here at the Department. So the Division of Family
 21 Health is quite large and we have have a pretty broad
 22 portfolio that does span the age group from birth
 23 through reproductive age and sort of cycles right
 24 back through again. I'm not going to go into each
 25 and every single area, but you can see that we have

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 2 child health. And I'll talk a little bit more about
 3 our programming for child's health as well as
 4 children and youth with special healthcare needs.
 5 And for our youngest, newborn hearing and early
 6 intervention. And for our adolescents, we do a lot
 7 to focus on interpersonal relationships preventing or
 8 mitigating sexual violence as well as addressing
 9 issues of mental health. And we have health equity
 10 really that crosses and is embedded in all of the
 11 work that we do. So we're a fairly good-sized
 12 division. We have a total budget that we are
 13 responsible stewards for around nine hundred and
 14 seventy-three million. Of that, we get a hundred and
 15 thirty-three million dollars in federal funding. The
 16 department --
 17 **MS. EISENHAUER:** Siegenthaler.
 18 **MS. SIEGENTHALER:** Yep.
 19 **MS. EISENHAUER:** Sorry to interrupt
 20 you. Your slides are not advancing on the screen.
 21 You just --.
 22 **MS. SIEGENTHALER:** Sorry. Thank you
 23 for letting me know .
 24 **MS. EISENHAUER:** You just still have
 25 the title slide.

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 2 **MS. SIEGENTHALER:** Let me see if I can
 3 change that. I stopped sharing, so you should --
 4 trying to see how to redo the entire screen.
 5 **DR. COOPER:** Amy, do you have the
 6 slides?
 7 **MS. SIEGENTHALER:** It's not -- it's
 8 not --.
 9 **MS. EISENHAUER:** It's not -- I can --
 10 I can share the slides and then --.
 11 **MS. SIEGENTHALER:** Okay. If you
 12 wouldn't mind, yeah. So we don't waste time. We
 13 don't lose time.
 14 **MS. EISENHAUER:** Not at all. Let me
 15 just grab them.
 16 **MS. SIEGENTHALER:** Oh, it says we
 17 can't display your shared content. Make sure you've
 18 allowed permissions and then try again.
 19 **MS. EISENHAUER:** Okay. That helps.
 20 **MS. SIEGENTHALER:** Okay. If you can
 21 share them, I'll start.
 22 **MS. EISENHAUER:** Sure.
 23 **MS. SIEGENTHALER:** It does help if you
 24 can actually see what I'm talking about.
 25 **MS. EISENHAUER:** Well, at first, I --

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 2 I was like, oh, okay. She's just going over things -
 3 -.
 4 **MS. SIEGENTHALER:** No, I was
 5 advancing.
 6 **MS. EISENHAUER:** Oh. All right. Give
 7 me one second and I will share --.
 8 **MS. SIEGENTHALER:** Sure. Technology,
 9 it's our friend.
 10 **MS. EISENHAUER:** Yes. All right. And
 11 then we will do --
 12 **MS. SIEGENTHALER:** Perfect. Yeah,
 13 this is it.
 14 **MS. EISENHAUER:** There we go.
 15 **MS. SIEGENTHALER:** All right. If
 16 you'll go to the first slide.
 17 **MS. EISENHAUER:** Sure.
 18 **MS. SIEGENTHALER:** Great. So here is
 19 a picture that would be much more interesting to look
 20 at, but our -- our portfolio really spans a broad
 21 range from birth through reproductive age. And, you
 22 know, health equity is both overlaid and also
 23 embedded in everything we do. You can see here, as I
 24 was saying earlier, that we have a focus on child
 25 health as well as children and youth with special

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 2 healthcare needs. And for the youngest, we have
 3 early intervention and newborn hearing screening.
 4 And then for our adolescents, we really focus on
 5 interpersonal relationships, sexual health, reducing
 6 or mitigating sexual violence, as well as addressing
 7 mental health concerns. So we can go to the next.
 8 So we're a large division. We're
 9 responsible for nine hundred seventy-three million
 10 dollars total funding. We receive a hundred and
 11 thirty-three million dollars of federal funding of
 12 which the Department of Health manages eighty
 13 million. And then we work with an affiliate that is
 14 called Health Research Incorporated. They're a
 15 501(c)3 that has a memorandum of understanding with
 16 the Department of Health to act as a bonafide agent.
 17 And so among that, federal money is the Title V Block
 18 Grant that I'll actually be spending my time on. But
 19 it is really actually important to understand that
 20 the Title V Block Grant is never meant to be a
 21 standalone. It's actually meant to be embedded with
 22 and to leverage broader funding both at the Federal
 23 and at the state level. And so we do receive
 24 appropriations through the state budget with grants
 25 of about a hundred and thirty million dollars.

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 2 And then we're responsible for a very
 3 large program for infants birth through three called
 4 the Early Intervention Program. And this provides
 5 habilitative services for infants and toddlers who
 6 are -- who are identified as having delays. And
 7 these services include physical therapy, occupational
 8 therapy, speech-language pathology, and special
 9 instruction. And so the -- in addition, we manage
 10 money through Medicaid and through the counties that
 11 collectively result in the full reimbursement for the
 12 program. So you can go to the next slide.
 13 So specifically, among this funding is
 14 something we call the Title V Block Grant. And why
 15 it -- it matters to this group is it actually comes
 16 from the same area of the Federal government where
 17 this children -- Pediatric Emergency Medical Services
 18 funding comes. So we're -- we're funded under the
 19 Maternal and Child Health Bureau in the Health
 20 Resources and Services Administration. And so we
 21 have the same sort of federal oversight, and we have
 22 had it indicated to us at recent events, you know,
 23 that it would be important to reach out to our
 24 Pediatric Emergency Medical Services counterparts and
 25 really try to first share who we are, introduce

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 2 ourselves, orient, and then if there are any ways
 3 that we could think about, you know, partnerships
 4 that -- that that would be something, you know, that
 5 we would be interested in as our state Maternal Child
 6 Health Services Block Grant recipient.

7 So the way that this block grant works
 8 is that every state and jurisdiction gets this money.
 9 It's actually called Title V because it's under Title
 10 V of the Social Security Act at the federal level.
 11 We receive thirty-eight million dollars per year, and
 12 that's based on a formula of the population. So New
 13 York is the fourth most populated state, so we
 14 receive the fourth largest block grant. It does
 15 require that the state match it seventy-five percent.
 16 So for every four dollars we get from the federal
 17 government, the state appropriation has to be matched
 18 three dollars. And we are required to spend thirty
 19 percent of it on preventive and primary care
 20 services, and thirty percent on services for children
 21 and youth with special healthcare needs. We can
 22 spend up to ten percent of our block grant on
 23 administration. And then the other twenty percent
 24 is, you know, sort of at the discretion of the -- the
 25 grantee and how the state priorities, you know, sort

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 2 of dictate, you know, what is needed.

3 And so the way that the Block Grant
 4 thinks about services just to -- you know, kind of
 5 use that word as very vague, is it can be population
 6 health related. In fact, they encourage us to move
 7 away from direct service delivery into more
 8 population health models of care, meaning that we are
 9 actually using the funding to improve the systems of
 10 care as opposed to pay for individual services. And
 11 so we're fortunate in New York because we have such a
 12 robust Medicaid system as well as excellent coverage
 13 especially of our children for insurance. And so we
 14 really do focus our work a lot on policy work, on
 15 convening and other sort of system building
 16 opportunities. So I'll go on to the next slide.

17 So this is just a little bit about the
 18 block grant. I -- I'm a very visual learner and I'm
 19 sure we can share these slides if we haven't already.
 20 I -- I believe maybe they have been as part of this,
 21 but this block grant has actually been around for a
 22 long time. It -- it really was birthed in 1912 as
 23 the Federal Children's Bureau, and that's actually
 24 the year that New Mexico became a state. And so, you
 25 know, we -- we have been around a long time. There

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 2 was a shepherd town or maternity in Infancy Act,
 3 which really then formed a lot of the state level
 4 maternal and child health efforts that ultimately was
 5 repealed be -- because of many reasons. Some of them
 6 were political, people thought it was an overreach of
 7 the government to really get engaged and -- and do
 8 this work of supporting the population as well as
 9 economic because 1929 was also the year of the -- the
 10 stock market crash and the beginning of the
 11 recession.

12 And so in 1935, the -- the Title V of
 13 the Social Security Act was actually put into place.
 14 And there's a picture of Amelia Earhart who actually
 15 made the first transpacific flight, solo transpacific
 16 flight. There is -- Elvis was born, and we were in
 17 the midst of a great dust storm in the middle of the
 18 country. And it wasn't until 1981 that Title V got
 19 turned into a block grant. And block grants are
 20 interesting. There aren't that many of them, but
 21 what they do is they really provide broad
 22 flexibilities for states to meet the needs of their
 23 community. But they have also a lot of challenges to
 24 them because of the broadness and because the state
 25 is quite large and has a lot of needs. And while

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 2 thirty-eight million dollars seems like a lot of
 3 money, it's -- it's not enough to necessarily meet
 4 all of those needs. So we'll go to the next slide
 5 please.

6 So the way that they organize our
 7 grant is into five domains, and so we have to really
 8 be concerned about all of these domains. So the
 9 first one is maternal and women's health, perinatal
 10 and infant health, child health, adolescent health.
 11 And then there's the crosscutting at the bottom of
 12 children and youth with special healthcare needs
 13 because that really crosses from birth through
 14 twenty-one. And then there's this issue of
 15 crosscutting systems building work that you can sort
 16 of overlay on top, which is health equity. But not
 17 limited to that, could be workforce development and
 18 other things that might not be restricted to one
 19 domain.

20 But we have to really be concerned and
 21 think about each of these. Now, the -- the domains
 22 themselves are a bit arbitrary, right? I mean,
 23 where's the delineation between maternal and women's
 24 health from perinatal and infant health, right? Like,
 25 we can't separate the two necessarily in many

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 2 aspects. And then like -- likewise, where is the
 3 delineation of child health and adolescent health, et
 4 cetera? You get -- you get the idea. But globally
 5 they do that just because it's a very large
 6 application of four hundred pages. And we need to --
 7 we need to have some divisions. So you can go to the
 8 next one.

9 So stepping back a little bit, the way
 10 that the actual work that we do is organized is we
 11 have to have a comprehensive needs assessment every
 12 five years. And we're actually in the midst of it
 13 right now, so this is the -- the time of our needs
 14 assessment. So it's another reason I, you know,
 15 wanted to reach out and think with all of you because
 16 now is an excellent time for us to gather information
 17 about what the needs are of the state from our
 18 various stakeholders. From that, we then take the
 19 information and we turn it into program priorities,
 20 which should really be our guideposts for the next
 21 five-year cycle of this grant. And those program
 22 priorities, you know, should really support and align
 23 with those five prior -- those five program domain
 24 areas. We ultimately need strategies that we turn
 25 into performance measures, strategy measures, and

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 2 outcome measures. Anyone who's familiar with the
 3 good logic model kind of gets the sense of, you know,
 4 this visualization is -- is kind of the logic model
 5 for how the grant application is organized. So you
 6 can go to the next slide.

7 So within the needs assessment, like I
 8 said, we're in the midst of it right now. And I'll
 9 focus on the middle, but we're really in the
 10 gathering of information phase right now. Our
 11 application is due in July of 2025. So we're
 12 finishing up our -- our -- you know, our information
 13 gathering, and then we're really going to be moving
 14 in the early spring into analyzing it and truly
 15 coming up with what are the priority areas by our
 16 different domains. The way that we're doing our
 17 needs assessment is really looking at good population
 18 health data. A lot of us are epi -- I'm an
 19 epidemiologist by training. We have epidemiologists
 20 on staff. We have community listening forums. So
 21 we've held -- held a series of listening forums with
 22 different stakeholder groups. We've released web-
 23 based surveys to both our consumers, to people
 24 who've, you know, participated in our programs as
 25 well as the providers who deliver those programs. We

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 2 have our own advisory council. We're doing an
 3 inventory of all of the programs we provide some
 4 funding or leadership to, and then we're looking at
 5 other people's needs assessment. You can go to the
 6 next slide. The next slide. There you go.

7 So I don't have the new priorities,
 8 but these are our current ones. I'm not going to
 9 read them all. But none will be surprising to you,
 10 right? Healthcare, right? Access to healthcare is a
 11 priority. Understanding and having awareness, but
 12 also ability to access community services especially
 13 ones that are accessible for families and youth. And
 14 with a focus on communities that are most impacted by
 15 systemic barriers, including racism. Those
 16 communities that have been historically un --
 17 underfunded in the past. Parent -- since we're a
 18 maternal and child health, parenting and family
 19 support's critically important. Now, this was done
 20 before COVID and one of the top findings was this
 21 idea of isolation and wanting to have opportunities
 22 to break down isolation. We -- we can imagine and
 23 are seeing that that isolation has only further been
 24 exacerbated by the pandemic. And this sort of, you
 25 know, more virtual world that we live in, which has

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 2 its benefits like being able to have this meeting,
 3 but also its challenges and being able to be
 4 connected to people. You can go to the next slide.

5 So healthy foods, community and
 6 environmental safety, issues of poverty. Awareness
 7 of resources just is always an issue. How do we --
 8 how do we get the right information to the right
 9 people at the right time when they want it and are
 10 ready for it, right? Housing and then transportation.
 11 So these are the priorities. I don't suspect that
 12 we'll see radically different priorities as we
 13 especially move towards this idea of social
 14 determinants of health more and more, and the issues
 15 that these are the -- the challenges that really
 16 prevent us from being able to access the -- the
 17 things that we need. So we'll go to the next slide.

18 So I'm not going to read every one of
 19 these. And again, we can -- we can get these shared
 20 with you, but for each area we have to have
 21 objectives. And you can go to the next slide. We
 22 have to have strategies, right? And then the next
 23 slide, we have some activities, right? So you know,
 24 these are the activities that we do that really
 25 support maternal and women's health. And since this

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 2 is a pediatric group, we'll -- we'll -- we'll go to
 3 the next slide. And so we have perinatal and infant
 4 health really focus work with our newborn screening
 5 and addressing infant mortality. You can go to the
 6 next slide. We have some broad strategies that we
 7 use that are related to surveillance, social
 8 determinants and then some domain specific strategies
 9 typically as our pattern. If you go to the next one.
 10 So for perinatal and infant health, we
 11 really focus a lot on clinical areas that we can
 12 support such as working with our hospitals to improve
 13 their perinatal care. We have newborn hearing
 14 screening -- newborn blood spot screening. We
 15 support environmental health and lead poison
 16 prevention. We have our early intervention program,
 17 and we work very closely with our colleagues who
 18 support vaccines as well as our Medicaid colleagues.
 19 So you can go to the next slide. For child health,
 20 we really -- because of the priority areas around
 21 healthy foods, you know, being able to get out into
 22 the environment and social cohesion, we focused our
 23 childhood -- child health area on physical activity
 24 and addressing childhood healthiness.
 25 You know, it -- I -- I don't want I --

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 2 we have many debates about B.M.I. and the challenges
 3 of B.M.I. We are very limited in the amount of -- of
 4 federally available data that they'll allow us to
 5 look at. And so B.M.I. is one of the areas that they
 6 have federally available data. It is not our
 7 priority in the sense that we are much more focused
 8 on creating healthy environments and getting
 9 activities -- you know, opportunities for children
 10 both to have access to healthy foods, which is great
 11 for both, you know, their wellbeing and their
 12 physical, you know, wellbeing as well as their mental
 13 health and oral health. So we'll go to the next
 14 slide.
 15 So we have some strategies. We'll go
 16 to the next slide where we actually -- so our big
 17 areas that we work on are school-based health
 18 centers. And so we work with about two hundred and
 19 fifty schools that have clinics in them. And they're
 20 served by about fifty article twenty-eight operators.
 21 And they receive a combination of state and federal
 22 funding for these centers and then for the visits
 23 themselves they billed Medicaid. But we work very
 24 closely with these school-based health centers. And
 25 it's an excellent avenue for providing primary care

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 2 to children in underserved areas where that might be
 3 a real challenge. We also really focus on oral
 4 health and the importance of oral health. We've seen
 5 a lot of children who go now to the emergency room,
 6 for example, for oral healthcare because they're
 7 really lacking from primary care and they -- you
 8 know, the -- the tooth decay advances.
 9 Again, we work with -- to -- and
 10 support vaccines for children both through our
 11 school-based health centers are all vaccine --
 12 vaccination sites, as well as we work with our local
 13 health departments and our partners to really promote
 14 vaccination for children. And then we work closely
 15 with our Medicaid. And so some of the things that
 16 Medicaid has done and is working on, you know,
 17 includes continuous coverage from birth through six
 18 years old, working with them on adverse childhood
 19 experience, screening and trauma-informed care work
 20 that we do as well as, you know, other areas that
 21 I'll get into for children and youth with special
 22 healthcare needs. So we'll go to the next slide.
 23 So for adolescent health, we really do
 24 think about adolescents, both their sort of sexual
 25 health, but also their transition to adulthood

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 2 because that's an area we know is a big challenge for
 3 our adolescents. You can go to the next slide. We
 4 have some strategies, and then our programs is the
 5 next slide. And so here we really work with our
 6 family planning programs. Our school-based health
 7 centers, again, are important areas for reproductive
 8 and development. We have sexual health grants that
 9 really focus on healthy relationship, financial
 10 literacy, and other work to support our adolescents.
 11 We have a center of excellence, and we are developing
 12 a youth advisory group. You can go to the next
 13 slide.
 14 So our children and youth with special
 15 healthcare needs, again, these crossover the age
 16 groups. But children and youth with special
 17 healthcare needs has a really broad definition. So
 18 it's anyone -- any childbirth through twenty-one who
 19 really requires supports beyond what would be
 20 considered typical. So that's it. That's the
 21 definition but, you know, typically we think of
 22 everything from children with asthma, which would be
 23 a much more common sort of special healthcare need to
 24 some of the more significant -- significant medical
 25 issues or developmental delays or including

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 2 intellectual disabilities. And go to the next one.
 3 We have some strategies, and then we have the next
 4 slide as our programs.
 5 So we work with our local health
 6 departments. We give them quite a bit of money to
 7 really serve as our local sort of boots on the
 8 ground, really engaging with their community members.
 9 We'd love to get them more engaged with, you know,
 10 all of the partners, including emergency rooms and
 11 emergency medical services. Because we would, you
 12 know, anticipate children with special healthcare
 13 needs might interact more frequently with -- with
 14 these places. We also fund a center of excellence
 15 because the broad range of children with special
 16 healthcare needs. It is so broad that we need really
 17 to have a resource for our local health departments
 18 so that they can get their questions answered as well
 19 as identify resources to help them when -- if -- when
 20 and if some conditions are relatively rare.
 21 We work with lead poison prevention as
 22 well as treatment if high lead rates are found. We
 23 have a sickle cell navigation program for
 24 adolescents. We work with our -- with five
 25 hemoglobin apathy centers who help individuals with

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 2 sickle cell as they transition from pediatric
 3 medicine into adult care. And then again, Medicaid
 4 initiatives really supporting children and youth with
 5 special healthcare needs. So our children's health
 6 home, for example, we've worked on them on changing
 7 their sickle cell requirements to making it a single
 8 qualifying diagnosis for health home. Again, we've
 9 worked on a number of other initiatives with
 10 Medicaid. So we can go to the next slide, and that's
 11 it.
 12 So that's -- that's in a very high
 13 level what your state Title V program is working on.
 14 You know, I -- I think it would be, you know,
 15 interesting to hear more if there are any
 16 opportunities you thought we could do to help. I
 17 know Dr. Kacica works closely with you on the toolkit
 18 that you've been working on. And we are here too to
 19 facilitate, you know, any emergency response we're
 20 supposed to have. You know, we're a part and Dr.
 21 Kacica has been part of a broader department team
 22 for, you know, health emergency preparedness. But I
 23 just wanted to share with you some of the higher --
 24 kind of at a higher level what we are doing in the
 25 public health arm to support children. So thank you

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 2 again for letting me get on and -- and share rather
 3 rapidly, you know, overview of our portfolio.
 4 **DR. COOPER:** Thank you, Dr.
 5 Siegenthaler. Marilyn Kacica, do you have anything
 6 you want to add at this point to Dr. Siegenthaler's
 7 presentation?
 8 **MS. KACICA:** No, I think she did a
 9 great job. And as she said, you know, we're -- we're
 10 here to be partners. So if you have things that you
 11 want to discuss with us, you think are good ideas,
 12 you want more information about our priorities, how
 13 to get involved, you know, please let us know.
 14 **DR. COOPER:** Okay. Any questions for
 15 Dr. Siegenthaler or Dr. Kacica? I think this is
 16 something we're going to have to take offline and
 17 think about a little bit there. I think there are,
 18 you know, several opportunities for collaboration
 19 here, you know. But, you know, your -- your
 20 portfolio is so vast and so broad, you know, that --
 21 you know, that I think, you know, our part of it
 22 would, you know, be not -- not large. But I guess
 23 the one thing that strikes me, you know, is -- in
 24 hearing your presentation is that -- is that the --
 25 the future plans call for, you know, metrics -- it --

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 2 you know, that -- you know, that -- that are
 3 suggestive of improvement in various health
 4 categories. You know, what I didn't hear, and I'm
 5 not -- this is not a criticism -- what I didn't hear
 6 is how successful you've been in the past in terms of
 7 -- you know, of meeting the metrics you set five
 8 years ago.
 9 **MS. SIEGENTHALER:** Sure, yeah.
 10 **DR. COOPER:** And -- and so on.
 11 **MS. SIEGENTHALER:** Yeah, we'd be
 12 welcome to come -- we'd be welcome to, you know, come
 13 back and talk even a little bit more specifically say
 14 about the child health domain and the work that we've
 15 done. I just -- I kept it, like I said, at a very
 16 high level, knowing that I only had about fifteen
 17 minutes. So but --.
 18 **DR. COOPER:** Yeah, no, that's fine.
 19 **MS. SIEGENTHALER:** Yeah, yeah.
 20 **DR. COOPER:** I'm just -- you -- I'm
 21 just -- you know, my -- my thought process is really,
 22 you know, not -- not meeting any criticism here, but
 23 basically to sort of see the areas in which, you
 24 know, you've been potentially more successful than
 25 others in terms of -- you know, in terms of meeting

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 2 the metrics that you set for yourself or yourselves,
 3 you know, and -- and so on. And, you know, whether -
 4 - whether the -- the therefore the -- the metrics
 5 you're putting forth for the next round are, you
 6 know, frankly, reasonably doable. Right? You know.
 7 **MS. SIEGENTHALER:** Yeah.
 8 **DR. COOPER:** I mean, we live in a --
 9 we live in a -- in an era of, you know, people
 10 wanting to see results and you know, the performance
 11 measures and -- and so on. And -- and you know, I
 12 think, you know, our -- our goal would be to, you
 13 know -- you know, as you say, work mutually to ensure
 14 that metrics on both sides are -- are improving,
 15 right? And -- and the direction we want to see them
 16 go and, you know -- and fast enough too. So --.
 17 **MS. SIEGENTHALER:** Yeah, for sure.
 18 I'll -- I mean, I'll just share, we -- you know, we
 19 struggle in the sense that this is one funding
 20 stream, and we're talking about typically our data,
 21 our population health data, and they're usually
 22 delayed --
 23 **DR. COOPER:** Yeah.
 24 **MS. SIEGENTHALER:** -- by three years.
 25 So it's always a bit of a give and take in relying

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 2 too heavily on some of those outcome measures to kind
 3 of understand where we are. We do like to look at
 4 them. I actually think more importantly, for
 5 strategic reasons, to figure out what are the big
 6 issues that are --
 7 **DR. COOPER:** Sure.
 8 **MS. SIEGENTHALER:** -- are addressing -
 9 - you know, that we need to address that are really
 10 affecting our children, right? And so the issues of
 11 mental health, you know, seeing that as so important.
 12 And so given the intersection of emergency medicine
 13 with mental health and specifically the pediatric
 14 population, that is not an area we are seeing
 15 improving. We're seeing quite the opposite. And so
 16 if we wanted to go from such a broad portfolio to
 17 maybe even thinking about some more specific topic
 18 areas, you know, I -- I think it -- we could
 19 certainly dig in in a number of locations and data
 20 might be a good way to start that conversation.
 21 **DR. COOPER:** I was thinking also
 22 about, you know, the challenge of trying to reduce
 23 childhood obesity, right? You know, I -- I don't --
 24 it seems to me, if anything, it's increasing rather
 25 than decreasing. And -- and, you know, that's

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 2 certainly true in -- in our practice here in the
 3 city. And just wondering if, you know, that's
 4 something that -- you know, that -- that the -- that
 5 the targets that you set for yourselves may be, you
 6 know, pretty optimistic. I don't know. You know,
 7 you would know better than I. But you know, these
 8 are thoughts that -- you know, that -- that I had as
 9 I was listening to your presentation.
 10 But we really do appreciate your
 11 coming and, you know, sharing that the -- the work
 12 that you do. I was stunned, you know, to see the
 13 vastness, you know, and the degree of funding that
 14 you -- that -- that your division has compared with
 15 our own little, you know, project here and the -- you
 16 know, the relative, you know, shall we say, pittance
 17 of funding that we receive from the federal
 18 government, even though it's all part of the same,
 19 you know section of -- of you know, the federal
 20 initiative. I don't know, just scratching my head on
 21 that one. So maybe there -- there are areas in which
 22 we could work together and maybe potentially sort of
 23 broaden our own reach at E.M.S.C. in collaboration
 24 with family health. So --
 25 **MS. SIEGENTHALER:** Yeah.

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 2 **DR. COOPER:** -- any other questions,
 3 comments?
 4 **MS. SIEGENTHALER:** Well, we would
 5 welcome it. We're not far from -- we're -- we're
 6 right here at the Department. Amy knows how to get
 7 in touch with us, so we're happy to join at any
 8 point.
 9 **DR. COOPER:** Great. Thank you so
 10 much. Okay. Thanks for coming and Marilyn, we'll
 11 see you next time of course. And let's move on to
 12 the next item, which is updates from our Department
 13 of Health partners and sister advisory committees,
 14 Bureau of Crisis Emergency Stabilization Initiatives.
 15 Jen Goldman and Alex Cappola, are you with us today?
 16 I don't see Alexa and I don't see Jennifer, so I
 17 guess we will have to wait till next time for a
 18 report from now. Amy, do have any information on --
 19 **MS. EISENHAUER:** Hey.
 20 **DR. COOPER:** -- pardon me?
 21 **MS. EISENHAUER:** Sorry I had to step
 22 away for a moment. So Alexa and Dr. Goldman will be
 23 on after three because I was going by -- yes.
 24 **DR. COOPER:** Okay. So --
 25 **MS. EISENHAUER:** So -- so they will be

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 2 on just after three. Dr. --.
 3 **DR. COOPER:** -- so we'll come back to
 4 them.
 5 **MS. EISENHAUER:** Yes, Dr. Osnaga and
 6 Dr. Efflen reached out and said they don't have a
 7 report for this meeting.
 8 **DR. COOPER:** Okay.
 9 **MS. EISENHAUER:** Yep.
 10 **DR. COOPER:** All right.
 11 **MS. EISENHAUER:** So I think that
 12 brings us down to --
 13 **DR. COOPER:** Peter Diane (phonetic
 14 spelling), or Brian Clemency or Susan -- I thought I
 15 saw Suzanne Burnett on. Is that -- or am I not -- am
 16 I mistaken? I do not see Suzanne Burnett. I don't
 17 see Peter Diane, and I don't see Brian Clemency.
 18 Okay. So no report from them unless you know
 19 differently Amy?
 20 **MS. EISENHAUER:** I do not, but they
 21 may also just be --
 22 **DR. COOPER:** Yeah. Okay.
 23 **MS. EISENHAUER:** We wait.
 24 **DR. COOPER:** Suzanne Stegich, and if I
 25 I'm saying that correctly, I apologize if I

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 2 mispronounced. And Krista Alfonso from Bohi
 3 (phonetic spelling), are you there?
 4 **MS. STEGICH:** It's Suzanne and I'm
 5 here, yep.
 6 **DR. COOPER:** Great.
 7 **MS. STEGICH:** So I'll -- I'll start
 8 and then Chris will follow me with the continuation
 9 of the report.
 10 **DR. COOPER:** No problem.
 11 **MS. STEGICH:** But it's pronounced
 12 Stegich and however you pronounce it is just fine.
 13 **DR. COOPER:** Got you, okay. Thank
 14 you.
 15 **MS. STEGICH:** All right. So under our
 16 child passenger safety the past year we had produced
 17 a video illustrating car seat installation
 18 instructions for limited English speaking and reading
 19 populations using the step one for the Four Steps for
 20 Kids Publication. This year we are in the process of
 21 a new script to produce the next video, which is step
 22 two in the Four Steps for Kids, which is forward
 23 facing car seat install -- installations in that
 24 series. Under our counterfeit car seat, we created a
 25 publication last year on the dangers of purchasing

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 2 and using counterfeit car seats. That publication
 3 will be available online and in print.
 4 This fiscal year, we will have two
 5 safe transportation for all children trainings. The
 6 first of the trainings was already completed, and
 7 that was done November 8th and 9th in Schenectady
 8 County. We will collaborate with subject matter
 9 experts to create a resource on crash dynamics --
 10 crash dynamics, which will include the misuse of car
 11 seats among families, caregivers and family service
 12 providers with special attention on proper
 13 installation and the use of car seats. Doesn't seem
 14 like we can ever get enough of that. There will be a
 15 child restraint system on school buses training
 16 February 19th at the Albany Marriott. And that
 17 training is developed for pupil transportation,
 18 administrators and supervisors along with school bus
 19 drivers and school bus monitors. And for what I
 20 understand, that class is full, which is great.
 21 And then under our Younger Driver
 22 Safety Program, our Driver Education Research and
 23 Innovation Center, which is the free standardized
 24 curriculum for driver education instructors. This
 25 fiscal year, we're planning to hold up to four of

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 2 those training workshops throughout New York State.
 3 These trainings are taught by the members of the New
 4 York State Driver Traffic Safety Education
 5 Association. And finally new, we are working with
 6 the Think Fast Interactive Program to hold five
 7 program sessions throughout New York State high
 8 schools to increase younger driver safety awareness
 9 and behaviors. The program is offered and focused on
 10 high schools that have been recognized in the
 11 vulnerable roadway user areas. Targeted schools were
 12 sent out an invitation, and those invitations went
 13 out to the Rochester, Yonkers, Ramapo, Brownsville
 14 and Albany areas. And five have already been
 15 scheduled, so we are booked for those. And they will
 16 be in -- two of them will be in Yonkers, two will be
 17 in Spring Valley, and one will be -- be in Sovereign.
 18 So we're excited about that new program. And Chris
 19 will follow-up with the rest of our programs.
 20 **MS. ALFONSO:** Thanks.
 21 **MS. STEGICH:** Uh-huh.
 22 **MS. ALFONSO:** Just one quick addition
 23 for myself. So actually was able to meet this
 24 morning with Amy Eisenhauer and other members of --
 25 of the Emergency Medical services and -- and Trauma

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 2 Systems Bureau to discuss what we will be doing to
 3 create a micro mobility publication. And that is
 4 going to be specifically for folks in E.M.S. to
 5 familiarize them with this emerging issue of micro
 6 mobility safety and to discuss things such as helmet
 7 use, force when folks are involved in a crash with a
 8 micro mobility device, and we're going to emphasize
 9 the -- the kinetics of that. And that's all for us.
 10 **MR. ALBERT:** Can I ask a question?
 11 **DR. COOPER:** All right. Thank you so
 12 much. Any questions? Any que- -- I'm sorry. Go
 13 ahead.
 14 **MR. ALBERT:** Out of my ignorance, what
 15 is micro mobility?
 16 **MS. ALFONSO:** That is actually a great
 17 question. So micro mobility is -- is a broader term
 18 that's used for things like e-bikes and e-scooters.
 19 And we've -- we've seen a -- an emerging issue with
 20 that specifically in New York State.
 21 **DR. COOPER:** Yeah. There's a pretty
 22 robust program in micro mobility here in the city,
 23 Kev -- Kevin. You know, the -- we see so many
 24 electric scooter and -- you know, and electric
 25 bicycle injuries here. It's probably -- in the kids

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 2 anyway -- it's probably more than half of our serious
 3 injuries now are coming from these toys, shall we
 4 say. And some of these injuries are pretty serious
 5 so, you know, it's -- it's -- it's a -- it's a
 6 problem. But micro mobility is the term of art, I --
 7 I don't know. If you're hit by one of these things,
 8 it's really not micro mobility, it's macro mobility,
 9 you know. And certain number of our adult
 10 counterparts are suffering with this issue as well,
 11 not just the kids. Any other questions for our
 12 intervention colleagues, that's Ms. Stegich and Ms.
 13 Alfonso?
 14 **MS. EISENHAUER:** I do.
 15 **DR. COOPER:** Okay.
 16 **MS. EISENHAUER:** This is Amy.
 17 **DR. COOPER:** Go ahead.
 18 **MS. EISENHAUER:** First, that might be
 19 interesting to add to the pamphlet some statistics on
 20 how many patients both pediatric and adults, right?
 21 We're seeing, and again, I know that may take some
 22 work because of how things are being documented, and
 23 we'd have to figure that out. But like Dr. Huber
 24 said, they're seeing a large amount of these
 25 patients. If we could qualify how many, that may

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 2 impress upon the people reading the brochures.
 3 **MS. ALFONSO:** Yeah, absolutely. We
 4 can work with our data and epidemiology team for that
 5 for sure.
 6 **MS. EISENHAUER:** Yeah.
 7 **MS. ALFONSO:** Thanks.
 8 **DR. COOPER:** Sounds -- sounds good.
 9 Thank you, Amy. Great point. Marilyn, do you have
 10 anything to add to the -- you know, the -- the Title
 11 V presentation that was done earlier with respect to
 12 your -- your division's activities? I would guess
 13 not, but you are listed on the agenda separately.
 14 Are you still with us? No, you are not still with us.
 15 Okay. So I guess the answer to that is no. Let's
 16 move to Kate Butler as a party and Brielle Phillips
 17 from the Health Emergency Preparedness Central
 18 Office. Guys anything new from you?
 19 **MS. RATIGAN:** Hi, good afternoon.
 20 This is Deanna Ratigan on behalf of the Office of
 21 Health Emergency Preparedness. Just a couple quick
 22 updates that we have. We have -- continues to track
 23 and monitor any grant or funding updates associated
 24 with the current administration change. As others
 25 mentioned earlier, we too have had some standing

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 2 meetings and other contact points with the federal
 3 partners paused. However, the hospital preparedness
 4 program deliverable review and development will
 5 proceed for budget period two recognizing that
 6 continuation guidance will likely be delayed. So any
 7 changes in that, we will share with the group as that
 8 continues.
 9 Additionally, OHEP continues to
 10 facilitate the previously discussed updates and
 11 revisions of the pediatric and obstetric emergency
 12 preparedness toolkit. The current goal is to be
 13 completed in June of this year and sent up the chain
 14 for final approvals. So we will continue to keep,
 15 again, this group updated on that as well. And then
 16 finally, we have recently filled the healthcare
 17 facilities preparedness manager position within OHEP.
 18 That was previously held by Kate Butler as a party
 19 and we filled that with Brielle Phillips, who is on
 20 the line. And I'm going to hand it over to her to
 21 give a brief intro of herself today. Brielle?
 22 **DR. COOPER:** Please, Brielle.
 23 **MS. PHILLIPS:** Hi. My voice is a
 24 little cracky because I have a respiratory illness,
 25 but I am so glad to be here. Some of you may know

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 2 me. I've been with OHEP for several years, and in my
 3 previous role I did emergency preparedness coalition
 4 hospital preparedness specifically for the Capital
 5 District region. And prior to that I was with Green
 6 County Public Health. And so I'm very excited for
 7 this new role and I look forward to continuing the
 8 great work that we do with you all.

9 **DR. COOPER:** Thank you so much.
 10 Welcome. Drew Fried from Long Island region of the
 11 Health Emergency Preparedness Program.

12 **MR. FRIED:** Yeah. Good -- good
 13 afternoon, everyone. Just a couple of things that
 14 we've been doing down here. A lot of this is also
 15 mirrored in our lower Hudson Valley region for the
 16 Marrow main region. We're in our threaten hazard
 17 assessment window meaning we're reviewing what is
 18 generally known as an H.V.A., hazard vulnerability
 19 analysis, except we look a little bit further into
 20 it, the probability and the usual -- some of the
 21 system. You know, we look at things like mortality
 22 and impacts on E.M.F.'s, impacts on E.D. visits,
 23 primary care offices, trauma centers, mental health
 24 impacts. We also look at community impacts, which
 25 might include how these different risks may affect

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 2 utilities, which thus would impact our pediatric
 3 population. We're also looking to drive mental
 4 concern, business continuity, and of course our
 5 access and functional needs.

6 That will be an ongoing project for
 7 the rest of this budget period which does end June
 8 30th. And hopefully we'll be able to provide some
 9 information as we did last year to this group. As
 10 part of this threat and hazard assessment, we're also
 11 now looking at utility disruption, mostly water and
 12 power and how that would interfere with healthcare on
 13 both the hospital and prehospital level. That's an
 14 ongoing work group, and we've met with some of the
 15 water companies to find out about restoration. And
 16 we'll be meeting this quarter and the fourth quarter
 17 with our major electrical companies to find out about
 18 their restoration projects as well. We are still
 19 looking to run a tabletop exercise for our coalition
 20 members on pediatric surge, and then something
 21 hopefully will be completed in the fourth quarter.

22 And lastly, I'd like to invite someone
 23 from this group, particularly Amy, possibly to our
 24 next -- epic or partners call, which includes Long
 25 Island and Hudson Valley to talk a little bit about

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 2 the pediatric readiness program as we did last year.
 3 We continue to partner with this group and E.M.S.C.
 4 in making sure that compliance with any surveys are
 5 done. And also we're looking to help out in getting
 6 the PEC program actually off the ground and maybe a
 7 hundred percent in our region both hospital and
 8 prehospital wise. So we would invite her to that and
 9 I'll talk to you about that, Amy, offline with the
 10 date of the -- of the call. It's actually a call
 11 because it'd be a very large group that we meet with.
 12 Other than that, we continue to work on ongoing -- on
 13 pediatric programs looking at training with our
 14 health training centers through Northwell. And hope
 15 that we can continue to be part of this group as we
 16 move forward. End of report.

17 **DR. COOPER:** Thank you, Drew, very
 18 much. Any questions for Drew Fried? Okay, we're
 19 hearing none. Let's move on to Dave Via- -- David
 20 Violante who chairs the New York State E.M.S.
 21 Council. David?

22 **MR. VIOLANTE:** Hi. Thanks, Dr.
 23 Cooper, and thanks everyone for having me here. This
 24 is my first -- first meeting. And I'd like to, first
 25 of all, thank Dr. McElroy for all the work that he's

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 2 done previously. Ryan talked about a lot of the work
 3 the state council in regs and what's coming up in the
 4 governor's budget. I'm really encouraged to hear
 5 about movement with i-gel and pediatrics and
 6 especially with continuous waveform capnography for
 7 airways and even just in any kind of airway
 8 management. So that's -- that's good work. Dr.
 9 Harris, I put my information in the chat for you. If
 10 you want to reach out, I'm very happy to send you
 11 data from the adult i-gel program that we did here in
 12 the Hudson Valley. The protocols were updated to be
 13 implemented in July and we're continuing to look at
 14 the clinical data coming in from the field and how it
 15 looks across the board. And that's about all I have
 16 for at the moment. Unless you have any questions for
 17 me, I'll have a more extensive report next time for
 18 you.

19 **DR. COOPER:** Any questions for David
 20 Violante? Hearing none. I see that my name is listed
 21 there, but it's actually Kim Wallenstein show. So,
 22 Kim, do you want to report on the recent pediatric
 23 trauma subcommittee meeting at STAC?

24 **MS. WALLENSTEIN:** Sure. Thank you,
 25 Dr. Cooper. And I think our names are both there.

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 2 So we met recently at the State Trauma Advisory
 3 Committee, just recent -- very recently. And in the
 4 pediatric subcommittee, we talked about a -- a few
 5 different things. One being some collaboratives that
 6 we're doing, including on imaging guidelines and
 7 either standardizing them following tracking
 8 compliance through each center. The things that are
 9 more interesting that were sort of new business for
 10 us are two things. One was we had a presentation
 11 from the program manager from Rochester talking about
 12 proposing a motion to require stop the bleed kits and
 13 teaching in public schools. And we're forming a
 14 small group in our interim meeting to draft a motion
 15 to that effect. We talked a little bit about the
 16 main STAC about how that would work and who would
 17 undergo that teaching because some people were
 18 concerned that we were going to propose having the
 19 children taught and stop the bleed. And I think that
 20 we're focusing mainly on teachers.
 21 We talked a little bit about how
 22 currently nurses are not permitted to use some of the
 23 medical parts of those kits, including quick clot.
 24 So I think that we are sort of focusing on teachers
 25 at this point. And so we'll be bringing that motion

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 2 forward at the -- hopefully the next meeting. The
 3 other thing we talked about briefly is tourniquets.
 4 The -- the trauma medical director from Rochester has
 5 seen several patients recently that had negative
 6 outcomes from tourniquets that were left on too long
 7 in transport. We are from Upstate New York where
 8 transport times are -- are very long at times and not
 9 as potentially fast as more down in the city. And so
 10 talking about what E.M.S. needs in terms of guidance
 11 for tourniquets and tourniquet conversions, we're
 12 going to be talking more about that next time and
 13 also involving the other groups. And that was the
 14 main thing.
 15 **DR. COOPER:** Thank you. Thank -- thank
 16 you, Kim. For all -- for all of you who don't know,
 17 Kim is chair of the Pediatric Trauma Subcommittee at
 18 -- at the STAC at the moment. I -- I -- I'm just a
 19 loyal member so --.
 20 **MS. WALLENSTEIN:** And always -- always
 21 value you.
 22 **DR. COOPER:** Thank you. Any questions
 23 for Kim? Okay. Well, hearing none. I did see that -
 24 - that Alexa Cappola had joined us, and so I think we
 25 can jump back up to the Bureau of Crisis Emergency

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 2 and Stabilization Initiatives. I did not see that
 3 Jennifer had been able -- oh, there she is. She did
 4 join us wonderful. So --
 5 **MS. GOLDMAN:** Yeah, I think she's able
 6 to hop on.
 7 **DR. COOPER:** Okay. So Jennifer and
 8 Alexa, please tell us what's going on in -- in your
 9 bureau.
 10 **MS. GOLDMAN:** Sounds great. Well,
 11 thank you so much for having us here today to provide
 12 this brief update. And I can talk a little bit about
 13 the work that I have been doing, but -- but also
 14 others at O.M.H., myself, Alexa, as well as
 15 representatives from Oasis. Dr. Grace Hennessy, and
 16 others have been doing with the SEMSCO E.M.S.
 17 Innovations and Research Subcommittee. We've been
 18 working on developing -- the first step of our
 19 collaboration was to develop a roadmap for the
 20 potential for E.M.S. to drop off to the new crisis
 21 stabilization centers. And I think we were here at a
 22 meeting. Alexa and I at an earlier meeting with this
 23 group to give you a brief overview of what those
 24 crisis stabilization centers are all about or will be
 25 all about.

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 2 And Alexa, after I'm done providing
 3 this -- my portion of the update, Alexa will share
 4 just a little bit more detail about where we're at
 5 with the development of those centers across the
 6 state. But just to say a little bit more about our
 7 collaboration. So we're working with SEMSCO
 8 representatives on the development of this roadmap to
 9 really outline our goal for how to integrate E.M.S.
 10 drop off for these centers and the next step. And so
 11 that -- that document, that roadmap document, you may
 12 have some familiarity with because it was brought
 13 before SEMAC and SEMSCO for review and feedback, and
 14 ultimately approved as an outline of the work we
 15 would plan to do in the year ahead. And so now here
 16 we are getting into the details of it. And we're
 17 working on the development of a model clinical
 18 guidelines document that would outline specifically
 19 we're starting with the intensive crisis
 20 stabilization centers.
 21 And so just for those of you who
 22 either might not have been there for our first update
 23 or certainly it was a while back, there are two --
 24 there are two types of -- of these crisis
 25 stabilization centers. They are community based 24/7

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 2 open access centers that provide mental health and
 3 substance use care to individuals that are seeking it
 4 voluntarily. And there are two different types,
 5 there's the supportive model and the intensive model.
 6 And the -- so the intensive model has more onsite
 7 clinical services. They all -- all centers are
 8 equipped with the knowledge and resources to link
 9 individuals to community-based care. But the
 10 intensive centers have, for example, a -- a
 11 prescriber that's available 24/7 to write
 12 medications. And so we are starting with the
 13 intensive centers in terms of the -- the E.M.S. drop
 14 off guidelines and going through some just general
 15 considerations for E.M.S. when thinking about the
 16 decision of making -- bringing an individual to a
 17 C.S.C. as opposed to -- to an emergency room.
 18 Because that's ultimately the goal.
 19 The goal is really to have another option available
 20 for patients. But certainly, and also for E.M.S.
 21 that can help to support individuals in crisis that
 22 does not necessitate hospital level care.
 23 And so the mono -- model clinical guidelines that
 24 we're developing are somewhat broad, but will include
 25 some -- some specifics such as the importance that

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 2 the individual is seeking the care voluntarily,
 3 certainly that they are medically stable, you know,
 4 within certain parameters. We really want this and
 5 we want these centers to be low barrier. So we're
 6 not trying to create a bunch of exclusionary criteria
 7 here. We're just trying to provide E.M.S. in the
 8 field some guidance for what to consider, who would
 9 be the most appropriate recipient to go to one of
 10 these centers.
 11 And the -- the most important thing I
 12 think about this document is that, ultimately, it's -
 13 - it's just a guideline and that we're understanding
 14 that there's such variability across the state in
 15 terms of resources, in terms of how E.M.S. might
 16 operate, in terms of how the crisis stabilization --
 17 the crisis stabilization centers might be designed.
 18 That ultimately these are guidelines that we hope
 19 then each region or each local -- you know, local
 20 E.M.S. provider and C.S.C. provider can take and then
 21 collaborate together on a shared process for how they
 22 would make referrals or how they'll do drop offs. So
 23 that's just a very brief overview and certainly as we
 24 get closer to having a document, I'd be happy to
 25 share that here for feedback.

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 2 **DR. COOPER:** Great. Thank you. Thank
 3 you, Jen. Is that shareable in draft form at this
 4 time or do you need to do more work on it?
 5 **MS. GOLDMAN:** We need to do a little
 6 bit more work. Our -- our hope was to have some kind
 7 of shareable draft in the next, I would say, month or
 8 two. As -- as can be the case with certainly O.M.H.,
 9 Oasis, government entities, we always need to have
 10 like our council weigh in and things like that. But
 11 --
 12 **DR. COOPER:** Sure.
 13 **MS. GOLDMAN:** -- I think the good news
 14 is there's a lot of alignment in where -- you know,
 15 from -- from the SEMSCO side, from O.M.H. and Oasis.
 16 I think we're all pretty aligned in what's important
 17 to have in there. And so now it's, you know, just
 18 going to get these extra looks and then we can open
 19 it up for additional feedback.
 20 **MS. CAPPOLA:** I'll also add that --
 21 **DR. COOPER:** Yeah. Let me -- let me
 22 just say if I might. I'm sorry, Alexa, just let me
 23 just ask Jen a little bit more about that. I -- you
 24 know, I think as we've discussed in the past two
 25 things, I mean, as a -- as a group, our -- our

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 2 concern is really more focusing on, you know, de-
 3 escalation of techniques rather than -- you know,
 4 rather than medication. And, you know, although
 5 there are those -- we do have the rather, you know,
 6 agitated very large adolescent patient who, you know
 7 -- you know, may end up requiring medication, we --
 8 we hope those circumstances will be pretty rare.
 9 And, you know, so -- you know, I -- I think that's a
 10 main concern of ours, you know, where our -- our --
 11 our, you know, sort of overactive adolescent patients
 12 fit into the mix. But also, you know, sort of a --
 13 on a -- on a smaller scale, literally bodily sized
 14 smaller scale, you know, they're really super, super,
 15 super overactive, you know, school age chi -- kids
 16 who just can't be controlled any other way, you know.
 17 I mean, these kinds of -- kinds of kids don't seem,
 18 at least first blush, the kind of person we'd want to
 19 send to a crisis stabilization center that they'd
 20 probably more directly want to go to an E.P. I -- I
 21 -- I -- I do think that if you haven't thought about
 22 some of these, you know -- you know, issues, special
 23 issues involving kids in your draft that -- that, you
 24 know, we might need to do that just so that there's -
 25 -

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 2 **MS. GOLDMAN:** Yes.
 3 **DR. COOPER:** -- pretty clear guidance
 4 as to, you know, who shouldn't be going to one of
 5 your centers and should rather be going to an E.P.
 6 **MS. GOLDMAN:** Yes. Thank you.
 7 Actually, I'm so glad you mentioned that because
 8 actually what I -- what -- what I did want to add in
 9 was that, well, I don't -- we certainly this
 10 guideline would not -- does not get into much into
 11 agitation management or medications because
 12 essentially -- because there is this voluntary
 13 requirement around individuals only being able to --
 14 **DR. COOPER:** Right.
 15 **MS. GOLDMAN:** -- go there, if they're
 16 voluntary -- voluntarily seeking the treatment. It
 17 automatically ends up discerning between individuals
 18 that would go to the hospital for that kind of, you
 19 know, agitation depending on what intervention
 20 happens in the field. But where we would really like
 21 your partnership, I mean, not only to have eyes in
 22 that regard, but also around -- we have no
 23 familiarity with some of the considerations for the
 24 children and adolescent populations around consent
 25 and voluntary -- and the voluntary nature of them

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 2 choosing to go. And so that is something actually
 3 that before -- before this even would go before any
 4 council's review or anything that we had wanted to be
 5 reaching out to all of our partner child, you know,
 6 experts to be able to give us that feedback and --
 7 and to put language --
 8 **DR. COOPER:** Yeah.
 9 **MS. GOLDMAN:** -- in there around, you
 10 know -- because I think someone that is -- that was
 11 on the E.M.S. Innovations and Research Committee
 12 mentioned that, for example, unaccompanied minors.
 13 There -- there are certain considerations there
 14 around consent and voluntarily choosing. And so
 15 that's definitely an area that we want your input on
 16 and expertise. So I think as you're saying it, I do
 17 think we should probably share an early, you know,
 18 early, early, early draft, which would probably be in
 19 the next couple weeks, with -- with you and your
 20 team, so that we can have you consider all of those
 21 factors.
 22 **DR. COOPER:** Sure. Yeah. I'm also
 23 thinking about the parent who -- you know, who has an
 24 agitated child who does not want to go to the E.P.,
 25 but is willing to go to a crisis center. You know,

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 2 fearing stigma and all the rest of that sort of
 3 thing, you know, but they're in a position to
 4 voluntarily give consent for the child, but the child
 5 may not like it. I -- you know?
 6 **MS. GOLDMAN:** That's right. Yes.
 7 **DR. COOPER:** You know.
 8 **MS. GOLDMAN:** Yeah. These are --
 9 **DR. COOPER:** So --
 10 **MS. GOLDMAN:** -- the complexities that
 11 I think we definitely need to think through for that
 12 child adolescent population.
 13 **DR. COOPER:** Yeah. Okay. Maybe we
 14 should -- we should -- once you get your draft
 15 together, Amy, maybe we should set up a call, you
 16 know, with those of us interested in this subject
 17 from our side and with Jen's team.
 18 **MS. GOLDMAN:** We would like -- we
 19 would really like that.
 20 **DR. COOPER:** Yeah.
 21 **MS. GOLDMAN:** That would be great.
 22 **MS. CAPPOLA:** And we're also
 23 collaborating --.
 24 **DR. COOPER:** Alexa, I didn't mean to
 25 cut you off.

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 2 **MS. CAPPOLA:** No, no, absolutely not.
 3 **DR. COOPER:** I didn't mean cut you off
 4 before, I -- please tell us what you've got.
 5 **MS. CAPPOLA:** Well, I was also just
 6 going to add that we are also collaborating with our
 7 O.M.H. division of Integrated Community Services for
 8 child -- children and families. I know that's a
 9 mouthful. So added into our mix between O.M.H. and
 10 Oasis, we'll be collaborating with Matthew Perkins,
 11 who's the medical director of that division as well
 12 as another program individual from the kid's side.
 13 So once we're ready to have -- we're -- we're in
 14 communication with them now but when we're also ready
 15 to meet with this group, we'll -- we will absolutely
 16 invite them in to have more experts in this -- in
 17 this field.
 18 **DR. COOPER:** Okay, great. So, wow, a
 19 lot of food for thought here, for sure. Any
 20 questions for either Jen or Alexa on this very
 21 interesting and very timely and very, very
 22 challenging subject?
 23 Okay. Hearing -- hearing none. We
 24 are very lucky and honored to -- to have Elise Van
 25 der Jagt join us a little bit later in the day that I

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 2 -- I know he would've liked. But Elise we were
 3 unfortunately finding ourselves having to pass over
 4 your procedural sedation work group report earlier
 5 because you weren't with us yet. But if you have
 6 time to give us a brief, you know, statement of where
 7 you are, where your work group is with that and now
 8 would be the time.
 9 **MR. VANDERJAGT:** Okay. Arthur, can
 10 you hear me okay?
 11 **DR. COOPER:** We can hear you just
 12 fine. Thank you.
 13 **MR. VANDERJAGT:** Okay. Thanks, I am
 14 sitting on --.
 15 **DR. COOPER:** And thanks for joining
 16 us.
 17 **MR. VANDERJAGT:** Yeah, I'm on vacation
 18 actually, as I -- I had told Arthur and Amy. I'm
 19 sitting here in the sunshine in Houston in the
 20 seventies, so it's kind of nice. But I didn't get a
 21 chance --.
 22 **DR. COOPER:** Now, why was that
 23 necessary? It was not necessary to get into that
 24 level of detail, Elise.
 25 **MR. VANDERJAGT:** Well, I just wanted

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 2 to make you all jealous, right? So --.
 3 **DR. COOPER:** And you succeeded -- you
 4 succeeded.
 5 **MR. VANDERJAGT:** Yeah. Thank you.
 6 And I am sorry I had to miss most of it because I
 7 wasn't able to be here for this. But anyway, the
 8 procedural sedation. We have not made any progress
 9 at this point because we had all had vacations since
 10 Dec -- in December, the holidays going on there. Our
 11 next steps really is -- was to create a survey for
 12 emergency departments. For those of you who don't
 13 know this -- this project, this project committee is
 14 looking at how pain and anxiety are -- are taken care
 15 of in emergency departments around the state,
 16 particularly with an emphasis on community hospitals
 17 not tertiary care centers, children's hospitals and
 18 looking predominantly right now, at least, at those
 19 procedures that are most common, which are basically
 20 around I.V. insertions, catheter insertions, things
 21 like that.
 22 So our next step is to create a very
 23 brief survey that we would be able to send out to
 24 E.D. directors and nursing directors of -- of E.D.s,
 25 so that we can get some sense of one, what -- how

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 2 great this issue might be. And then secondly what
 3 could be some easy steps for us to help in those
 4 things. Things like making sure that kids have
 5 topical anesthetics to some of these kinds of things
 6 that they have opportunity for intranasal meds if
 7 necessary for them and how that would go about doing
 8 it. We -- we plan to also use the material that is
 9 on the I.I.C. website or the E.M.S.C. website.
 10 Basically, where there are resources which are --
 11 they get in to pay attention to this as well. But
 12 anyway, right now there's no -- been no further
 13 progress in the last month and a half since we've
 14 really had our last meeting or two -- maybe almost
 15 two months now our -- our last meeting. But our plan
 16 is to move forward with -- with that project in the
 17 next few months and it will be definitely before the
 18 next meeting.
 19 **DR. COOPER:** Thank you so much, Elise.
 20 Any questions for, for Dr. Van der Jagt? For those of
 21 you interested in this subject, I just want to call
 22 everyone's attention to the Society for Pediatric
 23 Sedation Program. There is an online version of
 24 their pediatric sedation course and, you know, so
 25 that those of us who are interested in this subject

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 2 and participate especially meaningfully in this
 3 subject. I invite you to take a look at the website
 4 and think about signing on to the course.
 5 **MR. VANDERJAGT:** And are -- maybe I
 6 could --
 7 **DR. COOPER:** Go ahead, Elise.
 8 **MR. VANDERJAGT:** -- maybe I could just
 9 -- yeah. First of all, thank you for bringing that
 10 up again. Of course, I had spoken to that some -- to
 11 some degree in our last meeting. But the -- the big
 12 picture here also is to really partner, have the
 13 S.P.S., society for pediatric sedation, partner with
 14 E.M.S.C. since both organizations are very interested
 15 in the management of pain and anxiety across the
 16 spectrum of E.M.S.C. And so New York State, it seems
 17 to me, could be developing a prototype for that kind
 18 of partnership, which currently does not exist
 19 nationally, although there are also now efforts done
 20 that are being looked at.
 21 I am on the S.P.S. quality committee
 22 and there are a number of pediatric emergency
 23 physicians who were also on that who were involved
 24 with E.M.S.C. So the idea was that this kind of
 25 project could be a big quality assurance or not

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 2 quality -- quality improvement project for S.P.S.,
 3 but E.M.S.C. is really clearly interested in that
 4 area as well. And of note, there is also that under
 5 the -- the -- the pediatric ready for children survey
 6 that the national organization puts out, there is a
 7 lot of attention given to the availability of
 8 pharmacology and other avenues of assuaging the pain
 9 and discomfort for kids who work specifically in the
 10 E.D. So thanks for bringing that up, Arthur. That
 11 was really helpful.

12 **DR. COOPER:** Sure. Any other
 13 questions for Dr. Van der Jagt? All right. Well, we
 14 have completed our agenda. I am -- and we only were
 15 missing one -- one item due to Dr. Conway's
 16 unfortunate brief illness. We will -- I have more
 17 for you on that next time. But in the meantime, our
 18 next meeting is in May. I believe it is May 5th. Am
 19 I right, Amy?

20 **MS. EISENHAUER:** I believe so. Let me
 21 just look at a calendar and --.

22 **MR. GREENBERG:** Yeah, that sounds
 23 about right.

24 **MS. EISENHAUER:** May 5th. Yes --

25 **DR. COOPER:** And we have a meeting --.

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 2 **MS. EISENHAUER:** -- it's Monday, May
 3 5th, and it will be in Saratoga, more information
 4 will be coming.
 5 **DR. COOPER:** Right, right, right.
 6 Wonderful. Okay. Well, thank you so much, everyone.
 7 Does anybody have anything else that they want to
 8 raise for the -- for the good of the emergency care
 9 of children in New York State? Okay. Well, thank you
 10 all for your attendance and we hope you have a great
 11 rest of your day. Amy, as usual we've got a couple
 12 of things to follow-up on in terms of setting up a
 13 couple of additional calls.

14 **MS. EISENHAUER:** Yeah.

15 **DR. COOPER:** And I really want to
 16 thank everyone for coming and thank our special
 17 guests for all of their reports and -- and so on. So
 18 we will see you in May, okay? Take care everyone --

19 **MS. EISENHAUER:** Thank you, everyone.

20 **DR. COOPER:** -- and --.

21 **MS. EISENHAUER:** We can go off the
 22 record.

23 (The meeting concluded at 3:21 p.m.)
 24
 25

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2 STATE OF NEW YORK

3 I, DANIELLE CHRISTIAN, do hereby certify that the
 4 foregoing was reported by me, in the cause, at the time
 5 and place, as stated in the caption hereto, at Page 1
 6 hereof; that the foregoing typewritten transcription
 7 consisting of pages 1 through 122, is a true record of all
 8 proceedings had at the hearing.

9 IN WITNESS WHEREOF, I have hereunto
 10 subscribed my name, this the 21st day of February, 2025.

11

12 DANIELLE CHRISTIAN, Reporter

13

14

15

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18

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24

25

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